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

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

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

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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
Oct 1, 2020	2020_829757_0023	002662-20, 009613-20, 014547-20, 015649-20, 016956-20	Complaint

Licensee/Titulaire de permis

Shepherd Village Inc.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

Shepherd Lodge
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

DAVID SCHAEFER (757), CHAD CAMPS (609), JULIE KUORIKOSKI (621), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 21-24, 2020.

The following intakes were inspected during this Complaint inspection:
-a complaint regarding concerns related to staffing levels, snack and dining service, and residents' council.
-a complaint regarding concerns related to falls, plan of care, medication administration, and the complaints process.
-a complaint regarding concerns related to continence care and insufficient assessments.
-a complaint regarding concerns related to continence care and bathing.
-a complaint regarding concerns related to neglect, medication administration, skin and wound care, infection prevention and control, and plan of care.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Quality Compliance Manager, Director of Facility Services, Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant, Nurse Practitioner, Nurse Managers, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Activation Staff, and Personal Support Workers (PSWs).

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, internal investigation notes, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from physical abuse by PSW #121.

Ontario Regulation 79/10 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain". The resident's care plan stated that staff were to ask permission prior to touching the resident for care, were to stop and re-approach if the resident was not ready or was refusing care, and were to call for help if the resident was unmanageable during care. PSW #121 was in the resident's room alone to provide care; however, the resident was displaying responsive behaviours and was not cooperative with care at the time. PSW #115 entered the room and discovered that the resident had incurred an injury during this time. The home's Director of Care (DOC) and Quality Compliance Manager (QCM) confirmed that physical abuse had occurred. PSW #121 was disciplined citing that the allegations of abuse to the resident were substantiated and that they had "improperly caused a resident to sustain [an injury]".

Sources: Resident's care plan and progress notes; the home's internal investigation notes; and interviews with the DOC and QCM. [s. 19. (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. (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 substitute decision-maker (SDM) for a resident was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to a medical intervention.

The resident returned from the hospital to the home with a medical intervention in place. The SDM had requested the intervention be removed at the home. The SDM was not given an opportunity to participate in the physician's decision for the resident to remain with the medical intervention in place. There was an increased risk to the resident, as extended use of the intervention may cause infection.

Sources: Resident's electronic progress notes; and an interview with RPN #124. [s. 6. (5)]

2. The licensee has failed to ensure that the SDM for a resident was given an opportunity to participate fully in the development and implementation of the resident’s plan of care related to diet texture.

The resident was assessed by the Registered Dietitian (RD) as having risks associated with their diet, and recommend a change of the resident’s diet. The resident’s diet was changed without the consent of the SDM.

Sources: Resident's electronic progress notes; Prescriber Order sheets; and interviews with the RD and other relevant staff members. [s. 6. (5)]

3. The licensee has failed to ensure that the SDM for a resident was given an opportunity to participate fully in the development and implementation of the resident’s plan of care related to medications.

A medication was discontinued for the resident. The SDM for the resident was not notified that the medication had been discontinued.

Sources: Resident's electronic progress notes and medication administration records; and interviews with RPN #124 and other relevant staff members. [s. 6. (5)]

4. The licensee has failed to ensure that a resident's SDM was given the opportunity to participate fully in the development and implementation of the resident's plan of care related to recreation.

The Recreation Assistant (RA) #119 for the resident's unit indicated that the resident's SDM had provided personal recreation supplies and requested that these be included in the resident's care. The RA indicated that they had not included these recreation supplies in the resident's care plan, but would now include them.

Sources: Resident's care plan; and an interview with RA #119. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents, their substitute decision-makers, if any, and any other persons designated by the residents or substitute decision-makers are given an opportunity to participate fully in the development and implementation of the residents' plans of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident after a fall.

The resident had a fall. Following an assessment by RPN #118, the resident was found to have pain and limited movement to an area of their body. The home's Falls Prevention and Management policy stated "it is important for nursing staff to complete proper assessments of residents who [had] fallen prior to moving any resident", and "if there [was] any doubt about a ... fracture, the resident should NOT be moved!". RPN #118 stated that they had transferred the resident from the ground to their bed following this assessment. The RPN indicated that they knew residents should not be moved if there was an indication of a possible fracture in order to not cause further harm.

Sources: Resident's electronic progress notes; Critical Incident System (CIS) Report; the home's internal investigation notes; and interviews with RPN #118 and other relevant staff members. [s. 36.]

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 use safe transferring and positioning techniques when assisting residents after a fall, to be implemented voluntarily.

WN #4: 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, who was exhibiting altered skin integrity, 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.

RPN #125 observed an area of altered skin integrity on the resident. The RPN did not utilize an appropriate assessment instrument specifically designed for skin and wound assessment to assess this area. There was an increased risk to the resident, as not using an appropriate assessment instrument could increase the risk of further altered skin integrity.

Sources: Skin and Wound Care Program policy, Resident's electronic progress notes; and interviews with RPN #125 and other relevant staff members. [s. 50. (2) (b) (i)]

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 and other residents exhibiting altered skin integrity receive 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, if the home was not using a computerized system to monitor water temperatures, the water temperatures were monitored once per shift in random locations where residents have access to hot water.

It was identified that there had been an incident of hot water temperatures not being maintained in the home over the previous week.

During an interview with PSW #123, they reported that there was one day in the past week where water temperatures were an issue in the home.

During an interview with the Director of Facility Services, they reported that there had been contact maintenance work done on the home's water system, from September 15-17, 2020, inclusive, and confirmed that there had been some periodic problems maintaining water temperatures within the required temperature range, during the three day period. Further, they identified that they had received an email from RN #122 about a cold water temperature reading from the evening of September 17, 2020, which was addressed by the contract worker within three hours on the same evening. Finally, the Director of Facility Services reported that while the home had a computerized system to monitor the home's water temperatures, the system was unable to report individual temperatures where residents could access hot water in their rooms. They identified that once per shift, three times daily, random water temperatures were taken from two resident bathroom faucets and one resident accessible washroom on an identified unit, and recorded in the fourth floor temperature binder.

On review of the home's temperature log, it was identified that there were missing temperatures.

During a subsequent interview with the Director of Facility Services, they confirmed that the maintenance department's designated handyman did not take and record a water temperature for the sixth floor washroom, at 1200 hours on September 15, 2020, as required. Additionally, they reported that the department did not have a handyman working on the night shift of April 16, 2020, to complete the water temperature check at 1800 hours for resident room 322. They confirmed that the maintenance handyman on each shift was responsible for taking and recording the resident room and unit water temperatures as per legislative requirements, and did not.

Sources: Water Temperature policy; RN #122 email to the Director of Facility Services

and Nursing Management Team; September 2020 water temperature logs; and interviews with the Director of Facility Services and other relevant staff members. [s. 90. (2) (k)]

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 if not using a computerized system to monitor water temperatures, the water temperatures are monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when improper or incompetent treatment of a resident that resulted in harm was suspected, that the suspicion and the information upon which it was based was immediately reported to the Director.

A CIS report was submitted to the Director, by the home's QCM under section 24 (1) 1. of the Long-Term Care Home's Act (LTHCA), as an incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. The report was related to an incident that occurred on the previous day. The home's Mandatory and Critical Incidents policy indicated that staff were to immediately initiate and submit the online CIS report or call the after hours reporting line if the incident occurred after hours. No after hours report was submitted to the Director. The home's QCM indicated that they couldn't remember why they had not submitted the report immediately.

Evidence: CIS report; Mandatory and Critical Incidents policy; interview with the home's QCM. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision-maker (SDM) for a resident was immediately provided notification of the results of the investigation required under s. 23 (1) of the LTCHA.

A CIS report was submitted to the Director, by the home's QCM, related to allegations of physical abuse of a resident. The report indicated that the resident's SDM had been notified of the incident initially, and that they would be updated when the investigation was completed. The QCM stated that they had not notified the resident's SDM that the investigation into the incident had indicated that the allegation of physical abuse of the resident was founded. The DOC stated that notifying the SDM of the result of the investigation was their responsibility, but that they had not done so.

Sources: CIS report; and interviews with the QCM and DOC. [s. 97. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record of a verbal complaint was kept in the home.

A verbal complaint concerning a change of medication for a resident was brought forward to the DOC. The complaint was not documented by the DOC.

Sources: Complaint Procedure-Residents/Families policy; the home's complaints binder; and an interview with the DOC. [s. 101. (2)]

WN #9: 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 ensure that for a suspected incident of abuse of a resident by PSW #121, that the outcome or current status of the individuals involved in the incident were included in the report to the Director.

A CIS report was submitted to the Director, by the home's QCM under section 24 (1) 1. of the LTHCA, as an incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. PSWs #115 and #121 received letters from the home indicating that allegations of abuse had been made against them. The CIS report was not updated after the initial submission to include information indicating that the allegation of abuse against PSW #121 was determined to be founded and that the PSW was disciplined as a result of the home's investigation. The QCM indicated that they had forgotten to update the report.

Sources: CIS report; the home's internal investigation notes; and an interview with the home's QCM. [s. 104. (1) 3. v.]

Issued on this 6th day of October, 2020

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) :	DAVID SCHAEFER (757), CHAD CAMPS (609), JULIE KUORIKOSKI (621), MELISSA HAMILTON (693), STEVEN NACCARATO (744)
Inspection No. / No de l’inspection :	2020_829757_0023
Log No. / No de registre :	002662-20, 009613-20, 014547-20, 015649-20, 016956-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 1, 2020
Licensee / Titulaire de permis :	Shepherd Village Inc. 3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
LTC Home / Foyer de SLD :	Shepherd Lodge 3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cathy Fiore

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 Shepherd Village Inc., 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with s. 19 (1) of the LTCHA.

Specifically, the licensee must ensure that resident #003 is protected from physical abuse by staff.

Grounds / Motifs :

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

1. The licensee has failed to ensure that a resident was protected from physical abuse by PSW #121.

Ontario Regulation 79/10 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain". The resident's care plan stated that staff were to ask permission prior to touching the resident for care, were to stop and re-approach if the resident was not ready or was refusing care, and were to call for help if the resident was unmanageable during care. PSW #121 was in the resident's room alone to provide care; however, the resident was displaying responsive behaviours and was not cooperative with care at the time. PSW #115 entered the room and discovered that the resident had incurred an injury during this time. The home's Director of Care (DOC) and Quality Compliance Manager (QCM) confirmed that physical abuse had occurred. PSW #121 was disciplined citing that the allegations of abuse to the resident were substantiated and that they had "improperly caused a resident to sustain [an injury]".

Sources: Resident's care plan and progress notes; the home's internal investigation notes; and interviews with the DOC and QCM.

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

Severity: The incident of physical abuse resulted in actual harm and an injury to the resident.

Scope: The non-compliance was isolated as one resident was abused.

Compliance History: Two compliance orders (COs) were issued to the home under this subsection of legislation in the past 36 months. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 13, 2020

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 1st day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : David Schaefer

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