Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 9, 2020	2020_740621_0006	000365-20	Critical Incident System

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainy River Health Centre
114 Fourth Street P.O. Box 236 RAINY RIVER ON P0W 1L0

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

JULIE KUORIKOSKI (621)

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 25 - 27, 2020.

The following intake was inspected during this Critical Incident System (CIS) inspection:
- One intake related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Administrative Assistant (AA), a Registered Nurse (RN), a Physiotherapist (PT), Registered Practical Nurses (RPNs), and a Health Care Aide (HCA).

The Inspector also reviewed relevant resident health care records, internal incident and investigation reports, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (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 has failed to ensure that resident #001 was reassessed and that their plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in their plan was no longer necessary.

A Critical Incident System (CIS) report was received by the Director on a day in January 2020, for an incident resulting in a significant change in condition of resident #001, on an earlier day in January 2020.

During a review of resident #001's care plan, last revised on a specific date in January 2020, Inspector #621 found no update to the resident's plan of care following their significant change in status.

During a review of a specific number and type of home's policies, they identified that Registered Nursing staff were to develop a care plan in collaboration with the resident/substitute decision maker (SDM) to address the resident's identified individual needs, and be oriented towards a particular level of care status.

During an interview with RPN #102, they identified that resident #001's condition had changed on a specific date in January 2020, with a requisite change in care, following consultation with the SDM.

During an interview with RPN #104, they reported that when a resident's care status changed, the care plan of the resident was to be reviewed and updated by RPN staff in consultation with the SDM. Additionally, RPN #104 identified that there was to be removal of care plan interventions that were no longer appropriate, and inclusion of specific interventions consistent with family/SDM wishes and resident focused care. On review of resident #001's care plan, last updated on a specific date January 2020, they reported to Inspector #621 that the resident's final care plan, which was active when the change in care status occurred, had not been updated with the specified change in focus, and should have been.

During an interview with the Administrator/Director of Care (DOC), they confirmed to Inspector #621 that resident #001 had a significant change in health status, and as of a specific date in January 2020, required a change in their care to coincide with a particular focus. They identified that the resident's care plan should have been updated on the identified date in January 2020, to include a particular focus, with all care plan

interventions that were no longer consistent with the resident's change in care needs, discontinued. The Administrator/DOC confirmed that RPN staff were responsible for making the required changes to the resident's care plan, and that between two particular dates in January 2020, requisite changes had not been made. [s. 6. (10) (b)]

2. The licensee has failed to ensure that resident #002 was reassessed and that their plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in their plan was no longer necessary.

During an interview with the Administrator/DOC regarding additional residents in the home who were at risk for a specific type of incident occurring, it was reported to the Inspector that resident #002 was at risk for such incidents, and confirmed that the most recent incident of that nature had occurred on a specific day in February 2020.

During an observation of resident #002 with their mobility aide, the Inspector observed the presence of a specific number of safety devices.

On review of resident #002's most current care plan with a specific focus, the Inspector found no information which identified the resident utilized a specified number and type of safety devices. Additionally, on review of a particular screening, that was completed on a certain day in January 2020, it identified a specific risk score. However, on review of the care plan with a specific focus, it identified a different risk score which appeared to be from a screen completed in July 2019.

During an interview with HCA #103 and RPN #104, they reported that resident #002 was at risk for a particular incident, and part of their care plan, interventions included the use of a specific number and type of safety devices. Together with the Inspector, RPN#104 reviewed the resident's care plan, and confirmed that the care plan had not been reviewed and revised to reflect their current care needs with respect to the use of a specific number and type of safety devices, when engaged in a specified activity, and should have.

During an interview with the Administrator/DOC, they reported that it was their expectation that RPN staff ensured care plans were updated to reflect a resident's current care needs, and that strategies identified in a resident's care plan were individualized, for clarity and consistency with the home's specific program, policies and procedures. Additionally, the Administrator/DOC reviewed resident#002's most current care plan and confirmed that, when compared to the last screening completed on a day

in October 2019, resident #002's specific care plan had not been updated to reflect the resident's most current risk score. Further, they confirmed that resident #002's specific care plan had not been updated to reflect their current use of a specified number and type of safety devices when engaged in a particular activity, and should have. [s. 6. (10) (b)]

3. The licensee has failed to ensure that resident #003 was reassessed and that their plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in their plan was no longer necessary.

During an interview with the Administrator/DOC regarding additional residents in the home who were at risk for a specific incident occurring, it was reported to the Inspector that resident #003 was at risk for the identified incident in question, and confirmed that the most recent incident of that nature had occurred on a specific day in February 2020.

During interviews with HCA #103, RPN #104 and RPN #106, they reported to Inspector #621 that resident #003 was at risk for a specific type of incident occurring, and required as part of their care strategies, the use a specific type of safety device, when they were engaged in a specified activity. Additionally, they identified that resident#003 also required the another type of safety device engaged when they were in a certain location of the home. Further, RPN #104 identified that a specific number of other strategies were tried with this resident over the previous year and that the strategies had been discontinued for certain reasons.

During an observation of resident #003, the Inspector observed the presence of a specific type of safety device, while they were engaged in a specific activity.

On review of resident #003's most current care plan in place at the time of inspection, the Inspector found no intervention listed which identified the use the observed safety device, or for another safety device to be used when the resident was in a particular location of the home. Further, under another care plan focus, it continued to identify the use of a specific number of other safety devices, which staff reported were no longer being used.

During an interview with the Administrator/DOC, they identified that resident #003 required the use of a specific type of safety device when engaged in a particular activity. The Administrator/DOC reported that the current style of safety device was a better option for the resident, and the former safety device that had been used, was

discontinued in August 2019. Further, they identified that it was expected that the resident's care plan was individualized to the resident's specific care needs, and that at the time of inspection, the care plan with a specific focus for resident #003, had not been revised to include the use of the specific safety device when the resident was engaged in a particular activity, or for staff to ensure that another safety device was engaged when the resident was in a particular location of the home. Further, they confirmed that the resident's care plan was still referencing a specific number and type of other safety devic

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 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 has failed to ensure that, where Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, the licensee was required to ensure that a falls prevention and management program, to reduce the incidence of falls and risk of injury, was developed and implemented.

A Critical Incident System (CIS) report was received by the Director on a day in January 2020, for a fall with injury of resident #001, which occurred on a specified date prior.

A review of the home's internal investigation notes, it identified that resident #001's fall had been unwitnessed.

A review of the home's policy titled "Falls Prevention and Management Program – Post Falls Assessment and Management – Registered Nursing Staff Procedure, DEP – NUR-GEN-F-25", last updated September 26, 2019, identified that Registered Nursing staff were to complete the following:
- Initiate a specific type of assessment where there was evidence of injury, or the resident was unable to give an accurate description of the incident;
- Staff to complete a certain type of report, including specific criteria, ideally within a specific time frame; and
- Ensure that notification by electronic medical record (EMR) was sent to the Physiotherapist, for further assessment.

During a review of resident #001's health care record, Inspector #621 was unable to locate documentation to support the initiation of a specific assessment for an unwitnessed fall, completion of a specific staff report, or referral to a specific registered health professional, following the January 2020 fall.

During an interview with RPN #102, they reported that after the fall of a resident, RPN staff were required to follow the home's policy and complete the specific assessment for unwitnessed falls, and document this under a specific section of Point Click Care (PCC), at the appropriate time intervals. RPN #102 however, identified that there were issues with RPN staff not completing this assessment. Additionally, RPN #102 was unclear whether the home's staff routinely completed a review of the incident, and where information for that was kept. Further, RPN #102 indicated that after every fall, a referral was to be made through PCC for a specific registered health professional assessment. On review of resident #001's health care record with the Inspector, RPN #102 confirmed that the identified assessment, completion of a specific type of staff review of the incident, and a referral to a specific registered health professional, had not been completed following resident #001's fall in January 2020.

During an interview with RPN #104, they verified to the Inspector that, when a resident had a fall, the home's staff did not complete a specific review of the fall, within a certain time frame, nor did they complete any requisite documentation.

During an interview with Physiotherapist (PT) #105, they confirmed that they were to be notified by the home when a resident fell, in order to complete an assessment, and that a

electronic referral was the accepted method for notification. Further, PT #105 confirmed that for the January 2020, fall of resident #001, there had been no electronic referral notification sent from the home, to alert them of the fall.

During an interview with the Administrator/DOC, they reported that it was their expectation that if a fall of a resident was unwitnessed, and if the resident could not provide details concerning the incident, that a specific type of assessment was to be completed, with requisite documentation in a particular section within PCC. Additionally, they stated that after a fall, they expected that staff met to discuss the details of the fall, and documented this in a particular section of the resident's electronic health care record, as well as generated an electronic referral to a specified registered health care professional for further assessment. The Administrator/DOC confirmed that the home's RPN's had not followed the home's policy for post-falls program management of resident #001, following their January 2020 fall, as identified. [s. 8. (1) (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, where Ontario Regulation (O. Reg.) 79/10 requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was received by the Director on a day in January 2020, for a fall with injury of resident #001, on a specific day prior.

During a review of resident #001's health care record, Inspector #621 found no post-fall assessment completed following the January 2020 fall.

A review of the home's policy titled "Falls Prevention and Management Program – Post Falls Assessment and Management – Registered Nursing Staff Procedure, DEP-NUR-GEN-F-25", last updated in September 2019, it identified that Registered Nursing staff were to complete a Post-Fall Screening tool and/or Risk Assessment in the electronic medical record (EMR) to assist in identifying possible contributing factors.

During an interview with RPN #102, they reported to the Inspector that a Post-Fall Screen tool, (which served as the home's clinically appropriate Post-Fall Assessment), was to be completed after each fall of a resident. On review of resident #001's documentation, RPN #102 confirmed to the Inspector that a Post-Fall Screen tool had not been completed after resident #001's fall on a specific day in January 2020, and should have been.

During an interview with the home's Administrator/DOC, they reported to the Inspector that, it was their expectation that the Registered Practical Nurse (RPN) on duty would complete a post-fall assessment after every resident fall. [s. 49. (2)]

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 when a resident falls, the resident is assessed and that where the condition or circumstances of the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 16th day of March, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2020_740621_0006
Log No. / No de registre :	000365-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 9, 2020
Licensee / Titulaire de permis :	Riverside Health Care Facilities Inc. 110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	Rainy River Health Centre 114 Fourth Street, P.O. Box 236, RAINY RIVER, ON, P0W-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tammy McNally

To Riverside Health Care Facilities Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / No d'ordre : 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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6 (10) (b) of the Ontario Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

(a) Ensure that care plans for resident #002, #003 and all other residents of the home have been reviewed and revised to reflect their individualized and specific current care needs;

b) Ensure that when a resident requires a particular level of care, that Registered Nursing staff develop and implement a care plan consistent with a specific number and type of home's policies; and

c) Complete randomized audits of resident care plans to ensure that care plan foci, goals and interventions are current, individualized and specific to the residents care needs. The home is to keep a record of who completed each audit, including the date/time of the audit, the name of the resident, care plan details reviewed, any variances found, and corrective action taken.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was reassessed and that their plan of care was reviewed at least every six months, and at any other time

when the resident's care needs changed, or care set out in their plan was no longer necessary.

A Critical Incident System (CIS) report was received by the Director on a day in January 2020, for an incident resulting in a significant change in condition of resident #001, on an earlier day in January 2020.

During a review of resident #001's care plan, last revised on a specific date in January 2020, Inspector #621 found no update to the resident's plan of care following their significant change in status.

During a review of a specific number and type of home's policies, they identified that Registered Nursing staff were to develop a care plan in collaboration with the resident/substitute decision maker (SDM) to address the resident's identified individual needs, and be oriented towards a particular level of care status.

During an interview with RPN #102, they identified that resident #001's condition had changed on a specific date in January 2020, with a requisite change in care, following consultation with the SDM.

During an interview with RPN #104, they reported that when a resident's care status changed, the care plan of the resident was to be reviewed and updated by RPN staff in consultation with the SDM. Additionally, RPN #104 identified that there was to be removal of care plan interventions that were no longer appropriate, and inclusion of specific interventions consistent with family/SDM wishes and resident focused care. On review of resident #001's care plan, last updated on a specific date January 2020, they reported to Inspector #621 that the resident's final care plan, which was active when the change in care status occurred, had not been updated with the specified change in focus, and should have been.

During an interview with the Administrator/Director of Care (DOC), they confirmed to Inspector #621 that resident #001 had a significant change in health status, and as of a specific date in January 2020, required a change in their care to coincide with a particular focus. They identified that the resident's care plan should have been updated on the identified date in January 2020, to include a particular focus, with all care plan interventions that were no longer

consistent with the resident's change in care needs, discontinued. The Administrator/DOC confirmed that RPN staff were responsible for making the required changes to the resident's care plan, and that between two particular dates in January 2020, requisite changes had not been made. (621)

2. The licensee has failed to ensure that resident #002 was reassessed and that their plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in their plan was no longer necessary.

During an interview with the Administrator/DOC regarding additional residents in the home who were at risk for a specific type of incident occurring, it was reported to the Inspector that resident #002 was at risk for such incidents, and confirmed that the most recent incident of that nature had occurred on a specific day in February 2020.

During an observation of resident #002 with their mobility aide, the Inspector observed the presence of a specific number of safety devices.

On review of resident #002's most current care plan with a specific focus, the Inspector found no information which identified the resident utilized a specified number and type of safety devices. Additionally, on review of a particular screening, that was completed on a certain day in January 2020, it identified a specific risk score. However, on review of the care plan with a specific focus, it identified a different risk score which appeared to be from a screen completed in July 2019.

During an interview with HCA #103 and RPN #104, they reported that resident #002 was at risk for a particular incident, and part of their care plan, interventions included the use of a specific number and type of safety devices. Together with the Inspector, RPN #104 reviewed the resident's care plan, and confirmed that the care plan had not been reviewed and revised to reflect their current care needs with respect to the use of a specific number and type of safety devices, when engaged in a specified activity, and should have.

During an interview with the Administrator/DOC, they reported that it was their expectation that RPN staff ensured care plans were updated to reflect a

resident's current care needs, and that strategies identified in a resident's care plan were individualized, for clarity and consistency with the home's specific program, policies and procedures. Additionally, the Administrator/DOC reviewed resident #002's most current care plan and confirmed that, when compared to the last screening completed on a day in October 2019, resident #002's specific care plan had not been updated to reflect the resident's most current risk score. Further, they confirmed that resident #002's specific care plan had not been updated to reflect their current use of a specified number and type of safety devices when engaged in a particular activity, and should have. (621)

3. The licensee has failed to ensure that resident #003 was reassessed and that their plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in their plan was no longer necessary.

During an interview with the Administrator/DOC regarding additional residents in the home who were at risk for a specific incident occurring, it was reported to the Inspector that resident #003 was at risk for the identified incident in question, and confirmed that the most recent incident of that nature had occurred on a specific day in February 2020.

During interviews with HCA #103, RPN #104 and RPN #106, they reported to Inspector #621 that resident #003 was at risk for a specific type of incident occurring, and required as part of their care strategies, the use a specific type of safety device, when they were engaged in a specified activity. Additionally, they identified that resident #003 also required the another type of safety device engaged when they were in a certain location of the home. Further, RPN #104 identified that a specific number of other strategies were tried with this resident over the previous year and that the strategies had been discontinued for certain reasons.

During an observation of resident #003, the Inspector observed the presence of a specific type of safety device, while they were engaged in a specific activity.

On review of resident #003's most current care plan in place at the time of inspection, the Inspector found no intervention listed which identified the use the observed safety device, or for another safety device to be used when the

resident was in a particular location of the home. Further, under another care plan focus, it continued to identify the use of a specific number of other safety devices, which staff reported were no longer being used.

During an interview with the Administrator/DOC, they identified that resident #003 required the use of a specific type of safety device when engaged in a particular activity. The Administrator/DOC reported that the current style of safety device was a better option for the resident, and the former safety device that had been used, was discontinued in August 2019. Further, they identified that it was expected that the resident's care plan was individualized to the resident's specific care needs, and at the time of inspection, the care plan with a specific focus for resident #003, had not been revised to include the use of the specific safety device when the resident was engaged in a particular activity, or for staff to ensure that another safety device was engaged when the resident was in a particular location of the home. Further, they confirmed that the resident's care plan was still referencing a specific number and type of other safety devices, which were no longer part of the resident's plan of care.

The severity of the issue was determined to be level 2, as there was minimal harm to the residents inspected. The scope of the issue was a level 3, as non-compliance was identified with 100 per cent of residents inspected. The home had a level 3 compliance history, as it had previous non-compliance with the same subsection of the Ontario Long-Term Care Homes Act (LTCHA),2007., within the previous 36 months as follows:
- a WN was issued on November 22, 2018, in Resident Quality Inspection (RQI) report #2018_633577_0016. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2020

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 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:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 9th day of March, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Julie Kuorikoski

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