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
Oct 2, 2017	2017_646618_0018	020814-17	Resident Quality Inspection

Licensee/Titulaire de permis

HAROLD AND GRACE BAKER CENTRE
1 NORTHWESTERN AVENUE TORONTO ON M6M 2J7

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

HAROLD AND GRACE BAKER CENTRE
1 NORTHWESTERN AVENUE TORONTO ON M6M 2J7

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

CECILIA FULTON (618), ADAM DICKEY (643)

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): August 28, 29 and 30th, September 1, 4, 5, 6, 7, 8, 11 and 12, 2017.

During the course of this inspection the following Critical Incident Intake Logs were inspected: Log #'s 005333-17 and #020601-17 related to suspected/alleged abuse and 005827-17 related to side rail use.

The following Complaint Intake Log was inspected: #004688-17 related to falls management and the following Follow up intake log was complied: #004523-17.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Registered Dietitian (RD), Physiotherapist (PT), Social Worker (SW), Environmental Services Manager (ESM), Housekeepers (HSK), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Resident's family members.

During the course of the inspection, the Inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_268604_0017	618

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (4).
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

This inspection was initiated related to a follow up inspection to compliance order CO# 001 under inspection report 2016_268604_0017. The licensee was ordered to submit a plan to ensure that residents were not neglected by staff related to nutrition and hydration care. This order was complied during this inspection.

The sample size of residents to inspect this item was expanded to three as a result of noncompliance identified in the initial resident.

a. Record review of the Point Click Care (PCC) point of care (POC) dashboard on an identified date in 2017, revealed that resident #010 had eaten less than fifty per cent of his/her meal on six or more occasions in the past three days.

Review of the home's policy titled LTC Food and Fluid Intake Monitoring last reviewed on July 31, 2016, revealed that unregulated care providers document resident food and fluid intake on each shift. The nurse or delegate will review resident daily food and fluid intakes. Based on the review if a resident's food intake is recorded as less than fifty per cent for three consecutive days a referral is made to the Registered Dietitian (RD) for assessment and analysis.

Review of resident #010's POC task report on an identified date in 2017, for the activity of daily living (ADL) for eating revealed that he/she had eaten less than fifty per cent of his/her meals for twenty four consecutive days between identified dates in 2017. Review of the assessment tab on PCC failed to reveal a referral to the RD related to resident #010's intake at meals.

In an interview, RPN #124 stated that PSW staff who are assigned to the resident's care for that shift will document on the POC the resident's intake of food and fluids for meals and snacks. RPN #124 further stated that it was the responsibility of the night nurse to review resident intakes and after three days of poor intake to refer to the RD. RPN #124 stated that food and fluid RD referrals would be completed by the night nurse by completing the referral on PCC.

In an interview, RN #101 who was the charge nurse on the unit stated that the process in the home is that if a resident is eating less than fifty per cent at six or more meals for three days then registered staff would be responsible to refer the resident to the RD. RN #101 further stated that it was the responsibility of the night registered staff to review fluid intakes and refer to the RD any resident not meeting fluid requirements for three days. RN #101 stated that resident #010 had been due for a referral and initiated a referral on an identified date in 2017, related to his/her food intake at meals.

In an interview, the DOC stated that it was the expectation of the home for PSW staff to document a resident's intake of food and fluids at meals and snacks in the POC. The DOC further stated that it was the responsibility of the night registered staff to monitor the food and fluid intakes and an alert would be triggered on the dashboard of POC for the RN in charge of the unit. The DOC stated it was the responsibility of the night registered staff or the unit charge nurse to refer to the RD when a resident has eaten less than fifty per cent of six or more meals for three days. The DOC acknowledged that resident #010 had intakes of less than fifty per cent for greater than three days and should have been referred to the RD for assessment.

b. Review of the POC dashboard on an identified date in 2017, revealed that resident #008 had eaten less than fifty per cent of his/her meal on six or more occasions in the past three days.

Review of resident #008's POC task report on an identified date in 2017, for the ADL for eating revealed that he/she had eaten less than fifty per cent of his/her meals on three consecutive identified days in 2017, and for eight consecutive days between an identified time period in 2017. Review of the assessment tab on PCC failed to reveal a referral to the RD related to resident #008's intake at meal for the above mentioned dates.

In an interview, RPN #127 stated that if a resident is not eating or there is a change in pattern for two or three days then a referral to the RD would be made. He/she further stated that any registered staff can make this referral for poor food intake.

In an interview, RN # 107 who was the charge nurse of the unit stated that PSW staff will check the resident intakes and enter that directly into the POC. He/she further stated that it was the responsibility of the day shift nurse to review the food intake for residents. RN #107 stated that poor food intake would automatically be triggered on the POC dashboard and a referral would be made to the RD if a resident was not eating for a couple of days.

c. Record review of the POC dashboard on an identified date in 2017, revealed that resident #011 had eaten less than fifty per cent of his/her meal on six or more occasions in the past three days.

Review of resident #011's POC task report on an identified date in 2017, for the ADL for eating revealed that he/she had eaten less than fifty per cent of his/her meals on fifteen consecutive days between the period under review in 2017.

Review of the assessment tab on PCC failed to reveal a referral to the RD related to resident #011's intake at meals.

In an interview, RD #118 stated that it was the responsibility of PSW staff to record and document resident food and fluid at meals and snacks. RD #118 further stated that the nursing staff was responsible for referring a resident whose food intake at meals was less than fifty per cent for three consecutive days using the assessment tab and selecting nutrition referral. RD #118 stated that he/she did not receive nutrition referrals related to resident #008, #010 or #011 for the above mentioned dates.

RD #118 acknowledged that the licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of residents #008, #010 and #011's nutrition status.

The severity of the non-compliance and the severity of the harm were potential. The scope of the noncompliance was widespread (3/3). A review of the Compliance History revealed that there was a Written Notification (WN) in a similar care area issued in inspection 2015_219211_0025 dated December 22, 2015 related to the Long-Term Care Homes Act, 2007. [s. 6. (4) (a)]

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. 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 residents were protected from abuse by anyone.

An identified Critical Incident System Report (CIR) was submitted to the Ministry of Health and Long-Term Care on an identified date in 2017, related to incidents of suspected abuse of resident #008.

Review of the CIR revealed that a video camera placed in the resident #008's room, by his/her family captured footage from several identified dates in 2017, showing PSW #116 talking to resident #008 with an inappropriate tone of voice. Additionally, PSW #116 had shown an identified mannerism towards resident #008. The CIR further revealed PSW #117 responding to resident #008's care needs in an identified inappropriate manner.

Review of resident #008's Minimum Data Set (MDS) assessment reveals that resident requires extensive assistance with most Activities of Daily living.

In an interview, resident #008's Substitute Decision Maker (SDM) indicated that the resident had expressed care concerns related to a staff member.

Interview with Resident #008 revealed that he/she could recollect several occasions when a PSW may have acted in an identified manner during care.

Review of video footage provided by the home revealed several negative interactions between PSW #116 and resident #008 on identified dates in 2017.

Review of video footage provided by the home revealed an interaction between PSW #117 and resident #008 on an identified date in 2017. PSW #117 entered the room and spoke to resident #008 in an identified inappropriate manner. PSW #117 began to assist with personal care for resident #008 and continued to speak to resident #008 in this manner.

In an interview, PSW #116 stated that he/she was not aware that resident #008's care plan instructed staff to provide extensive assistance for an identified care area. PSW #116 further stated that he/she did not believe the actions taken toward resident #008 were abusive and that other staff have told him/her that resident #008 can provide the identified care measure himself/herself.

In an interview, PSW #117 denied that he/she had ever refused to provide the required care for resident #008 and further stated that he/she did not believe that his/her actions toward resident #008 were abusive. When asked if the interaction would be considered abusive the PSW #117 replied yes.

In an interview, the DOC stated that the home was unaware of the above mentioned interactions between PSWs #117 and #116 towards resident #008 until resident #008's family came forward and produced the video. The DOC confirmed that the video demonstrated abuse of resident #008 that had been ongoing over the identified time period in 2017.

The DOC acknowledged that the home failed to protect resident #008 from abuse. [s. 19. (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 residents are protected from emotional abuse by anyone,, to be implemented voluntarily.

WN #3: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

This item was triggered for inspection by Resident Quality Inspection (RQI), stage one observations of lingering odours in resident #001 and #005's room/washroom.

During the course of this inspection several observations were made of all above mentioned resident rooms and washrooms. In resident #001 and 005's rooms, urine odours were noted in the washrooms on almost all observations.

In an interview, resident #001 stated that the smell is always present in the shared washroom which he/she had reported to the housekeeping staff. Resident #005 was not able to be interviewed.

In an interview, housekeeping staff (HKG) #120 stated that he/she was aware of urine odours in resident #001's shared washroom and stated that he/she tries to clean that area additional times each day to control the odour. When asked if she has reported the issue to the Environmental Services Manager (ESM), he/she stated no because there is nothing else that can be done.

In an interview, HKG #121 that he/she was aware of odours in resident #005's washroom and that he/she will try to get in for a second cleaning on the days he/she is working to control the odour. When asked if he/she has reported the issue to the Environmental Services Manager (ESM), he/she stated no.

Review of the home's Environmental Services policy, ES C-25-15, dated January 21, 2015, revealed that there will be a method for identifying lingering odours and a procedure to investigate and eliminate them. The procedure includes the completion of the odour audit form. Attached to the policy were two completed odour audit forms. Both were dated in 2017, and identified issues related to two identified washrooms. Corrective actions were identified on the forms.

In an interview, the ESM stated that there was a system in place for staff, residents and visitors to report any housekeeping issues such as lingering odours to the housekeeping department. The ESM further stated that the management company changed the cleaning product line and all products were scent free and these products were not doing

a good enough job at eliminating lingering odours. The ESM stated that he/she was aware of the lingering odours in residents #001 and #005 shared washrooms and that the housekeeping staff were attempting to manage the urine odours by repeated cleaning but these attempts were ineffective.

The ESM acknowledged that a new procedure was not developed and implemented to deal with lingering odours. [s. 87. (2) (d)]

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 prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours,, to be implemented voluntarily.

Issued on this 26th day of October, 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) :	CECILIA FULTON (618), ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2017_646618_0018
Log No. / No de registre :	020814-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 2, 2017
Licensee / Titulaire de permis :	HAROLD AND GRACE BAKER CENTRE 1 NORTHWESTERN AVENUE, TORONTO, ON, M6M-2J7
LTC Home / Foyer de SLD :	HAROLD AND GRACE BAKER CENTRE 1 NORTHWESTERN AVENUE, TORONTO, ON, M6M-2J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Langton

To HAROLD AND GRACE BAKER CENTRE, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

Within 30 days of receiving this order, the Licensee shall conduct meeting(s) with all direct care staff and Registered Dietitian.
The purpose of the meeting(s) are to:

1. Review the home's policy titled LTC Food and Fluid intake monitoring, last reviewed July 31, 2016.
2. Review each staff's role in monitoring, assessing, recording and reviewing residents' food and fluid intake.
3. Review the criteria and process for making referrals to the Registered Dietitian.
4. Develop an audit system to ensure the Point Click Care dashboard is monitored and referrals to the dietitian are made as per the home's policy.
5. Maintain a record of the dates of the meetings, attendees and the discussion items and action plans identified in these meetings.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff and others involved in the different aspects of care the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

This inspection was initiated related to a follow up inspection to compliance

order CO# 001 under inspection report 2016_268604_0017. The licensee was ordered to submit a plan to ensure that residents were not neglected by staff related to nutrition and hydration care. This order was complied during this inspection.

The sample size of residents to inspect this item was expanded to three as a result of noncompliance identified in the initial resident.

a. Record review of the Point Click Care (PCC) point of care (POC) dashboard on an identified date in 2017, revealed that resident #010 had eaten less than fifty per cent of his/her meal on six or more occasions in the past three days.

Review of the home's policy titled LTC Food and Fluid Intake Monitoring last reviewed on July 31, 2016, revealed that unregulated care providers document resident food and fluid intake on each shift. The nurse or delegate will review resident daily food and fluid intakes. Based on the review if a resident's food intake is recorded as less than fifty per cent for three consecutive days a referral is made to the Registered Dietitian (RD) for assessment and analysis.

Review of resident #010's POC task report on an identified date in 2017, for the activity of daily living (ADL) for eating revealed that he/she had eaten less than fifty per cent of his/her meals for twenty four consecutive days between identified dates in 2017. Review of the assessment tab on PCC failed to reveal a referral to the RD related to resident #010's intake at meals.

In an interview, RPN #124 stated that PSW staff who are assigned to the resident's care for that shift will document on the POC the resident's intake of food and fluids for meals and snacks. RPN #124 further stated that it was the responsibility of the night nurse to review resident intakes and after three days of poor intake to refer to the RD. RPN #124 stated that food and fluid RD referrals would be completed by the night nurse by completing the referral on PCC.

In an interview, RN #101 who was the charge nurse on the unit stated that the process in the home is that if a resident is eating less than fifty per cent at six or more meals for three days then registered staff would be responsible to refer the resident to the RD. RN #101 further stated that it was the responsibility of the night registered staff to review fluid intakes and refer to the RD any resident not meeting fluid requirements for three days. RN #101 stated that resident #010 had been due for a referral and initiated a referral on an identified date in 2017,

related to his/her food intake at meals.

In an interview, the DOC stated that it was the expectation of the home for PSW staff to document a resident's intake of food and fluids at meals and snacks in the POC. The DOC further stated that it was the responsibility of the night registered staff to monitor the food and fluid intakes and an alert would be triggered on the dashboard of POC for the RN in charge of the unit. The DOC stated it was the responsibility of the night registered staff or the unit charge nurse to refer to the RD when a resident has eaten less than fifty per cent of six or more meals for three days. The DOC acknowledged that resident #010 had intakes of less than fifty per cent for greater than three days and should have been referred to the RD for assessment.

b. Review of the POC dashboard on an identified date in 2017, revealed that resident #008 had eaten less than fifty per cent of his/her meal on six or more occasions in the past three days.

Review of resident #008's POC task report on an identified date in 2017, for the ADL for eating revealed that he/she had eaten less than fifty per cent of his/her meals on three consecutive identified days in 2017, and for eight consecutive days between an identified time period in 2017. Review of the assessment tab on PCC failed to reveal a referral to the RD related to resident #008's intake at meal for the above mentioned dates.

In an interview, RPN #127 stated that if a resident is not eating or there is a change in pattern for two or three days then a referral to the RD would be made. He/she further stated that any registered staff can make this referral for poor food intake.

In an interview, RN # 107 who was the charge nurse of the unit stated that PSW staff will check the resident intakes and enter that directly into the POC. He/she further stated that it was the responsibility of the day shift nurse to review the food intake for residents. RN #107 stated that poor food intake would automatically be triggered on the POC dashboard and a referral would be made to the RD if a resident was not eating for a couple of days.

c. Record review of the POC dashboard on an identified date in 2017, revealed that resident #011 had eaten less than fifty per cent of his/her meal on six or more occasions in the past three days.

Review of resident #011's POC task report on an identified date in 2017, for the ADL for eating revealed that he/she had eaten less than fifty per cent of his/her meals on fifteen consecutive days between the period under review in 2017.

Review of the assessment tab on PCC failed to reveal a referral to the RD related to resident #011's intake at meals.

In an interview, RD #118 stated that it was the responsibility of PSW staff to record and document resident food and fluid at meals and snacks. RD #118 further stated that the nursing staff was responsible for referring a resident whose food intake at meals was less than fifty per cent for three consecutive days using the assessment tab and selecting nutrition referral. RD #118 stated that he/she did not receive nutrition referrals related to resident #008, #010 or #011 for the above mentioned dates.

RD #118 acknowledged that the licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of residents #008, #010 and #011's nutrition status.

The severity of the non-compliance and the severity of the harm were potential. The scope of the noncompliance was widespread (3/3). A review of the Compliance History revealed that there was a Written Notification (WN) in a similar care area issued in inspection 2015_219211_0025 dated December 22, 2015 related to the Long-Term Care Homes Act, 2007. [s. 6. (4) (a)] (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

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 2nd day of October, 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 : Cecilia Fulton

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