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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie 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
Jan 8, 2021	2020_595110_0013	004748-20	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 23, 24, 25, 26. December 3 and 4 am, 2020.

The purpose of this inspection was related to a complaint, log #004748-20 related to foot care and cutting of nails, the proper management of a resident's clinical diagnosis; bowel management; hydration management and behavioral management.

During the course of the inspection, the inspector(s) spoke with Executive Director/Director of Care, Associate Director of Care, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Director of Resident Programs and Admissions, Office Manager, Personal Support Workers and Resident Families.

During this inspection the Inspector conducted resident care and resident observations; reviewed health records including hospital discharge summaries, physician/NP orders, written care plans, bowel and fluid intake monitoring records in point of care (POC) and registered dietitian assessments. A review of relevant policies including the bowel management, hydration and complaint management programs. Mobile foot Care billing and service agreements.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Resident Charges

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

7 WN(s)
6 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. 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 the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A complaint was forwarded to the Ministry of Long Term Care (MLTC) as well as to the LTC home. The complainant alleged that resident #001 had not been provided with basic foot care and supporting evidence was provided.

PSW #104 confirmed resident #001's foot care had not been provided. Further PSW interviews revealed they had not been trained to provide basic foot care and were told in the past to only cut fingernails and not resident's toenails. PSWs revealed this practice of not trimming toenails had been in place for years.

Sources: Resident observations, LTC home complaint binder, care plan and staff interviews with PSW #101, #104, #106, RN #102, ADOC and other staff. [s. 35. (1)]

2. An interview with PSW #101 revealed that PSWs were not responsible for trimming resident's toenails and did identify that resident #005 had not been provided with basic foot care and were unsure of who was responsible for providing it. Resident #005's feet were observed by the Inspector and provided evidence of a prolonged lack of proper foot care. The Inspector's observations were confirmed by PSW #104. The home's ED/DOC was made aware and also joined the Inspector in observing the resident's feet.

Sources: Resident #005's feet and staff interviews including PSWs, ADOC and ED/DOC. [s. 35. (1)]

3. An interview with PSW #104 identified that after the complaint of resident #001's improper foot care resident #003's nails were also trimmed. A record review identified an entry that foot care provided to resident #003 by PSW #104. During the interview the PSW described the resident's toenails which confirmed the prolonged lack of proper foot care.

Sources: Progress notes and staff interviews. [s. 35. (1)]

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee of a long -term care home has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

A complaint was received by the MLTC that staff had not received training on the needs and approaches for an identified resident with specific needs. The complainant observed and communicated an incident of staff inappropriately managing the resident's responsive behaviors.

Interviews with PSWs #109, #110, #104, RN #111 and the ADOC shared they have not received any training on the needs and approaches of the identified resident. A review of progress notes and staff interviews confirmed the resident had episodes of responsive behaviors however the resident's plan of care lacked the planned care to address the

resident's needs. All staff confirmed the lack of planned care for resident #001 and their individual needs.

Sources: Progress note, care plan, home’s complaint log, staff interviews. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the Substitute Decision Maker (SDM) has been provided the opportunity to participate fully in the development and implementation of the plan of care.

A record review identified a number of communications between a SDM and management staff that included the SDM expressing preferred supportive approaches and the needs of an identified resident. A review of the resident's plan of care in addition to staff and SDM interviews failed to confirm that the SDM was provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: plan of care, progress notes, email communications with resident's SDM, staff interviews with PSW #109, #110, #104 and ADOC and an interview with resident #001's SDM. [s. 6. (5)]

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

The MLTC received a complaint, that the home was not providing the required care to resident #001. The care concerns were outlined.

A review of the resident's written plan of care included two care needs of resident #001 as expressed by the complainant. Multiple observations were conducted during the Inspection period of the specific care concerns. The Inspector identified that care had not been provided to resident #001 as specified in the plan.

Sources: Observations, PSW and ADOC interviews, plan of plan and record review of resident's health record. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O.Reg. 70/10, s. 50 (2) required the home to have a bowel management program that provides for, at a minimum, treatments and interventions to prevent constipation, including nutrition and hydration protocols.

The home’s Bowel Management Program, Policy #VII-D-10.70, revision date of April 2019, stated all residents will be on a bowel management program that promotes regular bowel movements and an individualized bowel routine for each resident that minimizes their need for medications and maximizes their intake of fibre and fluids.

Resident #001 had a significant change in status requiring the implementation of the bowel management program. The home failed to ensure that the resident’s dietary intake was assessed to maximize the resident’s intake of fibre and fluids.

Sources: Southlake Patient Discharge Summary, progress notes, dietary referrals, interview with registered dietitian. [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 the homes' Bowel Management program provides for, at a minimum, treatments and interventions to prevent constipation, including nutrition and hydration protocols, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

A record review identified complaint emails sent to the ED/DOC concerning the care of a resident on four separate occasions in 2020. The Inspector contacted CIATT Pretriage who confirmed that the LTC home had not submitted a complaint letter since April 2019.

Sources: Email complaints, CIATT and interview with ED. [s. 22. (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 the licensee immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident’s health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration whenever there was a significant change in the resident's health status.

Resident #001 was hospitalized with a condition where the presence of impacted feces in the colon is associated with inflammation and distention. Further a physician's note revealed the resident had frequent urinary tract infections, 5 in the past 2 months.

A review of the Fluid intake monitoring records from two and one half months prior to the resident's hospitalization revealed the resident met or exceeded their fluid goal of 13.5 servings 25% of the time.

The resident's hydration status and any risks to hydration were not assessed by the RD upon the resident's return from hospital.

Sources: Progress notes, Hospital Patient Discharge Summary, dietary referrals, Point of Care (POC) fluid intake records and interview with registered dietitian. [s. 26. (4) (a),s. 26. (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 registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration whenever there was a significant change in the resident's health status, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

A record review of a complaint email sent to the ED/DOC concerning the care of a resident was identified. A review of 'Initial Acknowledgement Letter' emailed to the complainant stated a full investigation was in progress and that a response will be provided upon completion.

An interview with the complainant and ED, along with a record review, confirmed the complainant had not been made aware of what the licensee had done to resolve the complaint and if the licensee believed the complaint was unfounded the reasons for the belief.

Sources: email complaint of September 24, 2020, Initial Acknowledgement Letter, interview with complainant and ED. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant

A record review of five complaint emails sent to the ED/DOC concerning the care of a resident were identified in 2020. A review of the home's Written and Verbal Complaint log for 2020 included one complaint. The log failed identify the four preceding written complaints at all, and the fifth logged complaint log failed to include the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

Sources: email complaints, the home's 'Written and Verbal Complaint' log for 2020, interview with ED. [s. 101. (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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident’s consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee had failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding from the Local Health Integration Network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by the LHIN under a service accountability agreement, and the Minister, under section 90 of the Act.

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

During PSW interviews staff shared they are not responsible for cutting resident's toenails only fingernails. A review of the billing records to Mobile Foot Care Service, an unfunded service, identified that on October 1, 2020, 28 out of 56 residents in the LTC home paid to receive foot care services at $33.00 a treatment. A review of the foot care services authorization form for resident #001 identified 'nail cutting and monitoring' under notes and requests and was signed by the resident's SDM. A call was placed to resident #001's SDM to inquire as to the reason for the entering into a contract with Mobile Foot Care services. The SDM identified that in the adjacent retirement home the resident paid to have their toenails trimmed and wanted to continue to have resident #001 toenails trimmed. The SDM was unaware that this service was provided without charge by the home. An interview with the Director of resident Programs and Admissions revealed that their communications with family could be clearer in making sure they understand that toenail trimming is the responsibility of the home.

Sources: Wellness Service Authorization Form, Mobile Foot Services Authorization for Treatment and payment form. Mobile Foot Services billing record and staff interviews. [s. 245. 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 residents were not charged for goods and services that a licensee was required to provide to residents using funding from the Local Health Integration Network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by the LHIN under a service accountability agreement, and the Minister, under section 90 of the Act, to be implemented voluntarily.

Issued on this 25th day of February, 2021

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	**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

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) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2020_595110_0013
Log No. / No de registre :	004748-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 8, 2021
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Cedarvale Lodge Retirement and Care Community 121 Morton Avenue, Keswick, ON, L4P-2M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anna Urbanowicz

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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 35 (1).

Specifically, the licensee must:
1. Ensure that all residents receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.
2. Contact all residents or SDMs who have entered into a contract with the home's unfunded footcare service and communicate the home's responsibility to provide residents with preventive and basic foot care, including the cutting of toenails. The communications shall include confirming the residents/SDMs desire to continue with the unfunded foot care service and agreement.
3. Records shall be keep of the communications as required in #2 above for review upon request by the Inspector.

Grounds / Motifs :

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

A complaint was forwarded to the Ministry of Long Term Care (MLTC) as well as to the LTC home. The complainant alleged that resident #001 had not been provided with basic foot care and supporting evidence was provided.

PSW #104 confirmed resident #001's foot care had not been provided. Further PSW interviews revealed they had not been trained to provide basic foot care and were told in the past to only cut fingernails and not resident's toenails. PSWs revealed this practice of not trimming toenails had been in place for

years.

Sources: Resident observations, LTC home complaint binder, care plan and staff interviews with PSW #101, #104, #106, RN #102, ADOC and other staff. [s. 35. (1)]

(110)

2. An interview with PSW #101 revealed that PSWs were not responsible for trimming resident's toenails and did identify that resident #005 had not been provided with basic foot care and were unsure of who was responsible for providing it. Resident #005's feet were observed by the Inspector and provided evidence of a prolonged lack of proper foot care. The Inspector's observations were confirmed by PSW #104. The home's ED/DOC was made aware and also joined the Inspector in observing the resident's feet.

Sources: Resident #005's feet and staff interviews including PSWs, ADOC and ED/DOC. [s. 35. (1)]
(110)

3. An interview with PSW #104 identified that after the complaint of resident #001's improper foot care resident #003's nails were also trimmed. A record review identified an entry that foot care provided to resident #003 by PSW #104. During the interview the PSW described the resident's toenails which confirmed the prolonged lack of proper foot care.

Sources: Progress notes and staff interviews. [s. 35. (1)]
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2021

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:

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

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 8th day of January, 2021

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : DIANE BROWN

Service Area Office / Bureau régional de services : Central East Service Area Office