Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 27, 2019	2019_505103_0005	023854-18	Critical Incident System

Licensee/Titulaire de permis

United Counties of Leeds and Grenville
746 County Road 42 P.O Box 100 ATHENS ON K0E 1B0

Long-Term Care Home/Foyer de soins de longue durée

Maple View Lodge
746 County Road, 42 East P.O. Box 100 ATHENS ON K0E 1B0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 14, 15, 19, 20, 2019.

Log #023854-18 (CIS #M554-000008-18)-unexpected resident death.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Dietary Aides, a Registered Practical Nurse (RPN), Registered Nurses (RN), Nutritional Manager (NM), Registered Dietitian (RD), Speech-Language Pathologist (SLP) and the Director of Care.

During the course of the inspection, this inspector reviewed the resident health care record including progress notes, SLP recommendations, dietary assessments and the resident plan of care, and the critical incident submitted by the home.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident.

On an identified date, resident #001 had a choking incident during the dinner meal.

PSW #105 was interviewed and indicated the choking incident occurred during the main course. They stated they were clearing dishes from tables adjacent to resident #001’s table and they knew something was wrong when they looked at resident #001. PSW #105 asked resident #001 if they were alright and the resident raised their hands to their mouth. PSW #105 stated they called to RPN #106 who immediately attended to resident #001.

RPN #106 was interviewed and stated they were standing at their medication cart and could hear a high pitched noise at the same time they heard PSW #105 asking resident #001 if they were choking. RPN #106 stated they ran over to resident #001 and asked if they were choking and the resident indicated yes by nodding their head. RPN #106 stated they then asked the resident what they had been eating and resident #001 pointed to the fruit on their plate.

RPN #106 administered the Heimlich maneuver to resident #001 several times with the assistance of the PSW staff with no effect. RPN #106 stated the resident quickly lost consciousness and cardiopulmonary resuscitation (CPR) was initiated. RN #101 was made aware of the incident and joined RPN #106 in administering CPR including the use of the defibrillator while awaiting the arrival of the paramedics. Resident #001 was transferred to hospital and subsequently died.

Resident #001's plan of care related to eating was reviewed and indicated the following:
-resident has difficulty swallowing and chokes easily,
- provide resident with a regular diet with cut meat, no bread (toast ok),
-soup with beneprotein at lunch and supper; yogurt with beneprotein at lunch and ensure pudding at supper,
-provide supervision with minimal set up or assistance ie. cut food for resident,
-assess and provide appropriate modified textured diet,
-POA signed a waiver for regular fluids; use a special straw that has a valve to hold fluids in the straw and does not need to suck up the straw with so much effort.

PSW #105 stated resident #001 was on a regular diet with meat cut up and stated the cutting up would be done by the dietary staff prior to serving. PSW #105 indicated resident #001 ate independently and did not require any additional foods cut or any additional set up assistance. They recalled resident #001 was eating the tropical fruit plate at the time of the choking incident which included chunks of pineapple, mango and melon, cottage cheese and banana bread. PSW #105 described the fruit as large chunks and a crispy texture. PSW #105 indicated the family had signed something to allow the resident to eat a regular diet. PSW #105 stated they checked the dietary sheets after the incident as they were worried the resident had received the wrong texture of food. According to PSW #105, the dietary sheets indicated "regular" and confirmed there were no additional instructions.

PSW #103 was interviewed and indicated they were in the same dining room as resident #001 at the time of the choking incident. PSW #103 stated they were not in close proximity, but heard PSW #105 asking resident #001 if they were choking and ran to provide assistance. PSW #103 indicated the resident was eating fruit when they choked and described the fruit as the size of a large grape. The PSW indicated they believed the resident was on a regular diet and was to have everything cut up. PSW #103 stated they believed all of resident #001's food was to be cut up prior to being served, but that the fruit did not appear to be cut up. PSW #103 indicated resident #001 had previously choked on other foods.

Dietary Aide #111 was interviewed and indicated they were working on the evening of the incident. They recalled the resident was served the tropical fruit plate. Dietary Aide #111 stated the dietary sheets were used to inform dietary staff about a resident’s type of diet, any likes or dislikes, and any restrictions. Dietary Aide #111 stated if a resident required the dietary staff to cut up any foods it would be indicated on this sheet, otherwise the PSW staff would cut up foods for the resident at the table. Dietary Aide #111 stated they recalled resident #001’s sheet had indicated “regular” with no additional instructions.

PSW #104 was interviewed, stated they were very familiar with resident #001. They indicated the resident was on a regular diet with meat cut up and the meat was cut prior to being served to the resident’s table. PSW #104 stated resident #001 ate independently and did not require any additional foods cut. PSW #104 stated resident #001 would not have been physically capable of cutting their own food due to an overall decline in condition. PSW #104 also indicated they were aware the family had signed something to allow the resident to eat regular food.

Dietary Aide #109 was interviewed and stated they were not working on the evening of this incident. They stated resident #001 was on a regular diet and that all of their foods were required to be cut. Dietary Aide #109 stated they cut all of the foods up for resident #001 prior to them being served. They stated they were familiar with the fruit mixture that was served that evening and described the fruit as large chunks with a crispy/crunchy texture. Dietary Aide #109 indicated the home no longer utilized this type of fruit mixture as there was concern there could be a subsequent choking incident and the current fruit mixture being used was smaller in size and a softer texture.

Nutritional Manager (NM) #110 was interviewed and stated resident #001 was ordered to have a regular diet with meat cut up. NM #110 indicated to their knowledge, resident #001 did not require any additional foods cut (other than meat) and that the entry in the resident care plan, specifically, “cut food for resident”, was inaccurate. They felt this was an automated response that had been checked off in the plan of care in error. This inspector noted that this entry had been present in the resident’s plan of care throughout the resident’s stay in the home.

NM #110 was interviewed in regards to the dietary sheets available in the servery and indicated they are updated weekly to reflect the resident’s diet texture and any specific resident requirements such as cut meats etc. The NM #110 stated previous dietary

sheets are shredded and was therefore unable to comment on what instructions had been on the dietary sheet at the time of the choking incident. NM #110 believed the sheets would have indicated regular diet and to cut meats.

During a review of the resident health care record, this inspector noted that the admission MDS assessment provided to the home by the Community Care Access Centre (CCAC) indicated resident #001 was on a special diet: regular but meats or foods need to be finely cut up and tender.

Registered Dietitian (RD) #102's nutritional assessments were reviewed. The RAP assessment dated January 2018 indicated the resident had requested small portions and no raw vegetables were to be sent. The RAP assessment dated April 2018 indicated resident #001 was agreeable to trying soup with beneprotein at lunch and supper and yogurt with beneprotein at lunch and ensure pudding at supper. This assessment also indicated resident #001's diet was mainly liquid with the exception of a few soft foods. The RAP assessment dated July 2018 stated the resident was responding to the interventions outlined in the care plan and that their clinical assessment had not changed from the last assessment.

Staff interviewed did not have an awareness of these requests or restrictions and lacked a clear understanding of the resident's set up assistance specifically as it related to the cutting up of foods. The licensee failed to ensure the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborated with each other.

As outlined above, a choking incident occurred on an identified date involving resident #001 and the resident subsequently died.

During a review of the resident health care record, a Speech-Language Pathology assessment was reviewed with the following recommendations:
-continue with a regular diet and thickened fluids as tolerated,
-provide a regular diet that is more smooth, even, uniform in texture, ie. easy to chew/swallow,
-don't garnish the plate, patient at risk to choke and/or swallow, ie. grape tomatoes,
-encourage dietary/kitchen to work together for safe and positive outcome with meals,

-monitor the patient for status change, ie. adapt diet as symptoms increase.

Speech-Language Pathologist (SLP) #112 was interviewed and indicated they were very familiar with this resident as they had assessed this resident when they lived at the previous LTC home. They stated they were often in this home assessing other residents and from time to time would be called over by resident #001 in the dining room. SLP #112 was asked about the recommendation that referenced "a regular diet that is more smooth, even, uniform in texture, easy to chew/swallow." SLP #112 indicated that it was important to respect a resident's wishes and to be able to provide a diet that gives them their quality of life, but that is also safe. SLP #112 indicated not all foods considered to be a part of a regular diet are off limits and that it would be important to support a resident in making safe choices, although ultimately the resident always has the right to choose. SLP #112 provided a number of examples of regular foods that were of a consistent texture/shape including mashed potatoes or steamed, tender vegetables cut to a uniform size, avoiding foods with a thick skin, smoother meats like chicken rather than steak/beef that could be tough and of a tougher texture. SLP #112 indicated their recommendations had been made in collaboration with resident #001 and their POA.

NM #110 was interviewed and stated they had seen the SLP recommendations at the time of resident #001's admission to the home, but believed the description of the regular diet by the SLP was the description of a pureed diet. NM #110 stated they were aware resident #001's POA had requested the resident receive a regular diet when the resident resided at the previous LTC home and therefore, a regular diet with meats cut up was ordered. NM #110 indicated they did not contact the SLP to clarify the recommendations at any time until after this inspection was initiated.

Registered Dietitian (RD) #102 was interviewed and indicated they were aware the SLP had completed an assessment one month prior to resident #001 being admitted to the home and had seen the recommendations. RD #102 stated shortly after admission, their POA had asked to sign a waiver such that the resident could receive regular fluids which was contrary to the prior SLP recommendations. RD #102 indicated a subsequent referral for a SLP swallowing test was ordered and the plan was to provide regular fluids until such time the SLP assessment was completed. It was eventually determined that the subsequent SLP assessment was never completed.

RD #102 indicated the resident's diet was based upon the previous LTC home's description of the diet as regular with cut meats. RD #102 indicated, at no time did they consult with the SLP in regards to their recommendations or discuss the specifics of the

recommendations with resident #001 or their POA. RD #102 indicated they had several conversations with resident #001 and their spouse and offered to place the resident on a minced or pureed diet, but this was always declined. RD #102 indicated staff had previously identified resident #001 as having difficulty with some of the menu items and would try to offer a different texture (minced or pureed) which was usually declined. RD #102 indicated that at no time was the home's menu cycle reviewed with the resident or spouse in order to identify regular textured foods that may have be better tolerated or to identify the foods that could increase their risk for choking and be more difficult for the resident to chew/swallow.

NM #110 and RD #102 indicated there were no guidelines provided to any of the direct care staff to assist resident #001 in choosing regular menu items that might mitigate the risk of choking. Nor were any guidelines provided to the direct care staff in the event resident #001 did choose to consume foods that potentially posed a higher threat of choking such as cutting the food into an identified size/shape.

PSW's #103, #104 and #105 and Dietary Aides #109 and #102 all reported they had been advised to offer a minced or pureed texture if the resident was having difficulty with the regular diet and there were no additional guidelines in place to assist resident #001 in making their food choices. RN #100 was interviewed and indicated on an identified date during the breakfast meal, they were assisting another resident in the dining room when they heard resident #001 coughing. RN #100 stated they went over to resident #001 to check on them, offered the resident something else to eat, but the resident declined. The RN was unable to recall what the resident was eating at the time, but indicated the resident was on a regular diet, with meat cut up and they could have bread as long as it was toasted. RN #100 indicated it was not unusual for the resident to experience coughing during meals and the staff had been directed to offer a minced or pureed texture if this happened.

The Director of Care #107 was interviewed and indicated it was their understanding that the SLP's recommendations had been reviewed and discussed with resident #001 and their POA. DOC #107 stated it was likely this would have been done during the initial, multidisciplinary care conference which was held within the first six weeks of admission. The notes from this care conference were reviewed and did not reflect this discussion.

The licensee failed to ensure staff and others involved in the different aspects of care of resident #001 collaborated with each other. [s. 6. (4) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 3rd day of March, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2019_505103_0005
Log No. / No de registre :	023854-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 27, 2019
Licensee / Titulaire de permis :	United Counties of Leeds and Grenville 746 County Road 42, P.O Box 100, ATHENS, ON, K0E-1B0
LTC Home / Foyer de SLD :	Maple View Lodge 746 County Road, 42 East, P.O. Box 100, ATHENS, ON, K0E-1B0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Chaplin

To United Counties of Leeds and Grenville, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The Licensee must comply with LTCHA, s. 6 (1) (c).

Specifically, the licensee must:

-Develop and implement strategies to ensure all direct care staff including dietary and nursing staff are aware of and have access to all dietary related interventions in a residents' plan of care and who is responsible for the interventions.
-Review and update all resident diet lists located in the dining rooms and kitchens to include all dietary related interventions in a residents' plan of care and who is responsible for the interventions. Ensure the interventions provide clear directions to the staff and others that provide direct care to the resident.
-Provide education to all direct care dietary and nursing staff on the provision of safe foods and fluids to residents specifically related to texture modified foods and fluids, dysphagia and other factors related to choking risk.

Grounds / Motifs :

1. The licensee has failed to ensure the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident.

On an identified date, resident #001 had a choking incident during the dinner meal.

PSW #105 was interviewed and indicated the choking incident occurred during

the main course. They stated they were clearing dishes from tables adjacent to resident #001's table and they knew something was wrong when they looked at resident #001. PSW #105 asked resident #001 if they were alright and the resident raised their hands to their mouth. PSW #105 stated they called to RPN #106 who immediately attended to resident #001.

RPN #106 was interviewed and stated they were standing at their medication cart and could hear a high pitched noise at the same time they heard PSW #105 asking resident #001 if they were choking. RPN #106 stated they ran over to resident #001 and asked if they were choking and the resident indicated yes by nodding their head. RPN #106 stated they then asked the resident what they had been eating and resident #001 pointed to the fruit on their plate.

RPN #106 administered the Heimlich maneuver to resident #001 several times with the assistance of the PSW staff with no effect. RPN #106 stated the resident quickly lost consciousness and cardiopulmonary resuscitation (CPR) was initiated. RN #101 was made aware of the incident and joined RPN #106 in administering CPR including the use of the defibrillator while awaiting the arrival of the paramedics. Resident #001 was transferred to hospital and subsequently died.

Resident #001's plan of care related to eating was reviewed and indicated the following:
-resident has difficulty swallowing and chokes easily,
- provide resident with a regular diet with cut meat, no bread (toast ok),
-soup with beneprotein at lunch and supper; yogurt with beneprotein at lunch and ensure pudding at supper,
-provide supervision with minimal set up or assistance ie. cut food for resident,
-assess and provide appropriate modified textured diet,
-POA signed a waiver for regular fluids; use a special straw that has a valve to hold fluids in the straw and does not need to suck up the straw with so much effort.

PSW #105 stated resident #001 was on a regular diet with meat cut up and stated the cutting up would be done by the dietary staff prior to serving. PSW #105 indicated resident #001 ate independently and did not require any additional foods cut or any additional set up assistance. They recalled resident

#001 was eating the tropical fruit plate at the time of the choking incident which included chunks of pineapple, mango and melon, cottage cheese and banana bread. PSW #105 described the fruit as large chunks and a crispy texture. PSW #105 indicated the family had signed something to allow the resident to eat a regular diet. PSW #105 stated they checked the dietary sheets after the incident as they were worried the resident had received the wrong texture of food. According to PSW #105, the dietary sheets indicated "regular" and confirmed there were no additional instructions.

PSW #103 was interviewed and indicated they were in the same dining room as resident #001 at the time of the choking incident. PSW #103 stated they were not in close proximity, but heard PSW #105 asking resident #001 if they were choking and ran to provide assistance. PSW #103 indicated the resident was eating fruit when they choked and described the fruit as the size of a large grape. The PSW indicated they believed the resident was on a regular diet and was to have everything cut up. PSW #103 stated they believed all of resident #001's food was to be cut up prior to being served, but that the fruit did not appear to be cut up. PSW #103 indicated resident #001 had previously choked on other foods.

Dietary Aide #111 was interviewed and indicated they were working on the evening of the incident. They recalled the resident was served the tropical fruit plate. Dietary Aide #111 stated the dietary sheets were used to inform dietary staff about a resident's type of diet, any likes or dislikes, and any restrictions. Dietary Aide #111 stated if a resident required the dietary staff to cut up any foods it would be indicated on this sheet, otherwise the PSW staff would cut up foods for the resident at the table. Dietary Aide #111 stated they recalled resident #001's sheet had indicated "regular" with no additional instructions.

PSW #104 was interviewed, stated they were very familiar with resident #001. They indicated the resident was on a regular diet with meat cut up and the meat was cut prior to being served to the resident's table. PSW #104 stated resident #001 ate independently and did not require any additional foods cut. PSW #104 stated resident #001 would not have been physically capable of cutting their own food due to an overall decline in condition. PSW #104 also indicated they were aware the family had signed something to allow the resident to eat regular food.

Dietary Aide #109 was interviewed and stated they were not working on the evening of this incident. They stated resident #001 was on a regular diet and that all of their foods were required to be cut. Dietary Aide #109 stated they cut all of the foods up for resident #001 prior to them being served. They stated they were familiar with the fruit mixture that was served that evening and described the fruit as large chunks with a crispy/crunchy texture. Dietary Aide #109 indicated the home no longer utilized this type of fruit mixture as there was concern there could be a subsequent choking incident and the current fruit mixture being used was smaller in size and a softer texture.

Nutritional Manager (NM) #110 was interviewed and stated resident #001 was ordered to have a regular diet with meat cut up. NM #110 indicated to their knowledge, resident #001 did not require any additional foods cut (other than meat) and that the entry in the resident care plan, specifically, “cut food for resident”, was inaccurate. They felt this was an automated response that had been checked off in the plan of care in error. This inspector noted that this entry had been present in the resident's plan of care throughout the resident's stay in the home.

NM #110 was interviewed in regards to the dietary sheets available in the servery and indicated they are updated weekly to reflect the resident's diet texture and any specific resident requirements such as cut meats etc. The NM #110 stated previous dietary sheets are shredded and was therefore unable to comment on what instructions had been on the dietary sheet at the time of the choking incident. NM #110 believed the sheets would have indicated regular diet and to cut meats.

Staff interviewed did not have a clear understanding of the resident's set up assistance specifically as it related to the cutting up of foods. The licensee failed to ensure the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident.
(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of February, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

Service Area Office / Bureau régional de services : Ottawa Service Area Office