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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 30, 2020	2020_621755_0003 (A3)	022733-19, 000983-20	Complaint

Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Amended by MANON NIGHBOR (755) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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The licensee inspection report has been amended to reflect a compliance due date extension. Inspection # 2020_621755_0003 compliance due date has been extended to November 30, 2020 due to COVID19 pandemic and completing training of staff.
A copy of the revised report is attached.

Issued on this 30th day of October, 2020 (A3)

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

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

Amended by MANON NIGHBOR (755) - (A3)

Amended Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 27,28,29,30,31, February 3,6 on site and February 26, March 5 and 6, 2020 offsite.

Log 000983-20 is a complaint related to wound care, lack of assessments, hydration, mobility, pain and alleged abuse.

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Registered Nurse, Practical Registered Nurse, Personal Support Worker, Dietitian, Support Services Manager, Physiotherapist, resident family member and a resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **4 WN(s)**
- **1 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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the nutrition care and hydration programs include the implementation of interventions to mitigate and manage risks of dehydration, for residents #004, #002 and #003.

The Health Care Aids/Personal Support Worker (PSW) are to “encourage fluid intake, document resident fluid intake and notify the registered staff if intake is less then 1500cc in 24 hours.”, as per the Continence Care and Bowel Management Program policy (Section 2, page 18) which indicates on page 5 of 14, number 4.

The Assistant Director of Care (ADOC) and Director of Care (DOC), both acknowledged that there was a gap in the fluid intake tracking system. The ADOC noted that if a resident had less then 125ml, this amount would be concerning, and Personal Support Worker (PSW) would be expected to report to the Registered Practical Nurse (RPN). The RPN would monitor the next shift to ensure the resident is voiding and drinking. If the resident didn’t void or drink the next shift, it is expected that the RPN would report to the Registered Nurse (RN).

During an interview with the RD, they said that it is difficult to assess fluid intake due to the lack of data available, relating to staff only tracking fluid intake during meals.

Resident #004 documented fluid intake was reviewed in Point Click Care (PCC). Between a specific period of time, resident #004's 24 hour minimum fluid requirement intake was below the minimum requirement for a number of days. The resident was hospitalized for a specific period of days. As per the Hospital Discharge Summary, the resident upon arrival to hospital and had a abnormal laboratory value, involving an acute episode, secondary to certain health ailments.

Resident #002 documented fluid intake was reviewed in Point Click Care. Between a specific number of days, resident #002's 24 hour minimum fluid requirement intake was below the minimum requirement of 1500 ml in 24 hours. According to their report practices between shifts, resident #002 had poor intake on a number of specific days during a specific period of time. Resident consumed oral nutrition supplement on one day during a specific period of time. Resident #002 refused oral nutrition supplement on a number of days during this period. On a specific day, resident #002 started treatment for a period of time, reason not specified in progress notes, dose was decreased due to health status. On a specific day, it was noted in progress notes that blood work has not been taken for a period of time as resident declined, therefore specific health status was not available.

Resident #003 documented fluid intake was reviewed in Point Click Care. Between a specific period of time, resident #003's 24 hour minimum fluid requirement intake was below the minimum requirement of 1500 ml in 24 hours. PSW reported to RPN as indicated on tour sheets that resident #003 had poor intake for a number of specific days. Signs and symptoms of possible health ailment were reported on a specific day and a sample was taken on another day. On a specific day, the physician was made aware of signs and symptoms of health ailment persisting and treatment was started on the same day. It was noted that the resident voided small amounts on specific days. A progress note written by staff # 101, on a specific day, stated that resident #003 completed a treatment and that resident appears to be consuming less than adequate amounts of fluids according to PCC to void moderate to large amounts of urine. Will advise staff to encourage resident to drink fluids to prevent complications. Will continue

to monitor resident for signs and symptoms of complications. Staff #118 wrote in progress notes on a specific day, that resident #003 had not voided on day shift, no actions documented.

Therefore, the licensee has failed to ensure that the organized program of hydration included the implementation of interventions to mitigate and manage dehydration risks. [s. 68. (2) (c)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 the Act or this Regulation required

the licensee of a long-term care home to have, institute or otherwise put in place any program policy, that the program policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1), the licensee was required to ensure that the
following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's Fall Prevention Program Policy, Section 2, Effective November 24, 2016.

The licensee's Fall Prevention Program policy states on page 5 of 10:

6. Initiate Head Injury Routine (HIR) for all un-witnessed and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.

7. Monitor every 15 minutes for 30 minutes, every 30 minutes for 90 minutes, every hour for 2 hours, every 4 hours for 20 hours (x5) and every 8 hours for 24 hours (x3) post fall for signs of neurological changes.

Three falls were reviewed for resident #001 where HIR was initiated by staff. Upon review of the Head Injury Assessment Forms, it was noted that staff completing the HIR had not done so at the specified time intervals.

During an interview with RN #102, they showed the inspector another HIR protocol. This HIR indicated that residents should be assessed every hour for 4 hours and then every 4 hours for 24 hours.

The inspector interviewed the DOC, who indicated that they had never seen this different HIR procedure and was unsure of its origin. The DOC further indicated that staff should be using the HIR that is detailed in the licensee's Falls Prevention Program Policy.

Resident #001 had a number of falls since a specific date where the HIR was initiated, but was not completed at the specified time intervals, as per the licensee's Falls Prevention Program. [s. 8. (1) (a),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 the licensee's head injury routine, as part of their licensee's Falls Prevention Program Policy program, is complied with , to be implemented voluntarily.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #001, related to falls prevention, was provided to the resident as specified in the plan.

Resident #001 was identified as being at risk for falls and their current written plan of care indicated that the resident should have a fall mat beside their bed. Interviews with staff members working on the resident's home area indicated that the resident has 2 fall mats that are put in place on either side of the resident's bed when they are in bed.

On a specific date, resident #001 was observed to be in bed asleep at an exact time. At the time of observation, the inspector noted that the two fall mats were not in place on either side of the bed, but were rolled up in the corner of the room.

Resident #001 was observed not to receive care as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that a provision of care set out in the plan of care for resident #001 related to skin and wound care, was documented.

Resident #001 was noted to have chronic skin integrity issues in a specific area.

The Nurse Practitioner ordered a particular topical agent on a specific day, a certain frequency for a certain lenght of time and to reassess. During this time period, there were two applications not signed for on the Treatment Administration Record (TAR).

Progress notes were made on a specific dates, by registered staff indicating that the particular topical agent continued to be used for resident #001.

On a specific day, the Physician assessed the resident and wrote a new order for a particular topical agent to the resident's specific skin area as needed (PRN).

Resident #001 continued to have weekly assessments and the area continued to be affected. The assessments noted treatment cream was being applied but did not specify which one.

Review of a specific monthly TAR did not show that this particular topical agent was listed as a treatment cream for resident #001.

Review of a specific monthly TAR showed the PRN order for the particular topical agent being added on a specific day, but no record that it was applied to the resident.

Review of a specific monthly TAR showed no documentation for the particular topical agent being used to treat the
resident, until the specific day, just after RPN #118 was interviewed in relation to the particular topical agent and its use for resident #001.

During the interview with RPN #118 on a specific day, they stated that staff use two topical agents to treat resident's affected skin area, a particular topical agent and another treatment cream. The RPN said the cream treatment agent is a regular order with a certain frequency and the other treatment cream is PRN. They indicated that staff have been using a certain topical agent recently, that it has been working well and the area appeared much better.

The use of this certain topical agent for resident #001, although referred to as being used for resident #001 in assessments, progress notes and staff interviews from a specific period of time, was not always documented as having been applied on the resident's TAR. [s. 6. (9) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received basic foot care services, including the cutting of toenails, to ensure comfort and prevent complications.

The licensee's Finger and Toenail care policy was reviewed and indicates that finger and toenails will be checked, cleaned and cut weekly on bath day.

The inspector was informed by PSW staff working on resident #001's home area that they document toenail care in tasks under bathing in PointClickCare (PCC). Two PSW's indicated that they will document "resident refused" if the resident

refused having their toenails trimmed and "no" if the toenail trimming was not done/offered during the bath.

PCC documentation for toenail care was reviewed from a specific time period for resident #001. During this time period, the resident was only documented to have received toenail care on a specific day. Every other bath date indicated either "resident refused" or "no". After a this particular day, the next time toenail care was documented was in the progress notes by an outside foot care provider on a specific day. The progress note stated that all very long nails were cut and filed with no other foot problems noted. The note also indicated that the resident tolerated the treatment well.

During an interview with the ADOC, they indicated that there was no clinical reason why the resident would require outside foot care and toenail trimming. The ADOC did indicate that there was a period of time when the resident was aggressive with staff, so they thought this may be the reason staff did not provide the care. When asked about the documentation, the ADOC could not explain why sometimes the staff indicated "no", that the care was not provided.

The inspector reviewed the resident's plan of care related to responsive behaviours and noted there was no mention of difficulty providing the resident with toenail care. There were also multiple notes made by a certain specialty Team PSW's that indicated the resident was cooperative with their bath on many occasions during the time period reviewed and there was no mention in these notes that the resident refused or was difficult with foot care/ toenail trimming.

During an interview with resident #001's substitute decision-maker, they indicated that they felt the home was not providing toenail trimming to the resident, so they hired outside help to provide the care.
The Director of Care indicated in an interview that resident #001 does not require additional footcare that the home cannot provide and that they were not aware of any reasons why the staff in the home could not provide toenail trimming to the resident.

Resident #001 did not receive preventative and basic foot care services, including cutting of toenails, for a specific period of time. [s. 35. (1)]

Issued on this 30th day of October, 2020 (A3)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MANON NIGHBOR (755) - (A3)
Inspection No. / No de l'inspection :	2020_621755_0003 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022733-19, 000983-20 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 30, 2020(A3)
Licensee / Titulaire de permis :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
LTC Home / Foyer de SLD :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alfred O'Rourke

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

To Sherwood Park Manor, you are hereby required to comply with the following order (s) by the date(s) set out below:

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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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 68(2)

Specifically, the licensee must:

1. Review and revise in consultation with a Registered Dietitian who is a member of the staff of the home, a process to monitor and evaluate the food and fluid intake of resident #002, 003 and 004 and all other residents with identified risks related to nutrition and hydration who are not meeting their minimum food and fluids consumed at both meal and snack times.

2. Identify and implement risks and interventions for residents #002, 003 and 004 and all other residents who are not meeting their food an fluids intake requirements to mitigate and manage risks of dehydration and incorporate specific changes in plan of care.

3. Ensure that the nutrition care and dietary services and hydration program policies and procedures relating to the system to monitor and evaluate the food and fluid intake of residents are being followed. Take any corrective action when policy and procedures are not being followed and keep a record of these actions taken.

Grounds / Motifs :

1. The licensee has failed to ensure the nutrition care and hydration programs include the implementation of interventions to mitigate and manage risks of dehydration, for residents #004, #002 and #003.

The Health Care Aids/Personal Support Worker (PSW) are to "encourage fluid intake, document resident fluid intake and notify the registered staff if intake is less then 1500cc in 24 hours.", as per the Continence Care and Bowel Management Program policy (Section 2, page 18) which indicates on page 5 of 14, number 4.

The Assistant Director of Care (ADOC) and Director of Care (DOC), both acknowledged that there was a gap in the fluid intake tracking system. The ADOC noted that if a resident had less then 125ml, this amount would be concerning, and Personal Support Worker (PSW) would be expected to report to the Registered Practical Nurse (RPN). The RPN would monitor the next shift to ensure the resident is voiding and drinking. If the resident didn't void or drink the next shift, it is expected

that the RPN would report to the Registered Nurse (RN).

During an interview with the RD, they said that it is difficult to assess fluid intake due to the lack of data available, relating to staff only tracking fluid intake during meals.

Resident #004 documented fluid intake was reviewed in Point Click Care (PCC). Between a specific period of time, resident #004's 24 hour minimum fluid requirement intake was below the minimum requirement for a number of days. The resident was hospitalized for a specific number of days. As per the Hospital Discharge Summary, the resident upon arrival to hospital and had a abnormal laboratory value, involving an acute episode, secondary to certain health ailments.

Resident #002 documented fluid intake was reviewed in Point Click Care. Between a specific number of days, resident #002's 24 hour minimum fluid requirement intake was below the minimum requirement of 1500 ml in 24 hours. According to their report practices between shifts, resident #002 had poor intake on a number of specific days during a specific period of time. Resident consumed oral nutrition supplement on one day during a specific period of time. Resident #002 refused oral nutrition supplement on a number of days during this period. On a specific day, resident #002 started treatment for a specific period of time, reason not specified in progress notes, dose was decreased due to health status. On a specific day, it was noted in progress notes that blood work has not been taken for a period of time as resident declined, therefore specific health status was not available.

Resident #003 documented fluid intake was reviewed in Point Click Care. Between a specific period of time, resident #003's 24 hour minimum fluid requirement intake was below the minimum requirement of 1500 ml in 24 hours. PSW reported to RPN as indicated on tour sheets that resident #003 had poor intake for a number of specific days. Signs and symptoms of possible health ailment were reported on a specific day and a sample was taken on another day. On a specific day, the physician was made aware of signs and symptoms of health ailment persisting and treatment was started on the same day. It was noted that the resident voided small amounts on specific days. A progress note written by staff # 101, on a specific day, stated that resident #003 completed a treatment and that resident appears to be consuming less than adequate amounts of fluids according to PCC to void moderate to large amounts of urine. Will advise staff to encourage resident to drink fluids to prevent complications. Will continue to monitor resident for signs and symptoms of

complications. Staff #118 wrote in progress notes on a specific day, that resident #003 had not voided on day shift, no actions documented.

Therefore, the licensee has failed to ensure that the organized program of hydration included the implementation of interventions to mitigate and manage dehydration risks. [s. 68. (2) (c)]

The severity of non compliance was such that there was actual risk of harm to resident #004. The scope of non compliance identified was widespread. The compliance history does not include any non compliance with section O. Reg 79/10 s. 68. (755)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2020(A3)

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

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

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

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

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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 30th day of October, 2020 (A3)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by MANON NIGHBOR (755) - (A3)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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