Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

London Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2018;	2017_536537_0046 (A1) (Appeal\Dir#: DR# 080)	028599-17	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Parkhill Long Term Care Residence
250 Tain Street P.O. Box 129 PARKHILL ON N0M 2K0

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 080)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on March 13, 2018.
Order(s) CO#001 was/were rescinded to reflect the Director's review DR# 080.

Issued on this 13 day of March 2018 (A1)(Appeal\Dir#: DR# 080)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 080)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 19, 20, 21, and 22, 2017

The following intake was completed within the Resident Quality Inspection:

Log # 024168-17/CIS 2632-000004-17 related to injury to a resident that resulted in a significant change in status.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Assistant Director of Care, Program and Support Services Manager, Food Services Manager/Environmental Manager, Developmental Service Worker, Registered Dietitian, two Registered Nurses (RN), three Registered Practical Nurses (RPN), two Personal Support Workers (PSW), Residents' Council representative, Family Council representative, residents and family members.

During the course of the inspection, the inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Residents' Council

Skin and Wound Care

During the course of this original 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	Legendé 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. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. **Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: A change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months; a change of 10 per cent of body weight, or more, over 6 months; any other weight change that compromised the resident's health status.

A) During the home's Resident Quality Inspection (RQI), during the staff interview, that an identified resident had been assessed as having a weight change and that no actions were taken to address the weight change.

During an interview with a Registered Nurse (RN) in stage one of the RQI, the RN stated that the resident did not receive any interventions to address the weight change.

The home's policy titled "Dietary Referral - LTC-CA-WQ-300-05-02", last revised January 2015, stated under the procedures section that reasons for dietary referrals may include significant weight loss/gain, and that the FNM (Food and Nutrition Manager) or Registered Dietitian (RD) would reply to the Dietary Referral using the RESPONSE Dietary progress note in PCC and follow up by making any appropriate changes to the required documents.

The resident's clinical record was reviewed and identified the weight change, a risk level and goals.

The Minimum Data Set (MDS) for a Significant Change in Status Assessment was reviewed and did not indicate that interventions were in place to address the weight change.

The care plan did not contain any current, resolved, or cancelled interventions related to the resident's weight change. The electronic Medication Administration Record (eMAR) in Point Click Care (PCC) did not contain any resolved, cancelled or struck-out orders of interventions for addressing the resident's weight change.

The identified resident was interviewed, verbalized concern with the weight change, and stated they did not recall being offered interventions regarding the

weight change.

The Developmental Service Worker (DSW) was interviewed and was unaware of any interventions for the resident.

Two Registered Practical Nurses (RPN) were interviewed and shared that the resident overall appearance had changed in the past few months, and that the resident had not had as part of their care, any interventions to address the weight change.

A RN was interviewed and explained that the Food Services/Environmental Manager (FSEM) reviewed the monthly weights and provided instruction for required re-weighs. The RN acknowledged that the resident did not receive interventions related to the assessed weight change.

FSEM was interviewed and stated that they had a monthly nursing and dietary meeting where the residents' monthly weights were reviewed and re-weighs were requested as needed. FSEM explained that they met with the RD to discuss the significant weight changes of the resident and discussed the resident's weight goals. FSEM continued that the RD decided when to initiate interventions for a resident who had experienced significant weight change. FSEM said that the RD addressed every significant weight change by documenting in a progress note in PCC, and that the note should include the change in weight, whether or not the change was expected, if any changes were made to the resident's plan, and how the RD would monitor the resident. FSEM shared that if a resident was assessed with a weight change, they expected interventions to be added to the resident's plan of care to address the weight change, and that if the resident was not receiving any interventions for weight change, there should be documentation to address why there were not any interventions in place. FSEM stated that the resident had been offered specific interventions in the past that were refused, and that no interventions were offered as it was expected that the resident would refuse any interventions. FSEM acknowledged that the resident had triggered for a significant weight change, but explained that the RD had not yet addressed weight changes for the month. FSEM reviewed the resident's care plan and progress notes and acknowledged that there was no documentation related to any trialled or implemented interventions to address the resident's weight change. FSEM stated that the RD was the only person who would chart interventions related to weight change. FSEM acknowledged that, based on the RD's documentation, it was not clear if weight changes were assessed using an interdisciplinary approach, and if

actions were taken and outcomes were evaluated.

The RD was interviewed and explained that they reviewed residents' significant weight changes monthly at a dietary-nursing meeting where they discussed what needed to be done, and when appropriate, would order the required interventions. RD stated that interventions were documented in quarterly assessments or in a progress note, as well as in the resident's care plan. RD added that when interventions were trialled, an actual order was entered into the resident's eMAR. RD stated that the resident had significant weight change. The RD continued that the resident had a significant change so a nutritional assessment was completed and acknowledged that they changed the resident's goals. RD acknowledged the nutritional risk of the identified resident and acknowledged they had never implemented any interventions to address the resident's significant weight change.

The licensee has failed to ensure that actions were taken and outcomes were evaluated for the change of body weight, over three months for an identified resident.

B) Review of the clinical record of an identified resident in PCC revealed significant weight changes:

The resident's clinical record was reviewed and identified the weight change, a risk level and goals.

The resident's care plan was reviewed and stated the identified risk level and diet. The care plan did not address weight goals for the resident, nor did it contain any current, resolved, or cancelled interventions related to the resident's weight change.

The resident was interviewed and stated that they never met the Registered Dietitian (RD) before and that their weight goals had never been discussed with them. The resident said that they were not content with their weight change.

Food Service/Environmental Manager (FSEM) was interviewed and stated that they had a monthly nursing and dietary meeting where the residents' monthly weights were reviewed and re-weighs were requested as needed. FSEM explained that they met with the RD to discuss the significant weight changes of all residents and discussed the resident's weight goals. FSEM said that the RD addressed every significant weight change by documenting in a progress note in PCC, and

that the note should include the change in weight, whether or not the change was expected, if any changes were made to the resident's diet, and how the RD would monitor the resident.

The RD was interviewed and stated that the resident had a recent significant change, but prior to that, the resident had not noted any concerns. The RD stated that the weight change was discussed in a recent care conference held with the resident and their family present, and it was determined that the resident desired no further weight change. RD shared that the weights were addressed along with Assistant DOC and Administrator/DOC during a meeting at the beginning of each month, and that it was not an undesired weight change, and they did not care plan specifically for the purpose of weight change for the resident. RD acknowledged there had not been any actions or interventions taken to prevent weight change for the resident.

The licensee has failed to ensure that actions were taken and outcomes were evaluated for the change of body weight, over three months for the identified resident.

Additional Required Actions:

(A1)(Appeal/Dir# DR# 080)
The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During the home's Resident Quality Inspection (RQI), it was identified during the staff interview that an identified resident had been assessed as having a weight change and that no actions were taken to address the weight change.

During an interview with a Registered Nurse (RN) in stage one of the RQI, the RN stated that the resident did not receive any nutritional interventions to address the weight change.

The home's policy titled "Dietary Referral - LTC-CA-WQ-300-05-02", last revised January 2015, stated under the procedures section that reasons for dietary referrals may include significant weight loss/gain, and that the FNM (Food and Nutrition Manager) or Registered Dietitian (RD) would reply to the Dietary Referral using the RESPONSE Dietary progress note in PCC and follow up by making any appropriate changes to the required documents.

The resident's clinical record was reviewed and identified the weight change, a risk level and goals.

The Minimum Data Set (MDS) for a Significant Change in Status Assessment was reviewed and did not indicate that interventions were in place to address the weight change.

The care plan did not contain any current, resolved, or cancelled interventions

related to the resident's weight change. The eMAR in PCC did not contain any resolved, cancelled or struck-out orders of interventions for addressing the resident's weight change.

The identified resident was interviewed, verbalized concern with the weight change, and stated they did not recall being offered interventions regarding the weight change.

The Developmental Service Worker (DSW) was interviewed and was unaware of any interventions for the resident.

Two Registered Practical Nurses (RPN) were interviewed and shared that the residents overall appearance had changed in the past few months, and that the resident had not had as part of their care, any interventions to address the weight change.

A RN was interviewed and explained that the Food Services/Environmental Manager (FSEM) reviewed the monthly weights and provided instruction for required re-weighs. The RN acknowledged that the resident did not receive interventions related to the assessed weight change.

FSEM was interviewed and stated that they had a monthly nursing and dietary meeting where the residents' monthly weights were reviewed and re-weighs were requested as needed. FSEM explained that they met with the RD to discuss the significant weight changes of the resident and discussed the resident's weight goals. FSEM continued that the RD decided when to initiate interventions for a resident who had experienced significant weight change. FSEM said that the RD addressed every significant weight change by documenting in a progress note in PCC, and that the note should include the change in weight, whether or not the change was expected, if any changes were made to the resident's plan, and how the RD would monitor the resident. FSEM shared that if a resident was assessed with a weight change, they expected interventions to be added to the resident's plan of care to address the weight change, and that if the resident was not receiving any interventions for weight change, there should be documentation to address why there were not any interventions in place. FSEM stated that the resident had been offered specific interventions in the past that were refused, and that no interventions were offered as it was expected that the resident would refuse any interventions. FSEM acknowledged that the resident had triggered for a significant weight change, but explained that the RD had not yet addressed weight

changes for the month. FSEM reviewed the resident's care plan and progress notes and acknowledged that there was no documentation related to any trialled or implemented interventions to address the resident's weight change. FSEM stated that the RD was the only person who would chart interventions related to weight change. FSEM acknowledged that, based on the RD's documentation, it was not clear if weight changes were assessed using an interdisciplinary approach, and if actions were taken and outcomes were evaluated.

The RD was interviewed and explained that they reviewed residents' significant weight changes monthly at a dietary-nursing meeting where they discussed what needed to be done, and when appropriate, would order the required interventions. RD stated that interventions were documented in quarterly assessments or in a progress note, as well as in the resident's care plan. RD added that when interventions were trialled, an actual order was entered into the resident's eMAR. RD stated that the resident had significant weight change. The RD continued that the resident had a significant change so a nutritional assessment was completed and acknowledged that they changed the resident's goals. RD acknowledged the nutritional risk of the identified resident and acknowledged they had never implemented any interventions to address the resident's significant weight change.

The licensee has failed to ensure that the resident and their substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care related to weight loss.

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During the home's Resident Quality Inspection (RQI), a resident was identified to have an area of altered skin integrity.

The home's policy titled "Skin Care Program Overview - LTC-CA-WQ-200-08-01", last revised November 2015, stated that a registered staff would complete a skin assessment using the SKIN-Initial Skin and Wound assessment in Point Click Care (PCC) with any newly identified alteration in skin integrity.

A RPN was interviewed and said that when any area of altered skin integrity was identified, they would complete an initial assessment in PCC if not previously completed. The RPN was not aware of the area of altered skin integrity for this resident.

An additional RPN was interviewed and said that for a new skin issue they would complete the initial skin assessment in PCC. The RPN was aware of the area of altered skin integrity for this resident, reviewed the resident's skin assessments, acknowledged there were none pertaining to the identified area of altered skin integrity, and said that the initial assessment for the area should have been completed in PCC.

The Wound Care Nurse (RN) for the home was interviewed and explained that registered staff members were responsible for assessing any new skin issues using the Initial Skin and Wound Assessment located in PCC, under the assessment tab. The RN stated that if a resident was assessed to determine if there were any skin problems, they would use the skin assessment tool, but if there were no issues, they would write a progress note. The RN said that they instructed other registered staff to, at minimum, write a progress note to document a skin assessment if there was no time to complete the appropriate skin assessment tool in PCC. The RN said that the identified resident had shown the RN their area of altered skin integrity. The RN acknowledged they did not complete a skin assessment for the resident's area of altered skin integrity, but just wrote a progress note.

Administrator/DOC was interviewed and stated that initial skin assessments should be completed for any new skin issue. Administrator/DOC said that the initial skin assessment should be documented in the skin assessment tool in PCC, and that a progress note was not an appropriate tool for documenting a skin assessment. Administrator/DOC acknowledged that the area of altered skin integrity identified should have been assessed using the initial skin assessment tool in PCC.

The licensee has failed to ensure that resident's area of altered skin integrity was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

The home's policy titled "Wound Care Treatment - LTC-CA-WQ-200-08-03" last revised November 2015, stated: "Residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or other wounds will receive a referral to the Registered Dietitian."

The home's policy titled "Dietary Referral - LTC-CA-WQ-300-05-02" last revised January 2015, stated: The need for nutrition intervention from the Food Service Department may be identified by any member of the health care team. Upon identifying this need, the health professional will complete a Dietary Referral progress note, supplying all relevant information. The Food Nutrition Manager (FNM) or Registered Dietitian (RD) on receiving the Dietary Referral will address the request within 30 days from when the referral was initiated. The FNM or RD will reply to the Dietary Referral using the RESPONSE Dietary progress note in Point Click Care (PCC) and follow up by making appropriate changes to the required documents such as resident care plan and resident information at point of service."

During stage one of the RQI, clinical record review for an identified resident showed that the resident had an identified area of altered skin integrity. A "Skin - Initial Skin and Wound" assessment had been completed, as a result of the area of altered skin integrity.

The clinical record for the resident included a Dietary Referral, identifying the specific area of altered skin integrity.

The Administrator/Director of Care stated that when a resident was assessed to have an area of altered skin integrity, that a referral would be sent to the Registered Dietitian using the Referral note in Point Click Care. She stated that the Registered Dietitian would review the referral, and would assess, and complete a PCC note of response. The Administrator/Director of Care reviewed the clinical record for the identified resident and stated that the resident had not been

assessed by a Registered Dietitian when a referral had been sent as a result of an area of altered skin integrity.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

Issued on this 13 day of March 2018 (A1)(Appeal/Dir# DR# 080)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 080)

Inspection No. / No de l'inspection : 2017_536537_0046 (A1)(Appeal/Dir# DR# 080)

Appeal/Dir# / Appel/Dir#: DR# 080 (A1)

Log No. / No de registre : 028599-17 (A1)(Appeal/Dir# DR# 080)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 13, 2018;(A1)(Appeal/Dir# DR# 080)

Licensee / Titulaire de permis : Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD : Chartwell Parkhill Long Term Care Residence
250 Tain Street, P.O. Box 129, PARKHILL, ON, N0M-2K0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lisa Smith

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR# 080)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 13 day of March 2018 (A1)(Appeal/Dir# DR# 080)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 080)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : London