Ontario

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 19, 2019	2019_570528_0004	006858-17, 015417-17, 016794-17, 022897-17, 029031-17, 021739-18, 028080-18, 031772-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Northridge
496 Postridge Drive OAKVILLE ON L6H 7A2

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

CYNTHIA DITOMASSO (528), PHYLLIS HILTZ-BONTJE (129)

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): January 23, 24, 25 and 28, 29, 30, 31 2019.

The Critical Incident Inspection includes the following inspection:

Log #015417-17, related to plan of care
Log #021739-18, CIS #2862-000014-18, related to safe transferring
Log #028080-18 CIS #2862-000016-17, related to medication management
Log #006858-17, CIS 2862-000013-17, related to allegations of resident to resident abuse
Log #022897-17, CIS #2862-000019-17, related to allegations of resident to resident abuse
Log #031772-18, CIS #2862-000018-18, related to allegations of staff to resident abuse and neglect
Log #029031-17, CIS #2862-000029017, related to allegations of staff to resident abuse
Log #016794-17, CIS #2862-000016-17, related to allegations of staff to resident abuse

This inspection was completed concurrently with Complaint Inspection Log #: 2019_549107_0002

Emmy Hartmann, LTC Homes Inspector #748 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), the Nurse Practitioner (NP), the Physiotherapist (PT), registered nurses (RN), Wound Care Champion, registered practical nurses (RPN), personal support workers (PSW), and residents.

During the course of the inspection, the inspector(s): observed the provision of care, reviewed documents, including but not limited to: medical records, investigation notes, policies and procedures, staff schedules.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **3 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Review of CIS #2862-000014-18, log #021739-18, submitted in August 2018, described an incident where resident #002 sustained an injury during care.

i. Review of the CIS report, outlined an incident on an identified day in August 2018, where resident #002 was assisted by PSW #107 and #108 using a device during which, resident #002 sustained an injury.
ii. Review of the plan of care for resident #002 identified that the resident was unsafe for the device for transferring and positioning . During an interview with PSW #108 in January 2019, they stated that they had used a device, which was not part of the resident's plan of care.
iv. Interview with DOC #101 confirmed that PSW staff #107 and #108 did not provide care as required in the resident's plan of care related to transferring and positioning, resulting in an injury to resident #002.
v. Furthermore, review of progress notes several months after the incident, identified that the resident had sustained a second injury. PSW staff noticed injury after assisting the resident with activities of daily living. Although, the home's investigation notes and interview with the DOC in January 2019, revealed that the home could not confirm how the injury had occurred; interviews with PT and the Wound Care Champion in January 2019, confirmed that both injuries were similar in nature. [s. 36.]

Additional Required Actions:

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

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of CIS #2862-000015-17, log #015417-17, submitted in July 2017, reported an incident where resident #001 fell resulting in injuries.

i. Review of the plan of care for resident #001 identified that the resident required assistance using a device for assistance with activities of daily living (ADLs).
ii. Review of the home's investigation notes confirmed that PSW #104 left resident #001 unattended when they went to assist a coresident.
iii. Interview with PSW #104 and DOC #101, in January 2019, confirmed that the resident was not provided with care, as specified in their pain, related to ADLs. Interview with DOC #101 confirmed resident #001 was harmed as a result of incident. (528) [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Review of CIS #2862-000014-18, log #021739-18, submitted in August 2018, related to unsafe transfers for resident #002.

i. During the course of the inspection, resident #002 was observed and was noted that they required specified assistance with ADLs.
ii. Review of the written care plan and Point of Care (POC) Kardex, identified that the resident required a device for meals.
iii. Interview with RPN #119 in January 2019, identified that the resident no longer required the device and confirmed that the plan of care was not updated when last reviewed to remove directions to staff, regarding the device. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, had occurred or may have occur shall immediately report the suspicion and the information upon which it is based to the Director.

Review of CIS #2862-000014-18, log #021739-18, submitted in August 2018, described and incident of improper care causing harm to resident #002.

i. Review of the plan of care for resident #002, identified an incident in December 2018, PSW staff assisted the resident with ADLs as specified in their plan and noted a new injury.
ii. Interview with the Wound Care Champion and Physiotherapist in January 2019, confirmed that the injury was similar in nature to the previous incident.
iii. Interview with the DOC in January 2019, revealed that the home could not confirm how the resident sustained the injury but that they required specified assistance of staff for ADLs and could not have injured themselves.
As a result of the previous incident and detailed investigation completed, the home would have had reasonable grounds to suspect that the injury could have occurred through improper care; however it was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours, where possible.

A. Review of CIS #2862-000029-17, log #029031-17 related to allegations of abuse from staff towards resident #008.

i. Review of the home's investigation notes, identified that PSW #113 reported allegations that they witnessed staff to resident abuse.
ii. Review of the plan of care for resident #008 revealed that they had multiple diagnosis, including responsive behaviours, and required extensive assistance for activities of daily living and specific interventions related to providing care.
Review of the home's investigation notes, identified that on an identified day in December 2017, PSW #108 and #113 provided care to resident #008. Although the resident displayed responsive behaviours, PSW #108 continued to provide care.
iii. Interview with the DOC #101 in January 2019, confirmed that the allegation of abuse was not substantiated; however, PSW #108 did not stop when resident #008 displayed responsive behvavious. Interview with ADOC #111 in January 2019, confirmed that the home's 'S.T.O.P. Aggressive Responsive Behaviours' approach is to be used for resident behaviours. Interview with PSW #108 during the course of the inspection, confirmed that they continued to provide care although the resident displayed responsive behaviours.

In December 2017, PSW #108 failed to implement the home's S.T.O.P. approach when resident #008 demonstrated responsive behaviours.

B. Review of CIS #2862-000818-18, log #031772-18, submitted in December 2018, described allegations of staff to resident abuse.

i. Review of the CIS notes, described an incident where resident #010 alleged abuse by PSW #112 , resulting in an injury.
ii. Review of the plan of care for resident #010 identified that the resident had multiple diagnosis with a history of responsive behaviours. The plan of care included specific interventions for staff related to assisting the resident with ADLs.
iii. Review of the home's investigation notes revealed that PSW #112 did not follow the resident's plan of care in December 2018.
iv. Interview with DOC #101 in January 2019, confirmed that on the identified day, PSW #112 did not implement specific interventions in resident #010's plan of care. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with Ontario Regulation 79/10, s. 114(2) " The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt storage, administration and destruction and disposal of all drugs used in the home".

The licensee's policy "LTC-Narcotic and Controlled Drug Management", identified as CAR13-020.1 with a reviewed date of March 2018, directed:
-Two nurses, together upon opening the narcotic and controlled drug(s) sealed container/bag, must verify, inspect for damage, and document drug amount received on a Narcotic and Controlled Drug Control Form.
-Two nurses , one from the ongoing shift and on from incoming shift, will count and sigh off on the Narcotic and Controlled Drug Count Form every shift change. When counting, narcotic vials and blister packs must be inspected to ensure accuracy.

Critical Incident log #028080-18 related to Critical Incident Report #2862-000016-18 identified a missing/unaccounted for controlled substance when it was reported in October 2018, that a controlled substance, that had been ordered for resident #003, was damaged.

During an interview with the Director of Care (DOC) in January 2018, they confirmed they had initiated an immediate investigation that involved interviewing all registered staff who would have completed end of shift narcotic/controlled drug counts for the controlled substance that had been ordered for resident #003. The DOC confirmed that the drug had entered the home in September 2018, and they had been unable to determine when or how it had been damaged.

Registered Nurse (RN) #121, RN #122, RN #123, RN #124, Registered Practical Nurse (RPN) #125, RPN #120, RPN #118, RPN #126 and RPN #127 acknowledged during interviews conducted and recorded by the Director of Care (DOC) in October 2018, that they had not complied with the above noted policy when:
a) they acknowledged they had not fully inspected the controlled substance that had

been sent from the pharmacy in September 2018, to ensure they had not been damaged.

b) they acknowledged they had not fully inspected the controlled substance while they completed shift change counts, when they failed to visually check the substances and label and if any of them had been damaged.
The DOC verified the accuracy of the above noted interviews and the action that was taken when the above noted staff verified that they had not complied with the licensee's policy noted above.

During observations made in January 2018, it was noted that while completing the narcotic/controlled drug count, RPN #127 did not inspect each controlled substance to ensure that items were labeled appopriately.

The DOC, nine identified registered nursing staff and observation confirmed that staff failed to comply with the licensee's policy when completing narcotic/controlled drug management procedures. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy 'Resident Non-Abuse: ADMIN-O10.01', effective August 2016, stated that where any person has reasonable grounds to suspect any abuse or neglect, they must immediately verbally report the suspicion and the information which it was based on to the person in charge. They will then together immediately report to the Director of the MOHLTC.

Review of Critical Incident System (CIS) #2862-000029-17, log #029031-17, submitted in December 2017, identified an allegation of abuse from a PSW towards a resident.

Review of investigation notes identified that in December 2017, PSW #113 reported to PSW #135 that they had observed staff to resident abuse. Interview with ADOC #111 confirmed that PSW #135 did not report the concerns to the ADOC until several days later. Interview with ADOC #111 and DOC #101 in January 2019, confirmed that PSW #113 and PSW #135 did not report the allegations immediately to the person in charge, as required in the home's 'Resident Non-Abuse' policy. (528) [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of CIS #2862-000014-18, log #021739-18, submitted in August 2018, described an incident of improper care causing harm to resident #002.

Review of medical records for resident #002 identified that in December 2018, the resident sustained an injury. Weekly reassessments of the injury continued until resolution, in January 2019. Review of weekly assessments revealed that two weekly assessments were not documented. Interview with the Wound Care Coordinator confirmed that weekly wound assessments were not completed for two weeks, as required. [s. 50. (2) (b) (iv)]

Ontario

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*

Issued on this 20th day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) :	CYNTHIA DITOMASSO (528), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2019_570528_0004
Log No. / No de registre :	006858-17, 015417-17, 016794-17, 022897-17, 029031-17, 021739-18, 028080-18, 031772-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 19, 2019
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Northridge 496 Postridge Drive, OAKVILLE, ON, L6H-7A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lesley Harris

Ontario

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

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must by compliant with s. 36 of Ontario Regulation 79/10.

Specifically, the licensee must:

i. ensure all staff are transferring resident #002, and all other residents, according to their plan of care
ii. conduct an interdisciplinary assessment to assess the safety of resident #002's environment, identify all potential causes of injury to the resident and to implement interventions to prevent any future injury
iii. document all assessments and update the resident's plan of care to include all safe transferring and positioning interventions
iv. ensure PSW #107, #108 and #115 (identified in incidents from August and December 2018 are retrained on the importance of following the plan of care for lifts and transfers.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Review of CIS #2862-000014-18, log #021739-18, submitted in August 2018, described an incident where resident #002 sustained an injury during care.

i. Review of the CIS report, outlined an incident on an identified day in August 2018, where resident #002 was assisted by PSW #107 and #108 using a device during which, resident #002 sustained an injury.
ii. Review of the plan of care for resident #002 identified that the resident was unsafe for the device for transferring and positioning . During an interview with PSW #108 in January 2019, they stated that they had used a device, which was not part of the resident's plan of care.
iv. Interview with DOC #101 confirmed that PSW staff #107 and #108 did not provide care as required in the resident's plan of care related to transferring and positioning, resulting in an injury to resident #002.
v. Furthermore, review of progress notes several months after the incident, identified that the resident had sustained a second injury. PSW staff noticed injury after assisting the resident with activities of daily living. Although, the home's investigation notes and interview with the DOC in January 2019, revealed that the home could not confirm how the injury had occurred; interviews with PT and the Wound Care Champion in January 2019, confirmed that both injuries were similar in nature. [s. 36.]
vi. The severity of the issue was determined to be actual harm to the resident. The scope of the issue was isolated, affecting one out of three residents. The home had a history of non related non-compliance. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 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 19th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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