



Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Aug 17, 20, 21, 23, 24, 2012; 2012_043157_0027; Complaint

Licensee/Titulaire de permis

EXTENDICARE TORONTO 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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Physiotherapist, one Registered Practical Nurse and the resident.

During the course of the inspection, the inspector(s) observed the resident, reviewed the residents clinical record, reviewed the home's policies related to Falls and Pain Assessment.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

2. Every resident has the right to be protected from abuse.

3. Every resident has the right not to be neglected by the licensee or staff.

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

5. Every resident has the right to live in a safe and clean environment.

6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

9. Every resident has the right to have his or her participation in decision-making respected.

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).
-

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be cared for in a manner consistent with his or her needs, was fully respected and promoted.
- Resident 01 is capable of communicating care needs.
 - Progress notes for resident 01 indicate that the the resident informed staff of experiencing a fall. There is no evidence that a post fall assessment was completed.
 - The resident voiced complaints of pain on twelve identified dates post fall.
 - The physician ordered analgesic medication for complaints of pain.
- Progress notes further indicate the following related to the resident's pain:
- Resident complaining of difficulties ambulating due to pain.
 - Resident "noted to be limping when walking if somebody is around esp. the staff and writer."
 - Resident asked staff why nothing is being done and was assured by the RN that an x-ray would be done the following day. An x-ray was not completed until eight days later.
 - Resident complained of significant pain and reported that pain medications were not effective.
- There is no evidence of assessment of the source of the resident's pain until an x-ray was completed which indicated "no fracture or dislocation".
- The resident continued to express experiencing pain. Progress notes identify that the resident had severe pain for over a month. Resident was transferred to hospital and diagnosed with a fracture.
 - the resident communicated to the inspector experiencing "very bad" pain and that no one would help.

The licensee failed to ensure that the resident was cared for in a manner consistent with identified needs related to a significant change in condition:

- there was no evidence that the resident's physical condition and pain were assessed to determine appropriate interventions when the resident reported an injury.
- the resident was assured that an x-ray would be completed but there was no evidence of investigation of the source of the resident's pain until an x-ray was completed eight days later.
- despite the resident's continued complaints of pain further investigation was not initiated until seventeen days later when an x-ray indicated the resident had suffered a fracture.[s.3.(1)4.]

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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

- (a) the planned care for the resident;
- (b) the goals the care is intended to achieve; and
- (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

- (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
- (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. Resident 01's written plan of care does not provide clear direction to staff as evidenced by:

- The resident's written plan of care, last reviewed July 31, 2012 directs the administration of an analgesic medication that had been discontinued by the physician.

- The plan of care does not provide clear direction or interventions required specific to current pain issues identified in the resident's progress notes.

- The home's policy "Pain Assessment" #RESI-05-08-01, Version January 2012, directs that the resident's plan of care is to identify a description of the current location, duration and severity of the resident's pain. The plan of care for resident 01 does not provide this information related to the resident's pain.[s.6.(1)(c)]

2. Staff and others involved in the different aspects of care of the resident failed to collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other as evidenced by post fracture assessment progress notes indicating that that charge nurse was provided recommendations from the the Physiotherapist for follow up treatment. There is no evidence of any action or follow up taken in response to this advice. [s.6.(4)(a)]

3. The resident's substitute decision maker (SDM) was not given the opportunity to participate fully in the development and implementation of the resident's plan of care as evidenced by the following:

Progress note entry by the Director of Care indicates the SDM was requesting information related to the resident's injury. There is no evidence that the residents SDM was advised of the resident's status, diagnostic treatments or treatment outcomes. [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: the resident's plan of care:

- the resident's written plan of care provides clear directions to staff and others who provide direct care to the resident related to pain management

- staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other

- the resident's substitute decision maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care when there is a significant change in the resident's status, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management
Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Resident 01 reported experiencing a fall. Progress notes indicate the following:

- There is no evidence of any physical assessment of the resident was completed and no evidence that a clinically appropriate assessment instrument was used.

The home was not in compliance with its policy "Falls" (policy RESI-09-02-01 - revised November 2011) which requires the following:

- when a resident falls, registered staff will complete an initial physical and neurological assessment of the resident
- ongoing monitoring requires a neurological assessment to be completed every 15 minutes for one hour, hourly for the next four hours

- all assessments and actions during the 24 hour post follow up are to be documented in the progress notes

There is no evidence of a physical or neurological assessment of resident 01 following a reported fall and no evidence of ongoing neurological assessment during the 24 hour post fall period. [r.49.(2)]

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 when a resident has fallen, the resident is assessed and where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :



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1. The resident's response and the effectiveness of analgesic medications administered was not monitored and documented when Tylenol 650 mg was administered on seven identified dates. There is no documentation to indicate an assessment of the effectiveness of Tylenol #2 ordered by the physician to be administered four times a day, or Tylenol #3 ordered by the physician to be administered three times a day.

The home's policy "Pain Assessment", RESI-05-08-01, Version January 2012, directs that the effectiveness of regular and PRN medications used to manage a resident's pain must be documented. The home did not comply with its policy as evidenced by:

- There is no evidence that the effectiveness of Tylenol 650 mg was documented on seven identified dates.
- There is no documentation to indicate that the effectiveness of Tylenol #2 ordered by the physician to be administered four times a day, or Tylenol #3 ordered by the physician to be administered three times a day.

[r.134.(a)]

Issued on this 24th day of August, 2012

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

A handwritten signature in cursive script that reads "Pat Brown".



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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des Soins de longue durée**

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Aux termes de l'article 153 et/ou
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Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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| Name of Inspector (ID #) / Nom de l'inspecteur (No) : | PATRICIA POWERS (157) |
| Inspection No. / No de l'inspection : | 2012_043157_0027 |
| Type of Inspection / Genre d'inspection: | Complaint |
| Date of Inspection / Date de l'inspection : | Aug 17, 20, 21, 23, 24, 2012 |
| Licensee / Titulaire de permis : | EXTENDICARE TORONTO INC 3000 STEELES AVENUE EAST, SUITE 700, 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 : | DEBORAH WOODS PINKY VIRDI |

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



**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

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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 # /
Ordre no : 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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
 - i. the Residents' Council,
 - ii. the Family Council,
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
 - iv. staff members,
 - v. government officials,



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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, implement and submit a plan to ensure that the right of every resident who exhibits a significant change in condition to be cared for in a manner consistent with his or her needs is fully respected and promoted. [s.3.(1)4.]

The plan shall be submitted to MOHLTC, Attention: Pat Powers, Fax 613-569-9670 by September 7, 2012.

Grounds / Motifs :



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1. 1. The licensee failed to ensure that every resident's right to be cared for in a manner consistent with his or her needs, was fully respected and promoted.

- Resident 01 is capable of communicating care needs.
- Progress notes for resident 01 indicate that the the resident informed staff of experiencing a fall. There is no evidence that a post fall assessment was completed.
- The resident voiced complaints of pain on twelve identified dates post fall.
- The physician ordered analgesic medication for complaints of pain.

Progress notes further indicate the following related to the resident's pain:

- Resident complaining of difficulties ambulating due to pain.
- Resident "noted to be limping when walking if somebody is around esp. the staff and writer."
- Resident asked staff why nothing is being done and was assured by the RN that an x-ray would be done the following day. An x-ray was not completed until eight days later.
- Resident complained of significant pain and reported that pain medications were not effective.

There is no evidence of assessment of the source of the resident's pain until an x-ray was completed which indicated "no fracture or dislocation".

- The resident continued to express experiencing pain. Progress notes identify that the resident had severe pain for over a month. Resident was transferred to hospital and diagnosed with a fracture.
- the resident communicated to the inspector experiencing "very bad" pain and that no one would help.

The licensee failed to ensure that the resident was cared for in a manner consistent with identified needs related to a significant change in condition:

- there was no evidence that the resident's physical condition and pain were assessed to determine appropriate interventions when the resident reported an injury.
- the resident was assured that an x-ray would be completed but there was no evidence of investigation of the source of the resident's pain until an x-ray was completed eight days later.
- despite the resident's continued complaints of pain further investigation was not initiated until seventeen days later when an x-ray indicated the resident had suffered a fracture.[s.3.(1)4.] (157)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2012



**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
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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 or by fax upon:

**Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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.



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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*

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075 rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur: (416) 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9^e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075 rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur: (416) 327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of August, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

PATRICIA POWERS

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