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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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Amended Public Copy/Copie modifiée 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
Dec 19, 2019	2019_763116_0003 (A1) (Appeal\Dir#: DR# 130)	013662-19, 017570-19	Complaint

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Maple Health Centre
10424 Keele Street Maple ON L6A 2L1

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

Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 130)

Amended Inspection Summary/Résumé de l'inspection modifié

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on December 19, 2019.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 130.
A copy of the Director Order is attached.

Issued on this 19th day of December, 2019 (A1)(Appeal\Dir#: DR# 130)

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

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

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

Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 130)

Amended 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): October 2, 3, 4, 7, 8, 9, 10, 2019.

The following intakes were inspected:

Log# 013662-19 related to shortage of staff and prevention of abuse and neglect,

and #017570-19 related to prevention of abuse and neglect, falls prevention management and responsive behaviours

Inspector #762 attended the inspection for shadowing purposes.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), registered nurses (RNs and RPNs), physiotherapist (PT), personal support workers (PSWs), residents and family members.

Note: non -compliance related to LTCHA, 2007, 79/10, s.19 was identified in inspection #2019_763116_0002 and has been issued in this inspection report, which was conducted concurrently with this inspection.

The inspectors reviewed residents' health records, staffing schedules, staff training records, internal investigation notes, conducted observations and reviewed and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
4 WN(s)
3 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 resident #002 and #003 were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, “physical abuse” means the use of physical force by a resident that causes physical injury to another resident (“mauvais traitement d’ordre physique”).

Critical incident system (CIS) reports were submitted to the Ministry of Long-Term Care (MLTC) on an identified date, reporting identified incidences involving resident #001, that resulted in resident #'s 002 and #003 sustaining injuries.

Record review indicated that resident #001 was admitted to the home under an identified program. Review of the admission record and specified assessment report submitted with the resident’s application indicated the resident was previously displayed an identified behaviour while in an identified health care setting due to an identified condition however, no longer has symptoms. The submitted assessment indicated the resident had no identified responsive behaviours.

On an identified date, after resident #001 was admitted, the home received an updated assessment from an external health service provider, detailing identified responsive behaviours displayed by the resident.

A review of resident #001’s progress notes indicated they exhibited identified behaviours on an identified date, towards residents #002 and resident #003.

Review of a CIS report submitted to the MLTC, indicated there was a resident to resident altercation. According to the CIS report; on an identified date, resident #003 rang the call bell at an established time, upon registered staff #117 attending the room resident #003 reported that an identified resident entered the room, struck them in an identified location and attempted to move resident #003 from

the to an identified location.

Review of resident #003's clinical health record indicated they sustained an identified injury requiring treatment for the injuries sustained by resident #001.

Inspector #116 reviewed the homes internal investigation notes and video footage from the homes closed-circuit television (CCTV) surveillance camera system for an identified date and time period. The recording does not contain audio.
In the video footage, resident #001 was observed in a resident home area, PSW staff #107 attempted to redirect resident #001 resulting in resident #001 hitting PSW staff #107 in an identified location of their body.

During an interview with resident #003 they were able to partially recall the event and stated they currently feel safe and protected.

During an interview with PSW #107, inspector #116 was informed that the identified incident portrayed by resident #001 towards PSW #107 occurred prior to the resident to resident altercation between resident #001 and resident #003. PSW # 107 further indicated they did not report the incident of identified behaviours resident #001 demonstrated towards them to the charge nurse to immediately take action as per the home's procedure. PSW #107 acknowledged that reporting the incident may have minimized the subsequent altercation between resident #001 and #002. [s. 19. (1)]

2. Review of a CIS report submitted to the MLTC, indicated that a subsequent resident to resident altercation occurred on the same date. The CIS detailed the following:
"During an investigation into the identified incident of resident #002, it was discovered that resident #001 was involved in an altercation with resident #002, which led to a subsequent incident".

Inspector #116 reviewed the homes internal investigation notes and video footage from the homes (CCTV) surveillance camera system for an identified date and time period. In the video footage, resident #001 and #002 are observed in an identified resident home area. The recording does not contain audio. Resident #002 was observed walking towards resident #001and appeared to verbalize something towards resident #001. Resident #001 was observed to hit an identified area of resident #002's body causing resident #002 to land on the ground.

Upon further review of the video footage, PSW staff #107 was noted to enter the identified resident home area, observed resident #002 on the ground and is observed passing the resident several times without attending to the resident.

An interview held with registered staff #117, stated they reported the incidences to the charge nurse #120 upon becoming aware however, charge nurse #120 was delayed in responding.

Interviews held with PSW #107 and registered staff #117, indicated being aware of the home's zero tolerance for abuse and neglect policy and acknowledged that physical abuse occurred when resident #001 hit resident #'s 002 and #003 in identified locations of their body resulting in injuries.

A review of the home's internal investigation notes indicated the LTCH had initiated disciplinary action against PSW #107 and registered staff #117. PSW #107 and registered staff #117 were required to be re-educated on identified home policies. PSW #107 was placed on an administrative leave for an identified period for failing to secure the area upon resident #002's incident and failing to complete the required re-education within the established time frame.

Interviews held with the ADOC, DOC and Administrator indicated that under the home's zero tolerance for abuse and neglect policy; the use of physical force by a resident that causes physical injury to another resident constitutes as physical abuse. The ADOC, DOC and Administrator acknowledged that physical abuse occurred when resident #001 hit resident **#**'s 002 and #003 on an identified date.

Record reviews, observations and interviews determined that a compliance order is warranted as the licensee failed to protect resident #'s 002 and #003 from physical abuse by resident #001 when resident #001 hit resident #'s 002 and #003 with physical force resulting in actual harm on an identified date. [s. 19. (1)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 130)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #007's written plan of care under an identified section indicates the resident is at an identified risk for falls and requires a specified device to be worn at all times.

On an identified date, inspectors #116 and #762 observed resident #007 in an identified area of the home without the required device in place.

An interview held with PSW staff member #119, assigned to resident #007 indicated being aware of the requirement for the device to be applied at all times. During the interview, PSW staff member #119 stated that upon commencement of the shift the required device was removed for a specified reason and unable to locate or reapply a replacement . PSW staff member #119 indicated they did not

report the findings to the charge nurse. [s. 6. (7)]

2. The following finding related to LTCHA, 2007, 79/10, s.6 (7) was identified during inspection #2019_763116_0002 and has been issued in this inspection report, which was conducted concurrently with this inspection.

The Ministry of Long-Term Care (MLTC) received a critical incident system (CIS) report on an identified date, related to a fall of resident #006. The resident was transferred to hospital after the fall and returned with identified diagnoses.

A review of resident #006's written plan of care under an identified location, documented the resident requires a specified device to be worn at all times.

An interview with PSW #111, indicated that resident #006 requires the specified device as one of the falls prevention interventions. During the interview PSW #111 acknowledged that resident #006 did not have their required device in place. PSW #111 indicated the device was removed from the resident during the shift and not re-applied. On the identified date, after completion of interview with PSW #111, inspector #751, observed PSW #111 transport resident #006 to an identified area and applied the required device.

In an interview with RPN staff #109, they stated that resident's #006 and #007 require the specified device to be worn at all times as an intervention for falls prevention and management.

An interview held with ADOC #108 indicated that resident's are provided with additional devices and further confirmed that the care set out in the plan of care was not provided as specified in the plan for resident **#**'s 006 and #007 with respect to the intervention of the identified device(s). (751) [s. 6. (7)]

3. On an identified date, the licensee submitted a CIS to the Director reporting an incident that caused an injury to resident #002 for which the resident was taken to an external health care setting. The injury resulted in a significant change in status due to sustaining an identified injury.
Subsequently, on a separate date, the Director received a complaint related to assertions of resident to resident physical abuse involving resident #002.

The CIS documented that on an identified date, resident #002 was discovered on the floor in an identified resident home area.

Inspector #116 reviewed the written plan of care for resident #002 created on an identified date, under an identified section indicated the resident was at risk for falls and requires the use of a specified mobility device at established times.

Inspector #116 reviewed the video footage captured on the CCTV surveillance camera on an identified date. Resident #002 was observed ambulating in a resident home area without the required mobility device. In the video footage, PSW staff #107 was noted to enter the resident home area and observed resident #002 without the identified mobility device and did not redirect or attempt to provide the required device to assist the resident. Subsequently, a resident to resident altercation occurred between resident #001 and #002 resulting in resident #002 landing on the ground. Resident #002 sustained a significant change within their mobility status resulting in the resident requiring the specified mobility device.

Interviews held with PSW staff **#**'s 107 and #113, indicated being aware of the requirement for the resident to use the identified mobility device at established times. During the interview with PSW #107 they stated that the resident tends to refuse usage of the specified mobility device at times and further confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan related to the use of the required mobility device on an identified date. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A review of resident #002's written plan of care under an identified section, indicates that identified equipment is to be placed on an identified location to promote safety and prevent other residents from entering the identified location and; an additional device is to be worn at all times for prevention of injuries.

Throughout the duration of the inspection, resident #002 was observed on several occasions without the required device applied and the equipment not in place on the identified location.

An interview held with PSW staff #114 assigned to resident #002 indicated they

were unaware of the resident's requirement for the equipment and identified device. PSW #114 further indicated that the required interventions were not implemented for the resident as they no longer require them.

An interview held with registered staff #105 indicated that upon resident #002's return to the home on an identified date, the specified equipment and device were suggested to the resident's substitute-decision makers (SDMs) as additional interventions to promote safety and minimize the prevention of injuries from falls. The SDM's were in agreement for the implementation of the equipment to be applied to a specified location and declined the use of the other identified device.

An interview held with the DOC indicated that the identified device was not initiated however, the required equipment was implemented upon the resident's return from the external health care setting and is no longer required as the risk is no longer present since resident #001 was discharged from the home. The DOC further confirmed that the plan of care was not revised when resident #002's care needs changed as the identified equipment is no longer necessary. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 has failed to ensure that any policy or procedure that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

In accordance with O. Reg. 79/10, r.49 (2) the licensee was required to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector #116 reviewed the current internal policy entitled “Post Fall Management Policy and Procedures”; policy number F2; which documents the following:

Any staff member who witnesses a resident fall or finds a resident on the floor or ground must:
1) Not move the resident unless the resident’s safety is at risk
2) Remain with the resident at all times until a registered nursing staff arrives to the scene
3) Prior to moving the resident, the registered nursing staff will complete a head to toe assessment of the resident as follows:
• Check for any injuries
Post Falls Assessment – The Registered staff will:
4) If no injury is evident, ask PSW to transfer the resident to a comfortable position using safe transfer techniques and appropriate lifting procedures as outlined in Positioning Transferring and Lifting Policy and Procedures (NPS 7.11).

On an identified date, the licensee submitted a CIS to the Director reporting an incident that caused an injury to resident #002 for which the resident was taken to an external health care setting. The injury resulted in a significant change in status due to sustaining an identified injury. Subsequently, the Director received a complaint related to assertions of resident to resident physical abuse involving resident #002.

Inspector #116 reviewed video footage recorded on the home's CCTV camera and noted the following observations:
Resident #001 hit resident #002 causing resident #002 to land on the ground. In the video footage, PSW staff #107 was noted entering the resident home area, observed resident #002 on the ground and observed walking past the resident without attending or remaining with the resident. Resident #002 remained on the ground and within full view of the camera for the entire footage.
RPN #117 was observed to render an incomplete assessment of the resident. Upon discovering resident #002 on the ground, PSW #107 and RPN #117 were observed transferring the resident from the ground to a standing position prior to assessing the resident for any injuries.

Inspector #116 reviewed resident #002's clinical health record and compared it against the observations captured in the video footage. The progress notes and incident report completed by RPN #117 document that all required areas of the assessment was completed which contravenes to the footage captured on the camera.

During an interview held with RPN #117, they indicated being aware of the requirement to complete all required areas of the assessment after any incident of falls. RPN #117 further stated that due to the sequence of events that occurred over a short period of time during the identified date, they conducted a partial assessment and failed to perform a complete assessment for resident #002.

During an interview with ADOC #108 they indicated that registered staff are directed to complete a full assessment including all components for any fall, transfer residents with a mechanical lift after they have fallen and are expected to remain with a resident upon discovering they had a fall or are discovered on the ground. [s. 8. (1) (a),s. 8. (1) (b)]

2. An interview held with the DOC indicated that staff documenting that a complete assessment was conducted was not considered an acceptable practice

in the home, and would be in non compliance with the licensee's policy.

The licensee failed to ensure that the current internal policy entitled "Post Fall Management Policy and Procedures"; policy number F2; was complied with, by not ensuring that a staff member remain with the resident at all times, moving the resident without a mechanical lift and providing an incomplete assessment. [s. 8. (1) (a),s. 8. (1) (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 the falls prevention and management program is complied with, to be implemented voluntarily.

WN #4: 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 :

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

On an identified date, the licensee submitted a CIS to the Director reporting an incident that caused an injury to resident #002 for which the resident was taken to an external health care setting. The injury resulted in a significant change in status due to sustaining an identified injury. Subsequently, the Director received a complaint related to assertions of resident to resident physical abuse involving resident #002.

The CIS documented that on an identified date, resident #002 was discovered on the floor in an identified home area. Resident #002 complained of pain to an identified location on their body. Staff attempted to transfer the resident but then realized that they couldn't, so they placed resident #002 back on the floor.

Inspector #116 reviewed the written plan of care for resident #002 under an identified section which indicated the resident was at risk for falls.

Inspector #116 reviewed footage recorded on the home’s closed circuit television (CCTV) camera for an identified date, which revealed resident #001 hit resident #002 causing resident #002 to land on the ground. Upon discovering resident #002 on the ground, PSW staff #107 and registered staff #117 were observed attempting to transfer the resident from the ground to a standing position prior to assessing the resident for any injuries as a result of being on the ground.

During an interview with ADOC #108, they indicated that staff members are instructed to use a mechanical hoyer lift to transfer a resident after being found on the ground as per the home's positioning, transferring and lifting policy and procedure.

An interview held with the DOC confirmed that staff did not use safe transferring techniques when assisting resident #002 on an identified date after discovering them on the ground. [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 19th day of December, 2019 (A1)(Appeal/Dir# DR# 130)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 130)
Inspection No. / No de l'inspection :	2019_763116_0003 (A1)(Appeal/Dir# DR# 130)
Appeal/Dir# / Appel/Dir#:	DR# 130 (A1)
Log No. / No de registre :	013662-19, 017570-19 (A1)(Appeal/Dir# DR# 130)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 19, 2019(A1)(Appeal/Dir# DR# 130)
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	York Region Maple Health Centre 10424 Keele Street, Maple, ON, L6A-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gautham Mekala

Ontario

Ministry of Long-Term Care

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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 The Regional Municipality of York, 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

(A1)(Appeal/Dir# DR# 130)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001

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

Linked to Existing Order/ Lien vers ordre existant :

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(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

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:

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

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

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

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 19th day of December, 2019 (A1)(Appeal/Dir# DR# 130)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 130)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central East Service Area Office