Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Téléphone: (705) 564-3130
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2017;	2016_562620_0030 (A1)	027397-16, 029708-16	Follow up

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension as the home will be experiencing a change of Administrator; therefore, the order has been extended to March 31, 2017.

Issued on this 27 day of February 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

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EXTENDICARE (CANADA) INC.
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Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 19-23, 2016, and January 18-20, and 23, 2017

This inspection included the review of two Follow-up (FU) logs:

-a FU related to the homes failure to provide resident care as specified in the plan of care; specifically compliance order (CO) #001 of report #2016_395613_0013, and

-a FU related to the homes failure to protect resident from abuse/neglect; specifically CO #001 of report #2016-395613-0007.

A concurrent critical incident (report #2016_562620_0031) and complaint (report #2016_562620_0029) inspection was also conducted. As a result, findings from the critical incident report have been included within the findings of this report.

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, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Support Services Manager (SSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 protected from abuse by anyone.

Compliance order (CO) #001 of inspection #2016_395613_0007 was issued to the licensee on August 14, 2016. Order #001 required the licensee to prepare, submit and implement a plan, ensuring that all residents were protected from abuse by anyone and not neglected by the licensee or staff by September 5, 2016. The plan was to include,

"- a detailed description of what steps the home will take to ensure that all residents are protected from abuse by anyone and shall ensure that all residents are not neglected by the licensee or staff.
-how the home will ensure the "Zero Tolerance of Resident Abuse and Neglect Program" including related and supplemental policies and procedures are followed by all staff when an alleged, suspected or witnessed incident of resident abuse or neglect occurs, through development of a check list or tracking system.
- how the home will ensure that management or designated staff who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.
- how the home will ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee, is immediately investigated. The plan shall also include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation."

While the licensee met the requirements as ordered, further non-compliance was identified during this inspection.

The Long Term Care Health Act 2007, defines emotional, physical, and verbal abuse as:

"emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences;

"physical abuse" means,
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;

"verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Inspector #620 reviewed a Critical Incident (CI) report that was submitted to the Director. The report described that at a specified dated and time, resident #001 reported to RPN #107 that PSW #105 had yelled at them for having to go to the bathroom too frequently. The resident advised RPN #107 that as a result of being yelled at, they were soiled because they were afraid to use their call bell for fear of being chastised again.

The On-call Manager was notified of the incident and as a result PSW #105 was reassigned to different part of the home away from resident #001. The following

day, resident #001 raised concerns with their Substitute Decision Maker (SDM) and PSW #108 regarding PSW #105's attitude toward them. Resident #001 reported that following their report to staff about verbal abuse the day previous, PSW #105 approached them and questioned them saying, "what is your issue with me?" Resident #001 described that they advised PSW #105 that they had concerns about the way care was being provided by PSW #105. The resident stated that when the care was provided that it was rough. The resident stated that they were emotionally upset and felt uncomfortable when they were approached by PSW #105. The CI report indicated that as a result of PSW #105 approaching resident #001, PSW #105 was removed from the schedule until the completion of an investigation.

A.) Inspector #620 reviewed the home's investigation records related to the incident. The records indicated that RPN #107 first became aware of the allegation of verbal abuse within hours of the incident occurring, and they notified the On-call Manager, who in turn consulted with ADOC #104. The On-call Manager then advised RPN #107 to switch PSW #105 to another area of the home on their next scheduled shift and that ADOC #104 would follow up with PSW #105 in two days. A CIS report was submitted to the Director two days following the incident.

According to the LTCHA, 2007, s. 24 (1), Any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. Please refer to WN #1 of critical incident report #2016_562620_0031.

B.) The home's investigation records further revealed that one day following resident #001's allegation, PSW #105 did approach resident #001 alone, in a specific area of the home, to confront them about the allegation brought forward. PSW #105 was subsequently sent home pending an investigation of the incident. There was no indication in the investigation notes that indicated that an investigation was immediately started; rather, the investigation began two days following the allegation.

According to the LTCHA, 2007, s. 23 (1), every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated. Please refer to WN #3 of critical incident report #2016_562620_0031.

C.) Inspector #620 interviewed PSW #105 who stated that they approached resident #001 alone in a specific area of the home to confront them. PSW #105 stated that they recognized that the resident appeared intimidated. PSW #105 stated that they were sent home for their actions and the home had disciplined them.

According to the LTCHA, 2007, s. 20 (1), the licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. Please refer to WN #1, section 2, of complaint report #2016_562620_0029. [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. 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).

Findings/Faits saillants :

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

Compliance order (CO) #001 of inspection #2016_395613_0013 was issued to the licensee on October 5, 2016. CO #001 required the home to,
"-Ensure the care as set out in the plan of care for resident #004 is followed, specifically that PSWs are to report certain symptoms of a medical condition to the

registered staff.
-Ensure the care as set out in the plan of care for resident #005, related to toileting is followed.
-Ensure the care as set out in the plan of care for resident #006, related to fall prevention interventions is followed."

While the licensee met the requirements as ordered, further non-compliance was identified during this inspection.

Inspector #620 reviewed CI report #3043-000090-16 that was submitted by the home, to the Director. The report was initiated as a result of an unexpected death. The report described that resident #004 experienced a fall from their bed which resulted in an injury. According to the CI report the resident had a certain fall prevention device in place; however, the device had not been activated during the fall. The resident passed away in hospital.

A review of resident #004's clinical record revealed that an assessment completed indicated that resident #004 was at a high risk for falls. The resident's care plan indicated that all shifts were to monitor a certain fall prevention device to ensure that it was in place, and working properly. Staff were also advised to, keep a certain mobility device in a specific location.

Inspector #620 interviewed PSW #106 who stated that they were the first person to find resident #004 post fall. They stated that the resident's fall prevention device was in place but because the device was not adjusted it had not been activated. PSW #106 denied adjusting the device. They stated that the bed was in its lowest position and that the resident's mobility aid was not where the plan of care indicated it should have been.

Inspector #620 interviewed ADOC #001 who stated that the resident's fall prevention device had not been activated. The ADOC stated that the device was determined to be functional and that they were unaware if the staff had checked the device's functionality. They were also unaware that the resident's mobility aid was not was not where the plan of care had indicated it should have been. [s. 6. (7)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

Issued on this 27 day of February 2017 (A1)

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALAIN PLANTE (620) - (A1)

Inspection No. / No de l'inspection : 2016_562620_0030 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 027397-16, 029708-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 27, 2017;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue, SAULT STE. MARIE, ON,
P6B-4J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Johanne Messier-Mann

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_395613_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 shall protect all residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Compliance order (CO) #001 of inspection #2016_395613_0007 was issued to the licensee on August 14, 2016. Order #001 required the licensee to prepare, submit and implement a plan, ensuring that all residents were protected from abuse by anyone and not neglected by the licensee or staff by September 5, 2016. The plan was to include,

"- a detailed description of what steps the home will take to ensure that all residents are protected from abuse by anyone and shall ensure that all residents are not neglected by the licensee or staff.
-how the home will ensure the "Zero Tolerance of Resident Abuse and Neglect Program" including related and supplemental policies and procedures are followed by all staff when an alleged, suspected or witnessed incident of resident abuse or

neglect occurs, through development of a check list or tracking system.
- how the home will ensure that management or designated staff who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.
- how the home will ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee, is immediately investigated.
The plan shall also include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation."

While the licensee met the requirements as ordered, further non-compliance was identified during this inspection.

The Long Term Care Health Act 2007, defines emotional, physical, and verbal abuse as:

"emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences;

"physical abuse" means,
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;

"verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other

than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Inspector #620 reviewed a Critical Incident (CI) report that was submitted to the Director. The report described that at a specified dated and time, resident #001 reported to RPN #107 that PSW #105 had yelled at them for having to go to the bathroom too frequently. The resident advised RPN #107 that as a result of being yelled at, they were soiled because they were afraid to use their call bell for fear of being chastised again.

The On-call Manager was notified of the incident and as a result PSW #105 was reassigned to different part of the home away from resident #001. The following day, resident #001 raised concerns with their Substitute Decision Maker (SDM) and PSW #108 regarding PSW #105's attitude toward them. Resident #001 reported that following their report to staff about verbal abuse the day previous, PSW #105 approached them and questioned them saying, "what is your issue with me?" Resident #001 described that they advised PSW #105 that they had concerns about the way care was being provided by PSW #105. The resident stated that when the care was provided that it was rough. The resident stated that they were emotionally upset and felt uncomfortable when they were approached by PSW #105. The CI report indicated that as a result of PSW #105 approaching resident #001, PSW #105 was removed from the schedule until the completion of an investigation.

A.) Inspector #620 reviewed the home's investigation records related to the incident. The records indicated that RPN #107 first became aware of the allegation of verbal abuse within hours of the incident occurring, and they notified the On-call Manager, who in turn consulted with ADOC #104. The On-call Manager then advised RPN #107 to switch PSW #105 to another area of the home on their next scheduled shift and that ADOC #104 would follow up with PSW #105 in two days. A CIS report was submitted to the Director two days following the incident.

According to the LTCHA, 2007, s. 24 (1), Any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. Please refer to WN #1 of critical incident report

#2016_562620_0031.

B.) The home's investigation records further revealed that one day following resident #001's allegation, PSW #105 did approach resident #001 alone, in a specific area of the home, to confront them about the allegation brought forward. PSW #105 was subsequently sent home pending an investigation of the incident. There was no indication in the investigation notes that indicated that an investigation was immediately started; rather, the investigation began two days following the allegation.

According to the LTCHA, 2007, s. 23 (1), every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated. Please refer to WN #3 of critical incident report #2016_562620_0031.

C.) Inspector #620 interviewed PSW #105 who stated that they approached resident #001 alone in a specific area of the home to confront them. PSW #105 stated that they recognized that the resident appeared intimidated. PSW #105 stated that they were sent home for their actions and the home had disciplined them.

According to the LTCHA, 2007, s. 20 (1), the licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. Please refer to WN #1, section 2, of complaint report #2016_562620_0029.

The decision to issue this compliance order was based on the scope which had been identified as isolated, the severity which indicated actual harm, and the compliance history which despite previous non-compliance having been issued with two compliance orders served to the licensee under report #2016_395613_0007 and #2014_281542_0006; non-compliance continued with this section of the legislation. (620)

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

Mar 10, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_395613_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall,

a) review all care plans for residents who are identified as high risk for falls, ensuring that:

1. the resident identified as being high risk for falls are receiving care as specified within their plan of care, and

2. the residents' care plans accurately reflect their assessed needs.

Grounds / Motifs :

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

Compliance order (CO) #001 of inspection #2016_395613_0013 was issued to the licensee on October 5, 2016. CO #001 required the home to,
"-Ensure the care as set out in the plan of care for resident #004 is followed,

specifically that PSWs are to report certain symptoms of a medical condition to the registered staff.
-Ensure the care as set out in the plan of care for resident #005, related to toileting is followed.
-Ensure the care as set out in the plan of care for resident #006, related to fall prevention interventions is followed."

While the licensee met the requirements as ordered, further non-compliance was identified during this inspection.

Inspector #620 reviewed CI report #3043-000090-16 that was submitted by the home, to the Director. The report was initiated as a result of an unexpected death. The report described that resident #004 experienced a fall from their bed which resulted in an injury. According to the CI report the resident had a certain fall prevention device in place; however, the device had not been activated during the fall. The resident passed away in hospital.

A review of resident #004's clinical record revealed that an assessment completed indicated that resident #004 was at a high risk for falls. The resident's care plan indicated that all shifts were to monitor a certain fall prevention device to ensure that it was in place, and working properly. Staff were also advised to, keep a certain mobility device in a specific location.

Inspector #620 interviewed PSW #106 who stated that they were the first person to find resident #004 post fall. They stated that the resident's fall prevention device was in place but because the device was not adjusted it had not been activated. PSW #106 denied adjusting the device. They stated that the bed was in its lowest position and that the resident's mobility aid was not where the plan of care indicated it should have been.

Inspector #620 interviewed ADOC #001 who stated that the resident's fall prevention device had not been activated. The ADOC stated that the device was determined to be functional and that they were unaware if the staff had checked the device's functionality. They were also unaware that the resident's mobility aid was not was not where the plan of care had indicated it should have been.

The decision to issue this compliance order was based on the scope which had been identified as isolated, the severity which indicated actual harm, and the compliance

history which despite previous non-compliance having been issued with two compliance orders served to the licensee under report #2016_395613_0013 and #2014_281542_0006, and a voluntary plan of correction served under report #2014_281542_0005; non-compliance continued with this section of the legislation. (620)

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

Mar 31, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection 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

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection 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

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

Issued on this 27 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ALAIN PLANTE

Service Area Office /
Bureau régional de services : Sudbury