Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, Dec 12, 2017	2017_626501_0022	025365-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE SCARBOROUGH
3830 LAWRENCE AVENUE EAST SCARBOROUGH ON M1G 1R6

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

SUSAN SEMEREDY (501), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 7, 8, 9, 10, 14, 15, 16, and 17, 2017.

During this inspection, the following intakes were inspected:
CIR Intake # 012658-17, 024763-16 related to transfer List and complaint #013268-17 related to improper transfer, and a follow up intake #003545-17.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nursing staff, Personal Support Workers (PSWs), Environmental Services Manager (ESM), Substitute Decision Makers (SDMs), Residents' Council President, Family Council President, family members and residents.

During the course of the inspection the inspectors conducted a tour of the home; observed medication administration, resident to resident interactions, staff to resident interactions and
the provision of care; reviewed resident health care records, meeting minutes for Residents' Council, and Family Council, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2016_302600_0021	501

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Review of Critical Incident Report (CIR) submitted to the Ministry of Health and Long-Term Care on identified date, revealed that there was an incident of improper or

incompetent treatment or care of resident #010 that resulted in harm to the resident. According to the CIR, PSW #109 was helping resident #010 with an identified care. The resident was sitting on the side of the identified assisting device because he/she was feeling unwell and needed time before receiving the care. The resident then fell backwards and sustained injury to his/her identified part of the body.

Record review revealed resident #010 was admitted to the home on identified date with an identified illness and needed the assistance of two persons for the identified care. According to a physician progress note on identified date, resident #010 was improving and needed only one person for the care. A progress noted on identified date, revealed the resident was noted to have an identified illness. A head to toe assessment on identified date, revealed the resident had an injury on identified part of the body which was sustained during the care. A further progress note on the identified day stated the resident was sent to the hospital for further assessment and admitted for the identified illness.

Review of a complaint investigation record on identified date, revealed resident #010's identified family member spoke with the ADOC claiming resident #010 told him/her that the resident sustained injury during an identified type of care provision. According to investigation notes, the DOC surmised the PSW was rushing the care while the resident was exhibiting the identified illness. The resident subsequently fell backwards and sustained injury to the identified part of the body. PSW #109 admitted he/she tried to provide the care when resident #010 fell backwards and sustained injury.

An interview with resident #012, who was resident #010's roommate at the time of the incident, revealed he/she was in the identified area and overheard the exchange between resident #010 and PSW #109. Resident #012 stated he/she heard resident #010 state he/she was not feeling well and needed time to get up. According to resident #012, PSW #109 would often get residents up on identified time of the day prior to his/her shift begins. Resident #012 stated he/she was in the area and saw resident #010 sitting on identified assisting device with the identified injury.

An interview with PSW #109 revealed he/she often would come in early for his/her shift that started at identified hours and would provide the identified care. According to PSW #109 resident #010 had not rung the call bell on the identified date, but did ask PSW #109 to provide the care. PSW #109 stated he/she was trying to provide the care and admitted resident #010 told him/her that he/she was unwell. The PSW then continued providing the care and resident sustained injury to the identified part of the body. The

PSW indicated to the inspector that maybe the resident was feeling unwell. The PSW stated he/she did not receive the identified report from registered staff prior to performing care to resident #010 on the identified date, and admitted this was not a safe practice.

An interview with RN #108, revealed that towards the end of his/her shift, PSW #109, who was working on the identified time of the day, came and told him/her that resident #010 sustained an injury. RN #108 found resident #010 sitting on the identified assistive device. Resident #010 told RN #108 that he/she was feeling unwell, needed more time and, felt like he/she was being rushed and did not want to get up on the identified time of the day. According to RN #108, PSW #109 often would come in early on the identified shift and provide care to residents prior to receiving the identified report. The RN stated it had been an issue that PSW #109 was coming in on the identified time of the day and management was aware.

An interview with RN #104 revealed he/she had spoken to PSW #109, before the above mentioned incident, regarding the safety of residents being put in jeopardy when he/she provide care without first receiving the identified report. RN #104 reported his/her concerns to the ADOC after the above mentioned incident.

An interview with the ADOC revealed PSW #109 should not have provided the identified care on the identified time of the day when the resident was unwell. The ADOC stated it is the practice in the home for PSWs to not attempt to provide the care if residents are not capable or ready and should report the problem to registered staff. The ADOC admitted the PSW did not provide the care safely. The ADOC stated he/she was not aware PSW #109 was coming in on the identified time of the day and providing the care prior to receiving report. The DOC also acknowledged that it is not a safe practice for PSWs to care for residents without receiving the identified report.

The scope of this noncompliance is isolated and the severity is potential for actual harm. Due to ongoing non-compliance with a previous compliance order related to O.Reg. 79/10, s.36, issued in inspection report 2016_302600_0021 dated February 6, 2017, a compliance order is being served. [s. 36.]

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors that residents do not have access to were kept closed and locked.

On the initial tour of the home on November 7, 2017, at approximately 0940 hours, inspector #501 observed the beauty salon on the first floor by the nursing station was open. There was a dental service using the room. Further observation on the same day by inspector #501 and #645, at approximately 1120 hours, revealed the door to the beauty salon was closed but not locked. There were various chemicals and beauty appliances within the room.

The inspectors brought this concern to the attention of the DOC who was nearby and he/she asked the RN at the nursing station for keys to lock the room. The DOC struggled to find the correct key and took several minutes to lock the door.

An interview with the Administrator confirmed the beauty salon door should be kept locked to prevent access by residents to the chemicals and appliances found within. [s. 9. (1) 1. i.]

2. The licensee has failed to ensure that any locks on toilet rooms must be designed and maintained so they can be readily released from the outside in an emergency.

During the initial tour of the home on November 7, 2017, observation revealed the staff washroom near to the identified nursing station was unlocked. Further observation revealed this door could be locked from the inside. The washroom was situated at a busy location where many residents, staff and visitors passed by.

The same washroom door was observed unlocked on November 9 and 10, 2017. On November 10, 2017, an interview with RN #001 revealed he/she could not open the door when it was rendered in the locked position. The RN had a large ring of keys and tried all keys but could not find one that would unlock the washroom door. The RN admitted this would be a risk if there was an emergency and a resident was locked inside. [s. 9. (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 all doors that residents do not have access are kept closed and locked and that any locks on toilet rooms must be designed and maintained so they can be readily released from the outside in an emergency, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of resident that resulted in harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Review of Critical Incident Report (CIR) submitted to the Ministry of Health and Long-Term Care (MOHLTC) on the identified date revealed that, there was an incident of improper or incompetent treatment or care of resident #010 that resulted in harm to the resident. According to the CIR, PSW #109 was providing an identified type of care on an identified time of the day. The resident was unwell during the care and sustained an injury to the identified part of the body.

An interview with the DOC, who submitted the above CIR, revealed he/she was on vacation and does not know why the MOHLTC was not notified sooner. An interview with the ADOC revealed he/she was aware of the incident on the identified date and started some questioning. Before submitting the CIR, the ADOC stated he/she wanted to get more information and get a clear picture of what happened before submitting the CIR.The ADOC acknowledged he/she should have immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (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 a person who has reasonable grounds to suspect that improper or incompetent treatment or care of resident that resulted in harm to the resident immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures were implemented for cleaning of supplies and devices, including personal assistance services devices, assistive aids and position aids.

Resident #001 triggered from stage one related to unclean ambulation equipment from resident observation due to the resident's identified assistive device looking unclean on November 8, 2017.

Further observations on November 9 and 10, 2017, revealed that the identified assistive device was still unclean. Record review of the home's device cleaning schedule revealed resident #001's identified device was to be cleaned on November 9, 2017, however, there was no initial for any staff member having completed this cleaning.

Interview with the ADOC and DOC confirmed resident #001's assistive device was unclean and had not been cleaned as scheduled. [s. 87. (2) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 207. Transfer list

Specifically failed to comply with the following:

s. 207. (2) The licensee shall place the name of a resident on the transfer list referred to in subsection (1) when the request for a transfer is received. O. Reg. 79/10, s. 207 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the name of a resident was placed on the transfer list when the request for a transfer was received.

Review of the identified intake revealed that there was an email sent to the Ministry of Health and Long-Term Care regarding resident #011 on an identified date. According to the resident #011, he/she wished to apply for transfer from identified type of accommodation to a different type of accommodation at a care conference in the spring of 2016 and made this known to the Administrator. According to the resident, he/she was told that she had to wait for one year before he/she could apply for the identified accommodation.

An interview with resident #011 revealed he/she could not recall the circumstances regarding his/her complaint.

Record review revealed the resident was admitted to the home on an identified date, and the resident agreed to the identified type of accommodation. A progress note on an identified date, revealed there was meeting where the Administrator, DOC, resident #011 and friends of the resident were in attendance. During this meeting, resident #011 requested to be put on the internal waiting list for the identified type of accommodation.

An interview with the Administrator revealed resident #011 is currently in an identified type of room paying the identified accommodation fee as of the identified date. The Administrator stated the resident was shown an alternative type of accommodation but refused.

Review of the home's internal wait list revealed resident #011 was placed on the waiting list on the identified date. Further interview with the Administrator revealed he/she did not put resident #011 on the internal wait list for the identified accommodation until then because after the meeting on May 11, 2016, he/she told resident #011 to put his/her request in writing which resident #011 failed to do. The Administrator stated he/she was

approached verbally again in November 2016, by resident #011 requesting to be put on the wait list for the identified type of accommodation and at this time the Administrator complied.

The Administrator acknowledged the name of resident #011 was not placed on the transfer list when the request for a transfer was received on the identified date. [s. 207. (2)]

Issued on this 12th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501), DEREGE GEDA (645)
Inspection No. / No de l'inspection :	2017_626501_0022
Log No. / No de registre :	025365-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 29, Dec 12, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE SCARBOROUGH 3830 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1G-1R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pinky Virdi

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

The licensee shall prepare, submit and implement a plan to ensure:
-All direct care staff receive shift report before caring for residents
-PSW #109 uses safe transferring and positioning techniques when transferring residents

For the above, please include how the home will implement such a plan. The plan is to be submitted via email to inspector susan.semeredy@ontario.ca by December 29, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Review of Critical Incident Report (CIR) submitted to the Ministry of Health and Long-Term Care on identified date, revealed that there was an incident of improper or incompetent treatment or care of resident #010 that resulted in harm to the resident. According to the CIR, PSW #109 was helping resident #010 with an identified care. The resident was sitting on the side of the identified assisting device because he/she was feeling unwell and needed time before receiving the care. The resident then fell backwards and sustained injury to his/her identified part of the body.

Record review revealed resident #010 was admitted to the home on identified date with an identified illness and needed the assistance of two persons for the identified care. According to a physician progress note on identified date,

resident #010 was improving and needed only one person for the care. A progress noted on identified date, revealed the resident was noted to have an identified illness. A head to toe assessment on identified date, revealed the resident had an injury on identified part of the body which was sustained during the care. A further progress note on the identified day stated the resident was sent to the hospital for further assessment and admitted for the identified illness.

Review of a complaint investigation record on identified date, revealed resident #010's identified family member spoke with the ADOC claiming resident #010 told him/her that the resident sustained injury during an identified type of care provision. According to investigation notes, the DOC surmised the PSW was rushing the care while the resident was exhibiting the identified illness. The resident subsequently fell backwards and sustained injury to the identified part of the body. PSW #109 admitted he/she tried to provide the care when resident #010 fell backwards and sustained injury.

An interview with resident #012, who was resident #010's roommate at the time of the incident, revealed he/she was in the identified area and overheard the exchange between resident #010 and PSW #109. Resident #012 stated he/she heard resident #010 state he/she was not feeling well and needed time to get up. According to resident #012, PSW #109 would often get residents up on identified time of the day prior to his/her shift begins. Resident #012 stated he/she was in the area and saw resident #010 sitting on identified assisting device with the identified injury.

An interview with PSW #109 revealed he/she often would come in early for his/her shift that started at identified hours and would provide the identified care. According to PSW #109 resident #010 had not rung the call bell on the identified date, but did ask PSW #109 to provide the care. PSW #109 stated he/she was trying to provide the care and admitted resident #010 told him/her that he/she was unwell. The PSW then continued providing the care and resident sustained injury to the identified part of the body. The PSW indicated to the inspector that maybe the resident was feeling unwell. The PSW stated he/she did not receive the identified report from registered staff prior to performing care to resident #010 on the identified date, and admitted this was not a safe practice.

An interview with RN #108, revealed that towards the end of his/her shift, PSW #109, who was working on the identified time of the day, came and told him/her that resident #010 sustained an injury. RN #108 found resident #010 sitting on

the identified assistive device. Resident #010 told RN #108 that he/she was feeling unwell, needed more time and, felt like he/she was being rushed and did not want to get up on the identified time of the day. According to RN #108, PSW #109 often would come in early on the identified shift and provide care to residents prior to receiving the identified report. The RN stated it had been an issue that PSW #109 was coming in on the identified time of the day and management was aware.

An interview with RN #104 revealed he/she had spoken to PSW #109, before the above mentioned incident, regarding the safety of residents being put in jeopardy when he/she provide care without first receiving the identified report. RN #104 reported his/her concerns to the ADOC after the above mentioned incident.

An interview with the ADOC revealed PSW #109 should not have provided the identified care on the identified time of the day when the resident was unwell. The ADOC stated it is the practice in the home for PSWs to not attempt to provide the care if residents are not capable or ready and should report the problem to registered staff. The ADOC admitted the PSW did not provide the care safely. The ADOC stated he/she was not aware PSW #109 was coming in on the identified time of the day and providing the care prior to receiving report. The DOC also acknowledged that it is not a safe practice for PSWs to care for residents without receiving the identified report.

The scope of this noncompliance is isolated and the severity is potential for actual harm. Due to ongoing non-compliance with a previous compliance order related to O.Reg. 79/10, s.36, issued in inspection report 2016_302600_0021 dated February 6, 2017, a compliance order is being served. [s. 36.]

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 12th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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