Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 29, 2021	2021_673672_0031	008023-21, 009125-21, 010709-21, 011469-21, 012559-21	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Haliburton
167 Park Street P.O. Box 780 Haliburton ON K0M 1S0

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

JENNIFER BATTEN (672)

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): August 16-20 and September 1-3, 2021

A Complaint inspection (Inspection #2021_715672_0030) was conducted concurrent to this inspection. Findings of non-compliance were also issued within that report.

The following intakes were completed during this Critical Incident System inspection:

Three intakes related to allegations of staff to resident abuse and/or neglect.

Two intakes related to resident falls with serious injury which resulted in transfer to hospital and significant changes in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Quality Lead, Environmental/Housekeeping/Food Services Manager, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Attendants, Housekeepers, Environmental Services Workers (ESW), screeners, essential visitors and residents.

The inspector(s) reviewed clinical health records of identified residents and internal policies related to Fall Prevention and Head Injury Review, Hot Weather management, Prevention of Resident Abuse and Neglect, Medication Administration and Infection Prevention and Control. The Inspector(s) also observed staff to resident and resident to resident care and interactions, medication administration and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Safe and Secure Home

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

- **4 WN(s)**
- **2 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	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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #014, #015 and #025, who required assistance with eating.

Residents #014, #015 and #025 were served their lunch meals and/or afternoon nourishment items and received assistance from staff with their intake while in unsafe positions for food/fluid intake.

Review of the residents #014, #015 and #025 plans of care indicated they were each at nutritional risk.

During separate interviews, PSW #120 indicated resident #014 was routinely in the observed position during meal and nourishment services for an identified reason. PSW #120 further indicated resident #015 did not normally eat in the observed position and verified resident #015 was in an unsafe position for eating and drinking purposes. PSW #121 indicated resident #025 was routinely in the observed position during meal and nourishment services for an identified reason.

During separate interviews, RN #119, RPNs #110, #117 and the DOC/Administrator indicated the expectation in the home was for residents to be seated in upright positions for all food and fluid intake, to minimize the risk of the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; record review of residents #014, #015 and #025 current written plans of care; interviews with PSWs, RPNs and the DOC/Administrator. [s. 73. (1) 10.]

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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #006. The resident was transferred to hospital and received specified diagnoses. The resident passed away in the home an identified period of time after the fall.

Review of the resident's progress notes indicated that following the fall, resident #006 was noted to be in pain. An identified intervention was implemented but was noted to be ineffective at times. Review of the resident's electronic healthcare record indicated no pain assessments were completed following the fall; upon return from hospital; when the identified intervention was implemented nor when the identified intervention was noted to be ineffective.

During separate interviews, PSWs #106, #115 and RPN #110 indicated resident #006 was in pain following the fall until they passed away. RPN #110 and the DOC/Administrator verified pain assessments were expected to be completed as outlined within the internal pain management policy and should have been completed for resident #006 following the fall, readmission from hospital, when the identified intervention was implemented and when the identified intervention was noted to be ineffective.

By not ensuring that when resident #006's pain was not relieved by initial interventions they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose, the resident was placed at risk of having uncontrolled pain.

Sources: Identified CIR; resident #006's electronic Medication Administration Record, progress notes and physician's orders; internal policy related to pain identification and

management and interviews with PSWs #106, #115, RPN #110 and the DOC/Administrator. [s. 52. (2)]

2. A Critical Incident Report was submitted to the Director related to a fall sustained by resident #007, which resulted in an identified injury. The resident was transferred to hospital, received an intervention and returned to the home several days later.

Review of the resident's progress notes indicated that upon return from the hospital, resident #007 was noted to be in pain. An identified intervention was implemented but was noted to be ineffective at times. Review of the resident's electronic healthcare record indicated no pain assessments were completed upon return from hospital; when the identified intervention was implemented nor when the identified intervention was noted to be ineffective.

By not ensuring that when resident #007's pain was not relieved by initial interventions they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose, the resident was placed at risk of having ongoing uncontrolled pain.

Sources: Identified CIR; resident #006's electronic Medication Administration Record, progress notes and physician's orders; internal policy related to pain identification and management and interviews with PSWs #106, #115, RPN #110 and the DOC/Administrator. [s. 52. (2)]

3. In order to expand the scope of inspection related to pain assessments, Inspector was informed by the DOC/Administrator that resident #023 had been struggling with new/worsening pain over the previous several months.

Review of the resident's progress notes indicated the resident had been complaining of new/worsening pain. Referrals to identified disciplines were completed and a plan of care was implemented which included identified interventions. The resident continued to complain of pain and an identified intervention was reviewed and altered several times.

During separate interviews, PSW #104, RPN #117 and the DOC/Administrator indicated resident #023 continued to struggle with pain management but they were reviewing and altering the resident's plan of care in an attempt to implement effective interventions. Review of the resident's electronic healthcare record indicated pain assessments were not completed when an identified intervention was implmented, altered and/or found to

be ineffective.

By not ensuring that when resident #023's pain was not relieved by initial interventions they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose, the resident was placed at risk of having ongoing uncontrolled pain.

Sources: Resident #023's electronic Medication Administration Record, progress notes and physician's orders; internal policy related to pain identification and management and interviews with PSW #104, RPN #117 and the DOC/Administrator. [s. 52. (2)]

Additional Required Actions:

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

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 the internal Neurological Signs/Head Injury Routine policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall 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.

Review of the internal policy related to neurological signs and head injury routine indicated that when a resident was placed on head injury routine assessment, staff were to use the Head Injury Routine form and follow the time frames indicated unless specific physician's orders were received which stated otherwise.

Resident #007 was noted to be at risk for falling and sustained an identified number of falls during a specified time period. On an identified date, the resident sustained a fall which resulted in head injury routine being required. Upon review of the head injury routine assessment, the assessment had not been completed in full, as per the directions listed in the internal policy and/or on the head injury routine neurological assessment. Inspector then reviewed the other head injury routine assessments completed for resident #007 and noted they had not been completed as directed in the internal policy. During separate interviews, RPNs #110 and #117 indicated it was a routine practice in the home for staff to sometimes not awaken a resident to complete head injury assessments.

By not ensuring head injury routine assessments were completed appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Identified CIR; resident #007's head injury routine neurological assessments completed during a specified time period; internal policy related to neurological signs and head injury routine and interviews with RPNs #110, #117 and the DOC/Administrator. [s. 8. (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 to ensure internal policies are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that personal items were labelled, as required.

Observations conducted revealed that in several shared resident bedrooms and bathrooms there were multiple personal items such as used rolls of deodorant, hairbrushes, nail clippers and toothbrushes which were not labelled with the resident's name.

During separate interviews, staff members could not indicate who the items belonged to. The Administrator verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted and interviews with PSWs, RPNs and the DOC/Administrator. [s. 37. (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 personal items are labelled as required, to be implemented voluntarily.

Issued on this 1st day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l’inspection :	2021_673672_0031
Log No. / No de registre :	008023-21, 009125-21, 010709-21, 011469-21, 012559-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 29, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Haliburton 167 Park Street, P.O. Box 780, Haliburton, ON, K0M-1S0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Nik Chandrabalan

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #014, #015 and #025, who required assistance with eating.

Residents #014, #015 and #025 were served their lunch meals and/or afternoon nourishment items and received assistance from staff with their intake while in unsafe positions for food/fluid intake.

Review of the residents #014, #015 and #025 plans of care indicated they were each at nutritional risk.

During separate interviews, PSW #120 indicated resident #014 was routinely in the observed position during meal and nourishment services for an identified reason. PSW #120 further indicated resident #015 did not normally eat in the observed position and verified resident #015 was in an unsafe position for eating and drinking purposes. PSW #121 indicated resident #025 was routinely in the observed position during meal and nourishment services for an identified reason.

During separate interviews, RN #119, RPNs #110, #117 and the DOC/Administrator indicated the expectation in the home was for residents to be seated in upright positions for all food and fluid intake, to minimize the risk of the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or

aspiration.

Sources: Observations conducted; record review of residents #014, #015 and #025 current written plans of care; interviews with PSWs, RPNs and the DOC/Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed attempting to eat while in an unsafe position.

Compliance History: One or more areas of non-compliance were issued to the home related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2021

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with section s. 52. (2) of O.Reg 79/10 of the LTCHA.

Specifically, the licensee must:

1. Ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

2. Conduct weekly audits for a period of six weeks to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. Keep a documented record of the audits completed and make available to Inspectors upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #006. The resident was transferred to hospital and received specified diagnoses. The resident passed away in the home an identified period of time after the fall.

Review of the resident's progress notes indicated that following the fall, resident

#006 was noted to be in pain. An identified intervention was implemented but was noted to be ineffective at times. Review of the resident's electronic healthcare record indicated no pain assessments were completed following the fall; upon return from hospital; when the identified intervention was implemented nor when the identified intervention was noted to be ineffective.

During separate interviews, PSWs #106, #115 and RPN #110 indicated resident #006 was in pain following the fall until they passed away. RPN #110 and the DOC/Administrator verified pain assessments were expected to be completed as outlined within the internal pain management policy and should have been completed for resident #006 following the fall, readmission from hospital, when the identified intervention was implemented and when the identified intervention was noted to be ineffective.

By not ensuring that when resident #006's pain was not relieved by initial interventions they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose, the resident was placed at risk of having uncontrolled pain.

Sources: Identified CIR; resident #006's electronic Medication Administration Record, progress notes and physician's orders; internal policy related to pain identification and management and interviews with PSWs #106, #115, RPN #110 and the DOC/Administrator. (672)

2. A Critical Incident Report was submitted to the Director related to a fall sustained by resident #007, which resulted in an identified injury. The resident was transferred to hospital, received an intervention and returned to the home several days later.

Review of the resident's progress notes indicated that upon return from the hospital, resident #007 was noted to be in pain. An identified intervention was implemented but was noted to be ineffective at times. Review of the resident's electronic healthcare record indicated no pain assessments were completed upon return from hospital; when the identified intervention was implemented nor when the identified intervention was noted to be ineffective.

By not ensuring that when resident #007's pain was not relieved by initial

interventions they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose, the resident was placed at risk of having ongoing uncontrolled pain.

Sources: Identified CIR; resident #006's electronic Medication Administration Record, progress notes and physician's orders; internal policy related to pain identification and management and interviews with PSWs #106, #115, RPN #110 and the DOC/Administrator.
(672)

3. In order to expand the scope of inspection related to pain assessments, Inspector was informed by the DOC/Administrator that resident #023 had been struggling with new/worsening pain over the previous several months.

Review of the resident's progress notes indicated the resident had been complaining of new/worsening pain. Referrals to identified disciplines were completed and a plan of care was implemented which included identified interventions. The resident continued to complain of pain and an identified intervention was reviewed and altered several times.

During separate interviews, PSW #104, RPN #117 and the DOC/Administrator indicated resident #023 continued to struggle with pain management but they were reviewing and altering the resident's plan of care in an attempt to implement effective interventions. Review of the resident's electronic healthcare record indicated pain assessments were not completed when an identified intervention was implmented, altered and/or found to be ineffective.

By not ensuring that when resident #023's pain was not relieved by initial interventions they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose, the resident was placed at risk of having ongoing uncontrolled pain.

Sources: Resident #023's electronic Medication Administration Record, progress notes and physician's orders; internal policy related to pain identification and management and interviews with PSW #104, RPN #117 and the DOC/Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents, as residents were placed at risk of having ongoing, uncontrolled pain when their pain was not being assessed as required.

Scope: The scope of this non-compliance was widespread, as three out of three residents inspected upon were affected.

Compliance History: A Voluntary Plan of Correction was issued to the home during Resident Quality Inspection #2018_643111_0017 on December 5, 2018. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 09, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 29th day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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