Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**Rapport d'inspection prévue 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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 9, 2019 | 2019_630589_0022 | 014980-19, 017075-19 | Critical Incident System |

## Licensee/Titulaire de permis

The Wexford Residence Inc.
1860 Lawrence Avenue East TORONTO ON M1R 5B1

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

The Wexford
1860 Lawrence Avenue East SCARBOROUGH ON M1R 5B1

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

JOANNE ZAHUR (589)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 17, 19, 20, 24, 25, 26, 27, & 30, 2019. October 1, 2, & 3, 2019, off-site.**

**The following intakes were inspected during this inspection:**
**-Log #017075-19 related to plan of care, and**
**-Log #014980-19 related to transfers.**

**Written Notification with Voluntary Plans of Correction related to O. Reg., 79/10, r. 36, identified in concurrent inspection #2019_630589_0020 will be issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director/Chief Executive Officer (ED/CEO), Director of Care (DOC), Nurse Managers (NM), Social Services Coordinator (SSC), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).**

**During the course of the inspection, the inspector(s) observed staff to resident interactions, resident and room observations, and the provision of care, reviewed health records, the Long Term Care Homes (LTCH) internal investigation notes, relevant annual program evaluations, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Medication**
**Pain**
**Personal Support Services**
**Reporting and Complaints**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

The licensee has failed to ensure that staff used safe transferring techniques when assisting residents' #002 and #004.

1. A complaint was received by the Director, which indicated the complainant had voiced concerns regarding a transfer that resulted in an injury to resident #002. The complainant further stated that resident #002's injury resulted in a transfer to hospital.

A review of resident #002's care plan indicated they require a one person stand and pivot for transfers. The transfer logo in the room also indicated the same transferring needs as outlined in the care plan.

During an interview, staff #110 stated that staff #113 had asked them to provide personal care to resident #002 and then to transfer resident #002 to a wheelchair. During the transfer, an identified body part of resident #002's pressed against an assistive aid causing the injury. Staff #110 further stated that when they saw the injury, they called for staff #113 to assess. Staff #110 stated they should have removed the assistive aid for the transfer to prevent injury and acknowledged they had used an improper transferring technique.

During an interview, staff #113 confirmed they had asked staff #110 to provide personal care and to transfer resident #002 into the wheelchair, and that the PSW called them to assess an injury sustained during the transfer.

During an interview, staff #100 acknowledged that staff #110 had not used safe transferring techniques when assisting resident #002. [s. 36.]

2. A Critical Incident System (CIS) report was submitted to the Director related to an unsafe transfer that occurred with resident #004. The CIS report indicated that staff #115 had used a mechanical lift to toilet resident #004 unassisted. The CIS also indicated this incident had been caught on the LTCH's video footage showing staff #115 entering the shower room with the resident and then leaving alone. During this time frame the video footage did not show anyone else entering to assist them with the transfer.

A review of resident #004's care plan indicated the use of a mechanical lift with two-person physical assist for all transfers.

During an interview, staff #115 admitted to using the mechanical lift unassisted with resident #004. Staff #115 stated they were rushing to give care and that they could not

find their co-worker to assist. Staff #115 denied having used any of the mechanical lifts unassisted prior to this incident.

A review of the LTCH's internal investigation notes indicated staff #115 received disciplinary action and was required to review specific LTCH policies prior to resuming their duties.

During an interview, staff #100 acknowledged that staff #115 had not used safe transferring techniques when assisting resident #004. [s. 36.]

***Additional Required Actions:***

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

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**WN #2: 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:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that resident #001 was fully respected and their right to participate in decision-making was promoted.

A CIS report was submitted to the Director on an identified date in August 2019, for an incident that occurred earlier the same month. The CIS report indicated that resident #001 had complained of pain to the registered staff and had asked to go to hospital. The CIS further indicated that the RPN had administered the LTCH's Medical Directive for pain and had stated to resident #001, to wait and see if this would help with the pain before transferring to the hospital.

A review of resident #001's health record indicated they had a mild cognitive impairment and was known to self-direct their care. A review of CIS report, the LTCH's internal investigation notes, progress notes and staff interviews for resident #001 indicated that they had requested to go to hospital.

During an interview, staff #106 acknowledged that they were familiar with resident #001 and even though this pain was a new complaint from the resident, they were trying to manage the situation on their own. Staff #106 further stated that approximately an hour later, they re-assessed resident #001 and they had agreed to stay in the LTCH. Staff #106 denied they had not respected resident #001's right to participate in decision-making when they had initially asked to go to hospital.

A review of progress notes for resident #001 indicated they were transferred to hospital approximately five hours later at the request of a family member. The family member was present in the home as a result of resident #001 calling their SDM to complain of pain and not being sent to hospital when they had asked to go.

During an interview, staff #108 stated that during their phone call with resident #001's SDM, they voiced concerns related to the lack of assessments completed and that resident #001's request to go to hospital had not been respected.

During interviews, staff #103 and staff #100 were reluctant to acknowledge that resident #001's request to go to hospital was an example of the resident self-directing their care and that their right to participate in decision making was respected. [s. 3. (1) 9.]

***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 every resident has the right to have his or her participation in decision-making respected, to be implemented voluntarily.***

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**WN #3: 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 :**

The licensee has failed to ensure that staff and other involved in the care of resident #001 collaborated with each other 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.

A CIS report was submitted to the Director on an identified date in August 2019, for an incident that occurred six days prior. The CIS report indicated that resident #001 had complained of pain to the registered staff at which time the Long Term-Care Homes (LTCH) Medical Directive for pain was administered.

In an interview, staff #106 stated they had not informed the RN in-charge of the LTCH on that shift about resident #001's complaint of pain. Staff #106 acknowledged that they were familiar with resident #001 and that the complaint of this type of pain was a new complaint from resident #001, and that they were trying to manage the situation on their own.

Resident #001 was transferred to hospital approximately five hours later and subsequently died in hospital.

During interviews, both staff #100 and staff #103 stated that staff #106 should have informed the RN in-charge of resident #001's complaints of pain and assessment completed so they could have completed their own assessment. Staff #100 acknowledged that staff #106 had failed to collaborate with the RN in charge in the assessment of resident #001's complaints of pain. [s. 6. (4) (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 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; so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee of the home has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 2 and in accordance with O. Reg. 79/10, s. 30, the licensee was required to have a pain management program to identify pain in residents and manage pain. Each program must, in addition to meeting the requirements set out in section 30, also provide for screening protocols, provide assessment and reassessment instruments and any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Specifically, staff did not comply with the licensee's policy tilted: "Pain Assessment and Management, index # H-15", revised January 29, 2019, which described under the procedures section item #2, that when a resident exhibited a change in their health status or pain is not relieved by initial interventions, the actions of the registered staff was to conduct a pain assessment utilizing a clinically appropriate instrument.

A CIS report was submitted to the Director on an identified date in August 2019. The CIS report indicated that resident #001 had complained of pain to the registered staff at which time the Long Term-Care Homes (LTCH) Medical Directive for pain was administered.

During an interview, staff #106 stated that resident #001's complaints of pain was a change in their health status, as this was the first time they had received complaints of

this type of pain from the resident.

A review of resident #001's assessment tab in the LTCHs electronic documentation system indicated an assessment had not been completed for resident #001's complaints of pain.

During an interview, staff #106 acknowledged that they had not completed an assessment.

During an interview, staff #103 acknowledged that staff #106 had not complied with the LTCHs policy related to Pain Assessment and Management by not completing a pain assessment for resident #001. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O. Reg. 79/10, s. 114 (1) (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy tilted: "Medication Administration, index # G-05", revised January 29, 2019, which described under the medication administration section item #7, to sign for medication on the e-MAR immediately after administering to the resident.

A CIS report was submitted to the Director on an identified date in August 2019. The CIS report indicated that resident #001 had complained of pain to the registered staff at which time the LTCHs Medical Directive for pain was administered.

A review of resident #001's electronic-medication administration record (e-MAR) for that day indicated the above mentioned medication was signed off as being administered an hour and 15 minutes after administration.

During an interview, staff #106 acknowledged that they had not signed the e-MAR immediately after administering the medication as they must have gotten distracted and that they did not indicate in the resident's progress notes the rationale for the late entry in the e-MAR.

During an interview, staff #100 acknowledged that the LTCHs policy related to medication administration had not been complied with by staff #106. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

**1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).**

**2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**

**3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**

**4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**

**5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**

**6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances of the unexpected death of resident #001.

A CIS report was submitted to the Director on an identified date in August 2019, for an incident that had occurred six days prior. The CIS report indicated resident #001 had complained of pain. The CIS also indicated that resident #001 was transferred to hospital approximately five hours later on the same day and subsequently died, approximately two hours after being transferred to hospital. The CIS report indicated that the Director had not been contacted on the same day using the after-hours pager about resident #001's death.

During an interview, staff #103 stated they had found out about the death of resident #001 on the same day and at the time, they had not considered resident #001's death as sudden. Staff #103 further stated the CIS report was submitted to the Director only after resident #001's Substitute Decision Maker (SDM) had voiced concerns to the LTCH's Social Worker. Staff #103 acknowledged that now in hindsight, the death of resident #001 had been sudden and that the Director should have been notified immediately and not six days later.
[s. 107. (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 ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs**
**Every licensee of a long-term care home shall ensure that,**
**(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and**
**(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.**

**Findings/Faits saillants :**

The licensee has failed to ensure that no medical directive or order for the administration of a drug to resident #001 is used unless it is individualized to the resident's condition and needs.

A CIS report was submitted to the Director on an identified date in August 2019. The CIS report indicated that resident #001 had complained of pain and had requested to go to hospital. The CIS also indicated that resident #001 was administered the Medical Directive for pain by staff #106.

A review of the LTCHs policy titled: Medical Directives (PRN), Index # G-25, last reviewed January 29, 2019, indicated that all medical directives or orders for the administration of a drug to a resident must be individualized to the residents' condition and need. A review of the Medical Directive in resident #001's e-MAR indicated the same directions as noted above.

A review of resident #001's progress notes did not indicate that an assessment that included the type of pain being experienced by the resident had been completed to determine their condition and needs related to their complaints of pain.

During interviews, staff #105 and #111 stated the Medical Directive did not provide clear direction for it to be used to meet resident #001's needs related to their complaints of pain.

During an interview, staff #100 acknowledged that the Medical Directive for pain needed to provide better parameters of when it should be administered. [s. 117. (b)]

***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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.***

**Issued on this 10th day of October, 2019**

**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**

**Ministère de la Santé et 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 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) :** | JOANNE ZAHUR (589) |
| **Inspection No. / No de l'inspection :** | 2019_630589_0022 |
| **Log No. / No de registre :** | 014980-19, 017075-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Oct 9, 2019 |
| **Licensee / Titulaire de permis :** | The Wexford Residence Inc.<br>1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1 |
| **LTC Home / Foyer de SLD :** | The Wexford<br>1860 Lawrence Avenue East, SCARBOROUGH, ON, M1R-5B1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Sandy Bassett |

To The Wexford Residence Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

## 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

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

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

Specifically, the licensee shall:

1. a) Ensure PSW #115 and agency staff working in the home are provided education on safe transferring techniques and specifically that PSW #115 is provided education on strategies to request assistance without leaving a resident unattended when providing care and assistance,
b) Ensure PSW #115 and agency staff working in the home receive training on the importance of being familiar with and following resident care plans related to transfer methods used in the home,
c) Ensure the home maintains a documented record of the education materials provided, date(s) of the education sessions, documented attendance of staff who attended and who provided the education, and
2. a) Develop and implement a documented auditing system that consists of audits of all PSW staff, specifically PSW #115 and agency staff working in the home to ensure they are using safe transferring and positioning techniques when assisting residents, and
b) The audits should include: the date of the audit, who completed the audit, the outcome of the audit and any actions taken as a result of the audit.

**Grounds / Motifs :**

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents' #002 and #004.

1. A complaint was received by the Director, which indicated the complainant had voiced concerns regarding a transfer that resulted in an injury to resident

#002. The complainant further stated that resident #002's injury resulted in a transfer to hospital.

A review of resident #002's care plan indicated they require a one person stand and pivot for transfers. The transfer logo in the room also indicated the same transferring needs as outlined in the care plan.

During an interview, staff #110 stated that staff #113 had asked them to provide personal care to resident #002 and then to transfer resident #002 to a wheelchair. During the transfer, an identified body part of resident #002's pressed against an assistive aid causing the injury. Staff #110 further stated that when they saw the injury, they called for staff #113 to assess. Staff #110 stated they should have removed the assistive aid for the transfer to prevent injury and acknowledged they had used an improper transferring technique.

During an interview, staff #113 confirmed they had asked staff #110 to provide personal care and to transfer resident #002 into the wheelchair, and that the PSW called them to assess an injury sustained during the transfer.

During an interview, staff #100 acknowledged that staff #110 had not used safe transferring techniques when assisting resident #002 (589)

2. 2. A Critical Incident System (CIS) report was submitted to the Director related to an unsafe transfer that occurred with resident #004. The CIS report indicated that staff #115 had used a mechanical lift to toilet resident #004 unassisted. The CIS also indicated this incident had been caught on the LTCH's video footage showing staff #115 entering the shower room with the resident and then leaving alone. During this time frame the video footage did not show anyone else entering to assist them with the transfer.

A review of resident #004's care plan indicated the use of a mechanical lift with two-person physical assist for all transfers.

During an interview, staff #115 admitted to using the mechanical lift unassisted with resident #004. Staff #115 stated they were rushing to give care and that they could not find their co-worker to assist. Staff #115 denied having used any of the mechanical lifts unassisted prior to this incident.

A review of the LTCH's internal investigation notes indicated staff #115 received disciplinary action and was required to review specific LTCH policies prior to resuming their duties.

During an interview, staff #100 acknowledged that staff #115 had not used safe transferring techniques when assisting resident #004.

The severity of this issue was determined to be a level two as there was actual harm to resident #002. The scope of the issue was a level two as it related to two of the three residents reviewed. The home had a level two compliance history of one or more unrelated non compliances in the last 36 months. (589)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jan 09, 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 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
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 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)
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 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 9th day of October, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Joanne Zahur

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