Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
Jul 29, 2021	2021_725522_0008	006884-21	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 Sarnia ON N7T 7X1

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

Heron Terrace Long Term Care Community
11550 McNorton Street Windsor ON N8P 1T9

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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 6, 7, 8, 9, 19, 20, and 21, 2021.

Critical Incident System (CIS) report #2898-000004-21/Log #006884-21 related to falls prevention was inspected during this inspection.

This inspection was completed concurrently with Complaint inspection #2021_725522_0009.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Manager of Environmental Services, Resident Care Coordinator, Nurse Practitioner, Resident Assessment Instrument Coordinator, Registered Nurse, Registered Practical Nurses, Personal Support Workers, a Resident Support Aide, Housekeepers and a Maintenance staff member.

The inspector also completed an Infection and Prevention and Control (IPAC) tour of the home, observed IPAC practices, the provision of resident care, reviewed residents' clinical records, the home's air temperature logs, and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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. 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 the home's "Fall Prevention and Management Program" policy was complied with.

O. Reg. 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home's "Fall Prevention and Management Program" policy stated, "Post Fall: A head injury protocol will be followed when a resident receives an injury to the head, a suspected injury to the head or an unwitnessed fall."

The home's Head Injury Routine (HIR) form stated, "Under the Level of Consciousness DO NOT chart "sleeping". The resident must be awakened to complete the head injury assessment."

The HIR was to be completed every 30 minutes x 4, every 1 hour x 4 and then on days and evenings on day 2 and day 3.

A) Review of resident #005's electronic clinical record noted resident #005 had an unwitnessed fall.

A HIR was initiated when the fall occurred, the next three 30 minute checks the resident was noted as "sleeping", the next four hourly checks were not completed and a check on day two was missing.

In an interview, Registered Practical Nurse (RPN) #117 reviewed resident #005's HIR with Inspector #522 and stated staff should not have put sleeping and should have woke resident #005 up to complete the HIR. RPN #117 stated the only time a HIR would not be completed was if a resident refused and that should be entered on the HIR form.

B) Review of resident #004's electronic clinical record noted resident #004 had an unwitnessed fall.

A HIR was initiated after the fall, the last hourly check noted "breakfast" and resident #004's HIR was not completed.

In an interview, Registered Practical Nurse (RPN) #116 reviewed resident #004's HIR with Inspector #522 and stated staff should not have put "breakfast" and should have completed the HIR at the scheduled time or if the resident was eating wait until the resident was finished.

C) Review of resident #001's electronic clinical record noted resident #001 had six unwitnessed falls.

A HIR was initiated for each fall. Review of each individual HIR form noted the forms were not completed in full. There were checks that were blank or noted as "missed" and on every form there were checks that were not completed and noted "sleeping".

In interviews, the Manager of Resident Care (MRC) reviewed resident #001's HIR with Inspector #522 for the above falls. The MRC confirmed that staff had not completed the HIR in full. The MRC stated staff should complete the HIR at the required intervals and should not have indicated resident #001 was sleeping instead of completing the HIR.

Sources:
Review of resident #001, #004 and #005's clinical records, the home's "Fall Prevention and Management Program" policy RCM 10-02-01 with a revision date of May 8, 2019, the home's HIR form RCM 10-02-02A and interviews with the MRC, RPN #116, RPN #117 and RPN #121. [s. 8. (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. (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 resident #004's falls prevention plan of care provided clear direction.

Review of resident #004's electronic clinical record noted resident #004 had an unwitnessed fall.

Resident #004's progress notes indicated the resident's falls prevention intervention was not set up appropriately.

Review of resident #004's care plan and Point of Care (POC) tasks noted no intervention related to the falls intervention.

In interviews, both Personal Support Worker (PSW) #119 and Registered Practical Nurse (RPN) #116 stated resident #004 had a specific falls intervention in place.

In an interview, the Resident Assessment Instrument Coordinator (RAI-C) reviewed resident #004's care plan and POC tasks. RAI-C acknowledged that use of the specific falls intervention was not indicated in the falls interventions for the resident and there was no task to apply the falls intervention.

RAI-C stated the registered staff could update a resident's care plan, but only the RAI-C and their back up could add the POC tasks. RAI-C added the intervention to resident #004's plan of care.

Sources:
Observations of resident #004, review of resident #004's clinical records and interview with the Manager of Resident Care (MRC), RAI-C, RPN #116 and PSW #119.[s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #001's falls intervention was in place as per their plan of care.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care regarding the fall of resident #001 that resulted in injury.

Review of resident #001's electronic progress notes noted a post fall note. The Action Plan/ Post Fall Huddle stated staff were to ensure that resident #001 had a specific falls intervention in place.

Review of resident #001's electronic plan of care noted resident #001 was to have a specific falls intervention in place.

In an interview, RPN #117 stated they responded to resident #001's fall and resident #001's falls intervention was not in place at the time of the fall.

In an interview, the MRC stated they had reviewed video footage and interviewed staff after resident #001's fall. The MRC stated a PSW had taken resident #001 to the bathroom and forgot to put resident #001's falls intervention in place. [s. 6. (7)]

3. The licensee has failed to ensure care provided as per the plan of care was

documented.

A) Resident #006 was observed with a specific falls intervention in place.

Review of resident #006's care plan noted the resident was to have the falls intervention in place as part of a falls prevention measure.

Review of resident #006's Point of Care (POC) documentation survey report noted no documentation or task related to applying the specific falls intervention.

In an interview, the RAI-C acknowledged that resident #006 did have the specific falls intervention in place and that it was not part of POC tasks for PSWs to document the application of the intervention.

RAI-C stated it should be included in tasks for PSWs and added the application of the specific falls intervention to the tasks in POC for documentation.

B) Review of resident #001's care plan noted the resident was to have a specific falls intervention in place as a falls prevention intervention.

Review of resident #001's POC documentation survey report noted no documentation for a specific month, that staff were applying resident #001's falls intervention.

In an interview, the MRC reviewed resident #001's POC documentation and acknowledged there was no documentation that resident #001's falls intervention had been applied and that the application of the falls intervention should be documented.

In an interview, the RAI-C stated they thought that when they updated resident #001's POC tasks after resident #001's fall and separated the tasks for specific falls interventions, that the system deleted the wording in the task for the previous months. RAI-C stated they should have resolved the task and then initiated new tasks for the specific falls interventions.

Sources:
Observation of resident #001 and #006, review of CIS report, resident #001 and #006's clinical records and interview with the MRC and RAI-C. [s. 6. (9) 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 residents' falls prevention plans of care provide clear direction, that falls prevention interventions are in place as per residents' plans of care and the application of falls prevention interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On a specific date, Inspector #522 observed a medication cart unlocked and unattended in the hallway outside the dining room at the entrance to a specific home area.

Registered Practical Nurse (RPN) #122 was observed in the dining room administering medication.

When RPN #122 returned to the medication cart they acknowledged they had left the medication cart unlocked.

RPN #122 stated they should have locked the medication cart before going into the dining room.

Sources: Observations of medication carts and interview with RPN #122. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to ensure that COVID-19 testing for new admissions was carried out as per Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated April 23, 2021, stated,

“All admissions and transfers into the LTCH must have a laboratory(lab)-based PCR COVID-19 test, unless the exception for recently recovered residents below applies.

For fully immunized residents, a lab-based PCR test is required at time of admission/transfer as above. The individual must be placed in isolation on Droplet and Contact Precautions if their test result is pending due to an unavoidable delay.”

Resident #002 was admitted to the home on a specific dated and was fully immunized against COVID-19.

Review of resident #002’s clinical record noted the absence of a polymerase chain reaction (PCR) COVID-19 test on record. Resident #002 was not noted to be in isolation.

In an interview, Registered Practical Nurse (RPN) #108 was unable to locate a PCR test result for resident #002.

In an interview, the Nurse Practitioner (NP) stated resident #002 had a negative rapid antigen test for COVID-19 on admission.

In an interview, Registered Nurse (RN) #113 stated they did resident admissions and that on admission a resident would have a PCR test or a rapid antigen test, depending on where they were admitted from.

In an interview, the Administrator stated staff should have performed a PCR test on resident #002 on admission.

Sources:
Observation of resident #002, review of resident #002’s clinical records and interviews with the Administrator, NP, RPN #108 and RN #113. [s. 174.1 (3)]

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 COVID-19 testing for new admissions is carried out as per Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Review of the home's “Additional Precautions” policy noted a sign would be posted on or at a resident’s door to notify all team members and visitors regarding the type of isolation and the personal protective equipment (PPE) to be used.

Review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated April 23, 2021, stated for “partially immunized or unimmunized residents, a lab-based PCR test is required at the time of admission/transfer as above and the resident must be placed in isolation on Droplet and Contact Precautions for a minimum of 10 days.”

Resident #003 was admitted to the home on a specific date.

In an interview, Registered Practical Nurse (RPN) #108 stated resident #003 was in isolation.

Observation of resident #003’s room noted no droplet and contact precaution signage. A PPE flag was above the door and a bin with clean gowns was outside the door.

In an interview, Registered Practical Nurse (RPN) #108 and Personal Support Worker (PSW) #109 both observed resident #003’s room and confirmed there was no droplet and contact precautions signage on resident #003’s door.

In an interview, the Administrator stated staff had found the droplet and contact precaution signage on the side of the garbage bin outside resident #003’s door. The Administrator stated staff did not know how the signage ended up on the side of the garbage can, but it should have been clearly visible on the door frame so staff and visitors were aware the resident was on droplet and contact precautions.

Sources:
Review of resident #003’s clinical record and the home's “Additional Precautions” policy ICM 04-01 dated April 30, 2020, observation of resident #003’s room, and interviews with the Administrator, the Nurse Practitioner, Registered Nurse #113, RPN #108, PSW #109, Resident Care Coordinator #110 and Resident Care Aide #111. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act , 2004 kept confidential in accordance with that Act.

On a specific date, Inspector #522 observed a medication cart unattended in the hallway outside the dining room at the entrance to a specific home area. The electronic Medication Assessment Record (eMAR) screen was open and resident personal health information was visible.

Registered Practical Nurse (RPN) #122 was observed in the dining room administering medication.

When RPN #122 returned to the medication cart they acknowledged they had left the eMAR open. RPN #122 stated they should have locked the eMAR before going into the dining room.

Sources:
Observations of medication carts and eMARs and interview with RPN #122. [s. 3. (1) 11. iv.]

Issued on this 29th day of July, 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

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2021_725522_0008
Log No. / No de registre :	006884-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 29, 2021
Licensee / Titulaire de permis :	S & R Nursing Homes Ltd. 265 North Front Street, Suite 200, Sarnia, ON, N7T-7X1
LTC Home / Foyer de SLD :	Heron Terrace Long Term Care Community 11550 McNorton Street, Windsor, ON, N8P-1T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amy Sworik

To S & R Nursing Homes Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 8. (1)(b).

Specifically,
A) All residents who have a head injury or unwitnessed fall have a head injury routine completed as per the home's head injury routine policy.
B) The home will complete re-education with all registered staff members related to the home's head injury routine policy.
B) A record must be kept of the training, including the dates of the training and the staff members who completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's "Fall Prevention and Management Program" policy was complied with.

O. Reg. 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home's "Fall Prevention and Management Program" policy stated, "Post Fall: A head injury protocol will be followed when a resident receives an injury to the head, a suspected injury to the head or an unwitnessed fall."

The home's Head Injury Routine (HIR) form stated, "Under the Level of Consciousness DO NOT chart "sleeping". The resident must be awakened to complete the head injury assessment."

The HIR was to be completed every 30 minutes x 4, every 1 hour x 4 and then on days and evenings on day 2 and day 3.

A) Review of resident #005's electronic clinical record noted resident #005 had an unwitnessed fall.

A HIR was initiated when the fall occurred, the next three 30 minute checks the resident was noted as "sleeping", the next four hourly checks were not completed and a check on day two was missing.

In an interview, Registered Practical Nurse (RPN) #117 reviewed resident #005's HIR with Inspector #522 and stated staff should not have put sleeping and should have woke resident #005 up to complete the HIR. RPN #117 stated the only time a HIR would not be completed was if a resident refused and that should be entered on the HIR form.

B) Review of resident #004's electronic clinical record noted resident #004 had an unwitnessed fall.

A HIR was initiated after the fall, the last hourly check noted "breakfast" and resident #004's HIR was not completed.

In an interview, Registered Practical Nurse (RPN) #116 reviewed resident #004's HIR with Inspector #522 and stated staff should not have put "breakfast" and should have completed the HIR at the scheduled time or if the resident was eating wait until the resident was finished.

C) Review of resident #001's electronic clinical record noted resident #001 had six unwitnessed falls.

A HIR was initiated for each fall. Review of each individual HIR form noted the forms were not completed in full. There were checks that were blank or noted as "missed" and on every form there were checks that were not completed and

noted "sleeping".

In interviews, the Manager of Resident Care (MRC) reviewed resident #001's HIR with Inspector #522 for the above falls. The MRC confirmed that staff had not completed the HIR in full. The MRC stated staff should complete the HIR at the required intervals and should not have indicated resident #001 was sleeping instead of completing the HIR.

Sources:
Review of resident #001, #004 and #005's clinical records, the home's "Fall Prevention and Management Program" policy RCM 10-02-01 with a revision date of May 8, 2019, the home's HIR form RCM 10-02-02A and interviews with the MRC, RPN #116, RPN #117 and RPN #121.

An order was made by taking the following factors into account:

Severity: Head Injury Routine assessments were incomplete for residents #001, #004 and #005 after they had a fall. This put the residents at actual risk as staff had the potential to miss post fall injuries.

Scope: The scope of this non-compliance was widespread as the home's Fall Prevention and Management Program policy was not complied for all three residents reviewed.

Compliance History: There was no previous noncompliance to this section of O. Reg. 79/10. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 29, 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 29th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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