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
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Bureau régional de services de Centre-Est
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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
Mar 3, 2022	2022_673672_0002	006756-21, 009906-21, 010348-21, 010519-21, 013230-21, 014573-21, 016058-21, 016137-21, 017701-21, 019460-21, 020651-21, 020836-21	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 Scarborough
3830 Lawrence Avenue East Scarborough ON M1G 1R6

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

JENNIFER BATTEN (672), AMA AGYEMANG (722469), CATHERINE OCHNIK (704957)

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): January 31, February 1, 2, 4, 7 and 8, 2022

A Complaint inspection (Inspection #2022_673672_0003) 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:

Seven intakes related to resident falls which resulted in significant injuries and changes to the resident's health status.

One intake related to an outbreak declared in the home.

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

One intake related to an incident of attempted suicide by a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care (ADOC), Dietary Manager (DA), Support Services Manager (SSM), Business Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Physiotherapists (PT) and physio assistants (PTA), Recreation Aides (RAs), Dietary Aides (DAs), Housekeepers, Screeners and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Falls Prevention, Prevention of Abuse and Neglect, Complaints and Responsive Behaviours. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 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 #001 was protected from incidents of

abuse.

For the purposes of the Act and Regulation, “Physical Abuse” is defined as:

“the use of physical force by anyone other than a resident that causes physical injury or pain.” O. Reg. 79/10.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #001 and PSW #100. The CIR indicated an assessment of the resident was completed following the alleged incident, and injuries to the resident were noted.

Resident #001 could not be interviewed during the inspection, as they were no longer in the home. PSW #100 could not be interviewed, as they were no longer employed in the home.

Review of the internal investigation notes indicated the allegation of staff to resident abuse was founded. Record review indicated that PSW #100 had been involved in a previous allegation of resident abuse, involving resident #002.

During separate interviews, the ADOC and DOC verified the allegation of abuse to resident #001 was substantiated. The ADOC and DOC indicated that all staff members received education related to the prevention of resident abuse and neglect.

Resident #001 was not protected from incidents of abuse by a staff member which resulted in the resident experiencing physical and emotional injuries.

Sources: Identified Critical Incident Report; internal policies related to Zero Tolerance of Resident Abuse and Neglect; internal investigation notes; resident #001’s plan of care and progress notes, pain and skin/wound assessments; PSW #100’s employee and internal educational records; interviews with the ADOC, DOC and Administrator. [s. 19. (1)]

2. The licensee failed to ensure that resident #002 was protected from incidents of abuse.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #002 and PSW #134, which

caused the resident pain.

Resident #002 and PSW #134 could not be interviewed during the inspection. During separate interviews, PSWs #102 and #103 verified they had observed PSW #134 abuse resident #002.

Review of the internal investigation notes indicated and during separate interviews, the ADOC and DOC verified the allegation of staff to resident abuse was founded. The ADOC and DOC indicated that all staff members receive education related to the prevention of resident abuse and neglect prior to working with any of the residents and then annually thereafter.

Resident #002 was not protected from incidents of abuse by a staff member which resulted in the resident experiencing physical pain and emotional injuries.

Sources: Critical Incident Report; internal policy related to Zero Tolerance of Resident Abuse and Neglect; resident #002's electronic health care record; internal investigation notes; internal incident report and interviews with PSWs #102, #103, the ADOC and DOC. [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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse of a resident that the licensee suspected may constitute a criminal offence.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #001 and PSW #100. The CIR indicated an assessment of the resident was completed following the alleged incident, and injuries to the resident were noted.

Review of resident #001's electronic health care record, internal investigation notes, internal incident report and Critical Incident Report did not indicate the appropriate police force was notified of the incident of abuse between resident #001 and PSW #100.

During separate interviews, the ADOC and DOC verified the allegation of staff to resident abuse was founded. The ADOC and DOC indicated a resident being abused in the manner of resident #001 could be considered as an incident of assault, which is a criminal code offence. The current practice in the home when an allegation of resident abuse was brought forward was for the family members to be asked if they wished to have the police notified, therefore the licensee did not routinely notify the police of incidents which they believed met the criteria of a criminal offence, unless directed by resident's family members.

Sources: Identified Critical Incident Report; internal policies related to Zero Tolerance of Resident Abuse and Neglect; resident #001's electronic health care record; internal investigation notes; internal incident report and interviews with the ADOC and DOC. [s. 98.]

2. A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #002 and PSW #134, which caused the resident pain.

Review of resident #002's electronic health care record, internal investigation notes, internal incident report and identified Critical Incident Report did not indicate the appropriate police force was notified of the incident of physical abuse between resident #002 and PSW #134.

During separate interviews, the ADOC and DOC verified the allegation of staff to resident abuse was founded and had caused the resident pain. The ADOC and DOC indicated a resident being abused in the manner of resident #002 could be considered as an incident of assault, which is a criminal code offence. The current practice in the home when an allegation of resident abuse was brought forward was for the family members to be asked if they wished to have the police notified. If the family declined, the licensee did not

routinely notify the police of incidents which they believed met the criteria of a criminal offence.

Sources: Identified Critical Incident Report; internal policies related to Zero Tolerance of Resident Abuse and Neglect; resident #002's electronic health care record; internal investigation notes; internal incident report and interviews with the ADOC and DOC. [s. 98.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #016 set out clear directions for staff and others who provided direct care.

A Critical Incident Report was submitted to the Director indicating that resident #016 had a fall with injury and was transferred to hospital. In review of the care plan, there were areas of concern related to the goals and interventions for the walking and locomotion focuses. Specifically, the goals and interventions were not consistent with the focuses indicated in the care pan. The focuses of walk in room/ corridor and locomotion on/off unit, both indicated the resident required a specified level of assistance. The goals and interventions for both areas indicated that the resident required a different specified level of assistance. The risk of harm related to this issue was that direct care staff did not have clear directions on appropriate interventions to meet the resident's care needs, which could increase the risk of falls for the resident.

SOURCES: Resident #016's care plan, Interview with DOC and Nurse #137, Progress Notes for Resident #016. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident plans of care set out clear directions for staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation related to resident #002 and PSW #134 were reported to the Director.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #002 and PSW #134, which caused the resident pain.

Review of the internal investigation notes indicated the allegations related to PSW #134 were founded and resident #002 had been abused during personal care. Review of the CIR did not indicate the outcome of the internal investigation, which included that the allegations were founded, the interventions implemented regarding PSW #134, or the response of the resident and/or the resident's family member to the initial allegation of abuse nor the outcome of the internal investigation.

During an interview, the ADOC indicated they were responsible for amending the CIR with the required information and verified they had not done so.

Sources: Identified Critical Incident Report; internal investigation notes; internal incident report and interviews with the ADOC and DOC. [s. 23. (2)]

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 results of abuse and/or neglect investigations are reported to the Director, to be implemented voluntarily.

Issued on this 8th day of March, 2022

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), AMA AGYEMANG (722469), CATHERINE OCHNIK (704957)
Inspection No. / No de l’inspection :	2022_673672_0002
Log No. / No de registre :	006756-21, 009906-21, 010348-21, 010519-21, 013230-21, 014573-21, 016058-21, 016137-21, 017701-21, 019460-21, 020651-21, 020836-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 3, 2022
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Scarborough 3830 Lawrence Avenue East, Scarborough, ON, M1G-1R6
	Pinky Virdi

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

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA.

Specifically, the licensee must:

1) Create and implement a plan to ensure that all residents are protected from incidents of abuse. Keep a documented record of the plan and make available to Inspectors upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from incidents of abuse.

For the purposes of the Act and Regulation, "Physical Abuse" is defined as:

"the use of physical force by anyone other than a resident that causes physical injury or pain." O. Reg. 79/10.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #001 and PSW #100. The CIR indicated an assessment of the resident was completed following the alleged incident, and injuries to the resident were noted.

Resident #001 could not be interviewed during the inspection, as they were no longer in the home. PSW #100 could not be interviewed, as they were no longer employed in the home.

Review of the internal investigation notes indicated the allegation of staff to

resident abuse was founded. Record review indicated that PSW #100 had been involved in a previous allegation of resident abuse, involving resident #002.

During separate interviews, the ADOC and DOC verified the allegation of abuse to resident #001 was substantiated. The ADOC and DOC indicated that all staff members received education related to the prevention of resident abuse and neglect.

Resident #001 was not protected from incidents of abuse by a staff member which resulted in the resident experiencing physical and emotional injuries.

Sources: Identified Critical Incident Report; internal policies related to Zero Tolerance of Resident Abuse and Neglect; internal investigation notes; resident #001's plan of care and progress notes, pain and skin/wound assessments; PSW #100's employee and internal educational records; interviews with the ADOC, DOC and Administrator.
(672)

2. The licensee failed to ensure that resident #002 was protected from incidents of abuse.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #002 and PSW #134, which caused the resident pain.

Resident #002 and PSW #134 could not be interviewed during the inspection. During separate interviews, PSWs #102 and #103 verified they had observed PSW #134 abuse resident #002.

Review of the internal investigation notes indicated and during separate interviews, the ADOC and DOC verified the allegation of staff to resident abuse was founded. The ADOC and DOC indicated that all staff members receive education related to the prevention of resident abuse and neglect prior to working with any of the residents and then annually thereafter.

Resident #002 was not protected from incidents of abuse by a staff member which resulted in the resident experiencing physical pain and emotional injuries.

Sources: Critical Incident Report; internal policy related to Zero Tolerance of Resident Abuse and Neglect; resident #002's electronic health care record; internal investigation notes; internal incident report and interviews with PSWs #102, #103, the ADOC and DOC.

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

Severity: There was actual harm to residents #001 and #002, which resulted in both physical and emotional injuries.

Scope: The scope of this non-compliance was patterned, as two out of three incidents of alleged resident abuse or neglect which were inspected upon were founded.

Compliance History: Within the previous 36 months, a Voluntary Plan of Correction was issued to the licensee in Complaint inspection report (Inspection #2019_626501_0012), issued on June 27, 2019. A second Voluntary Plan of Correction was issued to the licensee in Critical Incident System inspection report (Inspection #2021_784762_0007) issued on March 30, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2022

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. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee must be compliant with s. 98 of O.Reg 79/10.

Specifically, the licensee must:

1) Ensure the appropriate police force is immediately notified of every alleged incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Grounds / Motifs :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse of a resident that the licensee suspected may constitute a criminal offence.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #001 and PSW #100. The CIR indicated an assessment of the resident was completed following the alleged incident, and injuries to the resident were noted.

Review of resident #001's electronic health care record, internal investigation notes, internal incident report and Critical Incident Report did not indicate the appropriate police force was notified of the incident of abuse between resident #001 and PSW #100.

During separate interviews, the ADOC and DOC verified the allegation of staff to resident abuse was founded. The ADOC and DOC indicated a resident being abused in the manner of resident #001 could be considered as an incident of

assault, which is a criminal code offence. The current practice in the home when an allegation of resident abuse was brought forward was for the family members to be asked if they wished to have the police notified, therefore the licensee did not routinely notify the police of incidents which they believed met the criteria of a criminal offence, unless directed by resident's family members.

Sources: Identified Critical Incident Report; internal policies related to Zero Tolerance of Resident Abuse and Neglect; resident #001's electronic health care record; internal investigation notes; internal incident report and interviews with the ADOC and DOC.
(672)

2. A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #002 and PSW #134, which caused the resident pain.

Review of resident #002's electronic health care record, internal investigation notes, internal incident report and identified Critical Incident Report did not indicate the appropriate police force was notified of the incident of physical abuse between resident #002 and PSW #134.

During separate interviews, the ADOC and DOC verified the allegation of staff to resident abuse was founded and had caused the resident pain. The ADOC and DOC indicated a resident being abused in the manner of resident #002 could be considered as an incident of assault, which is a criminal code offence. The current practice in the home when an allegation of resident abuse was brought forward was for the family members to be asked if they wished to have the police notified. If the family declined, the licensee did not routinely notify the police of incidents which they believed met the criteria of a criminal offence.

Sources: Identified Critical Incident Report; internal policies related to Zero Tolerance of Resident Abuse and Neglect; resident #002's electronic health care record; internal investigation notes; internal incident report and interviews with the ADOC and DOC.

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

Severity: There was actual harm caused to residents #001 and #002, which constituted a criminal offence. By not reporting incidents as required, further incidents of resident abuse may continue to occur.

Scope: The scope of this non-compliance was patterned, as two out of three incidents of alleged resident abuse or neglect were impacted.

Compliance History: Within the previous 36 months, a Voluntary Plan of Correction was issued to the licensee in Critical Incident System inspection report (Inspection #2020_838760_0016) issued on August 17, 2020.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2022

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 3rd day of March, 2022

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