Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_746692_0004	001200-20	Complaint

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 Kelly Drive GRAVENHURST ON P1P 1P3

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

SHANNON RUSSELL (692), JENNIFER NICHOLLS (691)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 10-14, 2020.

The Following intake was inspected upon during this Complaint Inspection:
-One log, which was related to a complaint that was submitted to the Director related to resident care concerns.

A Critical Incident System Inspection #2020_746692_0005 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of Care (ADOC), Nurse Managers (NM), Housekeeper, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, the home's complaint log, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by staff.

A complaint was submitted to the Director on an identified date, regarding multiple resident care concerns. During an interview with Inspector #692, the complainant indicated that resident #009 had received improper care as the resident had activated their call bell, as they required the assistance of staff, yet no staff had responded to the call bell for over two and a half hours on one occasion. The complainant further indicated that there had been other incidents of resident #009 having to wait hours to receive the care that they required.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

a)Inspector #692 reviewed resident #009's health care records, identifying that they had multiple comorbidities. A review of the current resident's care plan indicated that the resident was a high risk for falls, requiring the supervision of staff for transfers and toileting.

Inspector #692 reviewed resident #009's progress notes, identifying documentation by Registered Practical Nurse (RPN) #118, dated on an identified date, indicating that the resident's Substitute Decision Maker (SDM) had left a message for the Associate Director of Care (ADOC) advising them that resident #009 had rang their call bell for staff assistance, and had to wait over two hours for staff to respond. The SDM stated that this had occurred on multiple occasions.

In an interview with resident #009, they indicated to Inspector #692 that they have activated the call bell and have had to wait for staff to help them with the assistance that they require for toileting, and care that they required. The resident indicated that they were unable to identify the dates or how long specifically they had to wait when they had initiated their call bell. Resident #009 stated, "sometimes there [was] not any point in pulling the call bell, [they] could be dead before anyone came to help".

Inspector #692 reviewed an identified document, which identified the times the call bell was activated by resident #009, and the time that staff had responded to the resident. The report indicated the following:
-the first date-activated and turned off three hours and 45 minutes later;
-the second date-activated and turned off three hours and 45 minutes later;

-the third date-activated and turned off two hours later;
-the fourth date-activated and turned off after two hours; activated and turned off after two hours and 42 minutes; and activated and turned off two hours and 15 minutes later;
-the fifth date-activated and turned off two hours and four minutes later;
-the sixth date-activated and turned off two and a half hours later;
-the seventh date-activated and turned off after three hours and 10 minutes; activated and turned off one and a half hours later;
-the eighth date-activated and turned off four hours and 18 minutes later; and,
-the ninth date-activated and turned off three hours and 20 minutes later.

b)Inspector #692 reviewed resident #006's health care records, identifying that they had multiple comorbidities. A review of the resident's current care plan indicated that the resident was a high risk for falls, in which an identified intervention was to be in place, and that they required the assistance of staff for transfers and toileting.

Inspector #692 reviewed an identified document, which identified the times the resident's room call bell was activated by resident #006, and the time that staff had responded to the resident. The report indicated the following:
-the first date-activated and turned off 35 minutes later;
-the second date-activated and turned off after one hour and 28 minutes; activated and turned off after two hours; and activated and turned off two hours and 42 minutes later; and,
-the third date-activated and turned off after one and a half hours; and activated and turned off one hour and 18 minutes later.

c) Inspector #692 reviewed resident #010's health care records, identifying that they had multiple comorbidities. A review of the resident's current care plan indicated that the resident was a high risk for falls, requiring the assistance of staff for transfers and toileting.

Inspector #692 reviewed an identified document, identifying the times the resident's call bell was activated and the time that staff had responded, which identified the following:
-the identified date-activated and turned off 51 minutes later.

A review of the home's policy titled, "Prevention of Abuse and Neglect of a Resident, #VII-G-10.00", last updated April 2019, indicated that abuse and neglect were not tolerated in any circumstance by anyone, and any deviation from this standard would not be tolerated.

During separate interviews with Personal Support Workers (PSW) #101, #106, and #120, they all indicated to Inspector #692 that when a resident activated their call bell, a message was sent to the PSWs pager alerting them to which room and resident require assistance. The call bell was deactivated when staff responded to the call bell, turning it off at the point of activation. The PSWs indicated that the aforementioned response times for the residents was not acceptable, and it should never have taken that long to respond, to assist the residents.

In separate interviews with RPNs #107, #121, and #122, they all indicated to Inspector #692 that when the resident activated the call bell it would initially send a message to the PSWs pagers, and if there was not any response by the PSWs it would escalate to the RPN pagers. The RPNs identified that staff were to respond to the call bells immediately, and if they were assisting other residents, then they were to respond as soon as they finished with those residents.

In separate interviews with Nurse Manager (NM) #109 and the ADOC, they both indicated to Inspector #692 that all staff were to respond to residents when they activated their call bell immediately. Both NM #109 and the ADOC identified that the aforementioned response times for residents #009, #006 and #010 was not acceptable and met the definition of neglect, as staff did not respond to their care needs.

During an interview with the Executive Director (ED), they identified to Inspector #692 that the residents would activate the call bell when they required the assistance of staff, and that staff were to respond immediately. Together, the ED and the Inspector reviewed the identified document for residents #009, #006 and #010, in which the ED indicated that the response times were not acceptable. The ED indicated that resident #009, #006 and #010 were neglected by staff, as staff had not responded to their needs, had not provided care as required, and they should have. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A complaint was submitted to the Director on an identified date, regarding multiple resident care concerns. During an interview with Inspector #692, the complainant indicated that identified equipment in resident #009's room was found to be dirty on multiple occasions.

During the inspection, Inspector #692 conducted observations of the identified equipment in resident #009's room for three consecutive days. During this period the Inspector observed that there was dried substances located in the same area on the front and underneath the identified equipment.

Inspector #692 reviewed the home's policy titled, "Equipment Cleaning - Resident Care and Medical, #IX-G-20.90", last revised April, 2019, identifying that the identified equipment was to be cleaned daily by housekeeping during their regular room cleaning routine.

Together, Inspector #692 and PSW #101 observed the identified equipment with the dried substances on it. PSW #101 indicated that the identified equipment was to be cleaned daily by housekeeping, and if they were notably dirty the PSWs would clean them. PSW #101 identified that if the identified equipment had the same dried substances on it for three consecutive days, then the identified equipment had not been cleaned daily.

During an interview with housekeeper #102, they identified that it was the responsibility

of the housekeeping staff to clean the identified equipment as part of their daily routine of cleaning the resident's rooms. Housekeeper #102 indicated that if the identified equipment became visibly soiled that the PSWs would clean it and call the housekeeping staff to complete a deep cleaning.

In separate interviews with Inspector #692, NM #108 and the ADOC indicated that it was the responsibility of the housekeeping staff to conduct daily cleaning of the resident rooms, which included the identified equipment. They both identified that if the same dried substances were observed on the identified equipment in resident #009's room for three consecutive days, that would indicate that the identified equipment were not cleaned daily; and it should have been, as per the home's policy.

Inspector #692 interviewed the ED, who identified that as per the home's cleaning policy it was the responsibility of the housekeeping staff to clean the identified equipment as part of their daily routine cleaning. The ED indicated that if the identified equipment had become dirty after the daily cleaning by the housekeeper, then it was their expectation that the PSWs cleaned it at that time. The ED identified that the identified equipment in resident #009's room had not been cleaned daily, and that it should have been. [s. 15. (2) (a)]

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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff.

A complaint was submitted to the Director on an identified date, regarding multiple resident care concerns. During an interview with Inspector #692, the complainant indicated that resident #009 had received improper care as the resident had activated their call bell, as they required the assistance of staff, yet no staff had responded to the call bell for over two and a half hours on one occasion.

Please see WN #1, finding #1, for further details.

Inspector #692 conducted a review of resident #009's health care records, identifying that the residents care plan identified that they were able to transfer themselves on the toilet, but that they required supervision from staff with toileting and assistance with their incontinent product.

During an interview with resident #009, they indicated to Inspector #692 that they were able to transfer themselves to the toilet; however, they would activate their call bell for staff to provide supervision, and assistance if needed, with washing and transferring off the toilet. The resident identified that there had been occasions that they had activated the call bell for staff to help them from the toilet, and that staff had not responded to help them for hours; therefore, they did not receive the assistance that they required.

During separate interviews with PSW #101 and #120, they both indicated that staff were to review the resident's care plan in order to know what care and the level of assistance they required. PSW #101 identified that resident #009 was independent with most of their Activities of Daily Living (ADL) but had required the supervision, and possible assistance, with certain tasks. PSW #101 indicated that when staff had not responded to when resident #009 had activated the call bell on multiple occasions, staff had not provided the assistance the resident required.

In separate interviews with RPN #122 and Registered Nurse (RN) #119, they both identified that staff would know what care the residents required and what level of assistance they needed by reviewing their individual care plans. Both RPN #122 and RN #119 indicated that it was the responsibility of the registered staff to ensure that the resident's care plan was up to date and reflected their current needs. Both the RPN and

RN identified that resident #009 required supervision of staff when toileting due to their multiple comorbidities. RPN #122 and RN #119 identified that staff did not provide the assistance with toileting, as required to resident #009.

In an interview with the ED, they identified to Inspector #692 that staff were to review the resident's individual care plan to know what care needs they required. Together, the ED and the Inspector reviewed resident #009's care plan, identifying that they required supervision for toileting. The ED indicated that staff had not followed the residents care plan, as they had not provided the assistance required for toileting, and that they should have. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHANNON RUSSELL (692), JENNIFER NICHOLLS (691)
Inspection No. / No de l'inspection :	2020_746692_0004
Log No. / No de registre :	001200-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 21, 2020
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 Kelly Drive, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long Term Care Homes Act (LTCHA), 2007.
Specifically, the licensee shall:
1. Develop and implement a process to audit the monitoring of the call bell system reports routinely, and follow up with any deficiencies;
2. Ensure all staff are trained on the call bell system and the process of responding to the activated call bells immediately; and,
3. Maintain a record of re-training provided, including dates, times, attendees, trainers and material taught.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by staff.

A complaint was submitted to the Director on an identified date, regarding multiple resident care concerns. During an interview with Inspector #692, the complainant indicated that resident #009 had received improper care as the resident had activated their call bell, as they required the assistance of staff, yet no staff had responded to the call bell for over two and a half hours on one occasion. The complainant further indicated that there had been other incidents of resident #009 having to wait hours to receive the care that they required.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

a)Inspector #692 reviewed resident #009's health care records, identifying that they had multiple comorbidities. A review of the current resident's care plan indicated that the resident was a high risk for falls, requiring the supervision of staff for transfers and toileting.

Inspector #692 reviewed resident #009's progress notes, identifying documentation by Registered Practical Nurse (RPN) #118, dated on an identified date, indicating that the resident's Substitute Decision Maker (SDM) had left a message for the Associate Director of Care (ADOC) advising them that resident #009 had rang their call bell for staff assistance, and had to wait over two hours for staff to respond. The SDM stated that this had occurred on multiple occasions.

In an interview with resident #009, they indicated to Inspector #692 that they have activated the call bell and have had to wait for staff to help them with the assistance that they require for toileting, and care that they required. The resident indicated that they were unable to identify the dates or how long specifically they had to wait when they had initiated their call bell. Resident #009 stated, "sometimes there [was] not any point in pulling the call bell, [they] could be dead before anyone came to help".

Inspector #692 reviewed an identified document, which identified the times the call bell was activated by resident #009, and the time that staff had responded to the resident. The report indicated the following:
-the first date-activated and turned off three hours and 45 minutes later;
-the second date-activated and turned off three hours and 45 minutes later;
-the third date-activated and turned off two hours later;
-the fourth date-activated and turned off after two hours; activated and turned off after two hours and 42 minutes; and activated and turned off two hours and 15 minutes later;
-the fifth date-activated and turned off two hours and four minutes later;
-the sixth date-activated and turned off two and a half hours later;
-the seventh date-activated and turned off after three hours and 10 minutes; activated and turned off one and a half hours later;
-the eighth date-activated and turned off four hours and 18 minutes later; and,
-the ninth date-activated and turned off three hours and 20 minutes later.

b)Inspector #692 reviewed resident #006's health care records, identifying that they had multiple comorbidities. A review of the resident's current care plan indicated that the resident was a high risk for falls, in which an identified intervention was to be in place, and that they required the assistance of staff for transfers and toileting.

Inspector #692 reviewed an identified document, which identified the times the resident's room call bell was activated by resident #006, and the time that staff had responded to the resident. The report indicated the following:
-the first date-activated and turned off 35 minutes later;
-the second date-activated and turned off after one hour and 28 minutes; activated and turned off after two hours; and activated and turned off two hours and 42 minutes later; and,
-the third date-activated and turned off after one and a half hours; and activated and turned off one hour and 18 minutes later.

c) Inspector #692 reviewed resident #010's health care records, identifying that they had multiple comorbidities. A review of the resident's current care plan indicated that the resident was a high risk for falls, requiring the assistance of staff for transfers and toileting.

Inspector #692 reviewed an identified document, identifying the times the resident's call bell was activated and the time that staff had responded, which identified the following:
-the identified date-activated and turned off 51 minutes later.

A review of the home's policy titled, "Prevention of Abuse and Neglect of a Resident, #VII-G-10.00", last updated April 2019, indicated that abuse and neglect were not tolerated in any circumstance by anyone, and any deviation from this standard would not be tolerated.

During separate interviews with Personal Support Workers (PSW) #101, #106, and #120, they all indicated to Inspector #692 that when a resident activated their call bell, a message was sent to the PSWs pager alerting them to which room and resident require assistance. The call bell was deactivated when staff responded to the call bell, turning it off at the point of activation. The PSWs indicated that the aforementioned response times for the residents was not

acceptable, and it should never have taken that long to respond, to assist the residents.

In separate interviews with RPNs #107, #121, and #122, they all indicated to Inspector #692 that when the resident activated the call bell it would initially send a message to the PSWs pagers, and if there was not any response by the PSWs it would escalate to the RPN pagers. The RPNs identified that staff were to respond to the call bells immediately, and if they were assisting other residents, then they were to respond as soon as they finished with those residents.

In separate interviews with Nurse Manager (NM) #109 and the ADOC, they both indicated to Inspector #692 that all staff were to respond to residents when they activated their call bell immediately. Both NM #109 and the ADOC identified that the aforementioned response times for residents #009, #006 and #010 was not acceptable and met the definition of neglect, as staff did not respond to their care needs.

During an interview with the Executive Director (ED), they identified to Inspector #692 that the residents would activate the call bell when they required the assistance of staff, and that staff were to respond immediately. Together, the ED and the Inspector reviewed the identified document for residents #009, #006 and #010, in which the ED indicated that the response times were not acceptable. The ED indicated that resident #009, #006 and #010 were neglected by staff, as staff had not responded to their needs, had not provided care as required, and they should have.

The severity of this issue was determined to be a level two, as there was minimal harm/minimal risk. The scope of the issue was a level three, as the incident was widespread. The home has a level two compliance history with no related noncompliance with this subsection in the last 36 months with this section of the LTCHA.

(692)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 03, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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