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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 14, 2021	2021_829757_0002 (A1)	020934-20, 021208-20	Critical Incident System

Licensee/Titulaire de permis

Nipigon District Memorial Hospital
125 Hogan Road Nipigon ON P0T 2J0

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

Nipigon District Memorial Hospital
125 Hogan Road P.O. Box 37 Nipigon ON P0T 2J0

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

Amended by SHELLEY MURPHY (684) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Request to extend CO#001 CDD to April 30, 2021 approved to support compliance audit completion, review and monitoring.

Issued on this 14th day of April, 2021 (A1)

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

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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 14, 2021	2021_829757_0002 (A1)	020934-20, 021208-20	Critical Incident System

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

Amended by SHELLEY MURPHY (684) - (A1)

Amended 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): January 25-28, 2021.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

-An intake related to the improper oral care of a resident.

-An intake regarding an allegation of neglect related to medication administration.

Follow up inspection #2021_829757_0003 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Activity Coordinator, Physiotherapist (PT), Registered Dental Hygienist (RDH), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

7 WN(s)
2 VPC(s)
2 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. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents received oral care to maintain the integrity of their oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

The Director of Care (DOC) stated that the home had completed an investigation related to a resident's oral care, and subsequently identified that this resident had not received twice daily mouth care. The resident was identified as having received little to no mouth or oral care over a period of months, and it was identified that their oral health had deteriorated upon examination by the Registered Dental Hygienist (RDH). The DOC indicated that after broadening their investigation, it was identified that two other residents had also not received twice daily mouth care, and the lack of twice daily mouth care was a prevalent care issue in the home.

Sources: Three resident's Point of Care (POC) documentation for oral care and care plans; A Critical Incident System (CIS) report; The home's critical incident investigation file; “Oral Health Program" policies; and interviews with the DOC, and other relevant staff members. [s. 34. (1) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person hired as an Administrator had successfully completed, or was enrolled in, a program in long-term care home administration or management that was a minimum of 100 hours in duration of instruction time.

During an interview, the home's Administrator identified that they had been in the role since November 2, 2020, but had not completed or enrolled in a program in long-term care administration or management at the time of inspection.

Source: Interview with the Administrator. [s. 212. (4) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plans of care for three residents was documented.

Three residents were identified as having not received adequate mouth and oral care (refer to WN #1 for details). The POC documentation records for these residents identified gaps related to staff documenting the provision of oral care. The DOC confirmed that the residents' oral care interventions had corresponding gaps in documentation, and that staff had not followed the home's policy to document all care that was provided to residents in POC.

Sources: Three resident's POC documentation and care plans; A CIS report; The home's critical incident investigation file; “Oral Health Program” policies; “Care Plans and Plan of Care” policy; and interviews with the DOC, and other relevant staff members. [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 that the provision of care set out in the plans of care for residents is documented, to be implemented voluntarily.

WN #4: 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 the medication administration policies and procedures included in the required medication management system were complied with by RPN #112 and four other RPNs.

Ontario Regulation (O. Reg.) 79/10, s. 114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate dispensing and administration of all drugs used in the home.

The home's medication administration policy stated "medications are not pre-poured under any circumstances", "medication administration is documented on the resident's Medication Administration Record at the time the medication is given by the person who administered the medication", and "medications are administered within one (1) hour of the scheduled time". Over four days, RPN #112 pre-poured medications for a resident which were then administered by four other RPNs. Although administered by the other RPNs, RPN #112 signed that they had administered the medications. A medication was scheduled for administration to the resident at 1400 hours; however, it was administered at 1230 hours over these dates. The DOC stated that the RPNs had not complied with the home's medication administration policy.

Sources: A CIS report; The home's critical incident investigation file; "Administration of Medications – General Guidelines" policy; A resident's Medication Administration Record (MAR); and interviews with the DOC, RPN #112, and other relevant staff members. [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 home's medication administration policies and procedures are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff complied with the home's zero tolerance of abuse and neglect of residents policy, with regard to a resident's oral care.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

The home's investigation related to the oral care of the resident identified that they had little to no mouth care or oral care completed over a period of months, and that their oral health had deteriorated upon examination by the RDH. The RDH indicated that they had assessed the resident months prior, at which time the resident’s oral health was in a non-concerning condition. They indicated that due to COVID-19 restrictions they had not assessed the resident again until months later, and at that time the resident’s oral health had drastically declined. The RDH indicated that upon assessment, they identified that the resident had not been receiving proper oral care, including twice daily brushing of their teeth, and that this had resulted in harm to the resident.

Sources: A CIS report; The home's critical incident investigation file; A resident's progress notes and care plan; "Zero Tolerance of Abuse and Neglect of Residents" policy; and interviews with the RDH, DOC, and other relevant staff members. [s. 20. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect neglect of a resident by staff that resulted in harm or a risk of harm, was immediately reported.

Pursuant to subsection 152 (2) of the Long-Term Care Homes Act (LTCHA): where an inspector finds that a staff member has not complied with subsection 24 (1), the licensee shall be deemed to have not complied with the relevant subsection. An RPN was made aware of allegations of neglect related to a claim by a resident that they had not received a medication for days. The RPN did not report the allegation of neglect to the DOC immediately, instead reporting it three days later. Once informed, the DOC submitted the CIS report to the Director related to the allegation of neglect.

Sources: A CIS report; and interviews with an RPN, the DOC, and other relevant staff members. [s. 24. (1) 2.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to include in the report to the Director: the outcome or current status of a resident who was involved in an incident of neglect.

The home submitted a CIS report to the Director, related to an incident of neglect regarding a resident. The CIS report did not include the results of the home's investigation; including the outcome or current status of the resident.

Sources: A CIS report; The home's critical incident investigation file; "Mandatory Reporting Requirements" policy; "Zero Tolerance of Abuse and Neglect of Residents" policy; and interviews with the DOC, and other relevant staff members. [s. 104. (1) 3.]

Issued on this 14th day of April, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHELLEY MURPHY (684) - (A1)
Inspection No. / No de l'inspection :	2021_829757_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020934-20, 021208-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 14, 2021(A1)
Licensee / Titulaire de permis :	Nipigon District Memorial Hospital 125 Hogan Road, Nipigon, ON, P0T-2J0
LTC Home / Foyer de SLD :	Nipigon District Memorial Hospital 125 Hogan Road, P.O. Box 37, Nipigon, ON, P0T-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Dorval

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Nipigon District Memorial Hospital, 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. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,

(a) mouth care in the morning and evening, including the cleaning of dentures;

(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and

(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Order / Ordre :

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

The licensee must comply with s. 34 (1) (a) of O. Reg. 79/10.

Specifically, the licensee must:

1) Provide education to all Personal Support Worker (PSW) staff on required oral care and document the education provided, who provided it, and staff attendance.

2) Have all PSW staff review the home's requirements for the documentation of the provision of care to residents, and sign off that they understand the requirements.

3) Conduct weekly audits to ensure that oral care is being provided and documented in both the morning and evening. Where gaps in oral care or documentation of the provision of oral care are identified, the home must review the gaps with the responsible PSW(s), take corrective action as needed, and document any action taken as well as the PSW's response. Document the audits and continue auditing until no concerns related to missing oral care or documentation of the provision of oral care are identified for two weeks.

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

Grounds / Motifs :

1. The licensee has failed to ensure that three residents received oral care to maintain the integrity of their oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

The Director of Care (DOC) stated that the home had completed an investigation related to a resident's oral care, and subsequently identified that this resident had not received twice daily mouth care. The resident was identified as having received little to no mouth or oral care over a period of months, and it was identified that their oral health had deteriorated upon examination by the Registered Dental Hygienist (RDH). The DOC indicated that after broadening their investigation, it was identified that two other residents had also not received twice daily mouth care, and the lack of twice daily mouth care was a prevalent care issue in the home.

Sources: Three resident's Point of Care (POC) documentation for oral care and care plans; A Critical Incident System (CIS) report; The home's critical incident investigation file; “Oral Health Program" policies; and interviews with the DOC, and other relevant staff members. [s. 34. (1) (a)]

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

Severity: There was actual harm to a resident as neglect of their oral care lead to a deterioration of their oral health.

Scope: The scope of this non-compliance was widespread as it was identified in three of the three residents reviewed during this inspection.

Compliance History: The licensee had no history of non-compliance to this subsection in the past 36 months. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 30, 2021(A1)

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: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,

(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration;

(b) has at least three years working experience,

(i) in a managerial or supervisory capacity in the health or social services sector, or

(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d);

(c) has demonstrated leadership and communications skills; and

(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Order / Ordre :

The licensee must comply with s. 212 (4) (d) of Ontario Regulation (O. Reg. 79/10).

Specifically, the licensee must ensure that the Administrator for the home has completed or has been enrolled in a program in long-term care administration or management that is a minimum of 100 hours in duration of instruction time.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the person hired as an Administrator had successfully completed, or was enrolled in, a program in long-term care home administration or management that was a minimum of 100 hours in duration of instruction time.

During an interview, the home's Administrator identified that they had been in the role since November 2, 2020, but had not completed or enrolled in a program in long-term care administration or management at the time of inspection.

Source: Interview with the Administrator. [s. 212. (4) (d)]

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

Severity: There was minimal risk to the management and operation of the home related to the Administrator not having the specific education required for the position.

Scope: The scope of this non-compliance was widespread as it affects all management and operations of the home.

Compliance History: A compliance order (CO) was issued to the home related to this subsection in the past 36 months. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 16, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 14th day of April, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SHELLEY MURPHY (684) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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