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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2017	2017_524500_0002	021329-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

YORK REGION NEWMARKET HEALTH CENTRE
194 EAGLE STREET NEWMARKET ON L3Y 1J6

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

NITAL SHETH (500), ROMELA VILLASPIR (653), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 2017.

The following intake were inspected concurrently during this inspection:

Critical Incident System (CIS) Log # (s):
- 027726-16, 029511-16, 015191-17 related to responsive behaviour
- 016679-16 related to falls
- 019278-16, 028288-16 related to injury with unknown cause
Complaint intakes log # (s):
- 023111-15 related to authorization of admission in the home
- 024156-16 related to plan of care, recreational and social activities, laundry services, and prevention of abuse and neglect
- 010023-17 related to responsive behaviour, Residents' Bill of Rights, and personal support services
Follow-up intakes log # (s): 002846-17 related to plan of care and skin and wound care

During the course of the inspection, the inspector (s) conducted a tour of the resident home areas, observed dining room services, medication administration, observed staff to resident interactions, reviewed staff schedule, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Supervisors of Care (SOC), Manager of Production Support Services, Registered Dietitian (RD), Physiotherapist (PT), Occupational Therapist (OT), Just Culture of Collaborative Safety Project Specialist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Activationists, Personal Support Workers (PSWs), Housekeeping staff, Presidents of Residents' and Family Council, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #003	2016_168202_0022	210
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_168202_0022	210
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2016_168202_0022	210

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.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 protect residents from physical abuse by anyone.

A review of Critical Incident System (CIS) report revealed that resident #008 approached resident #010 in the identified area and ask for help. Resident #010 became upset and made a contact with resident #008's identified part of the body, later on resident #008 was identified with an impaired skin integrity on the same part of the body.

A review of resident #008's written plan of care revealed that the resident had identified types of responsive behaviour and staff were directed to distract the resident.

A review of resident #010's written plan of care revealed that the resident had identified types of responsive behaviour.

A review of the progress note revealed resident #008 sustaining an impaired skin integrity on an identified part of the body after the occurrence of the above mentioned incident.

Interview with Activations #113 revealed that he/she witnessed the above mentioned incident.

Interview with RPN #114, RN #146, and Supervisor of Care (SOC) #107 revealed the above mentioned incident happened and resident #010 exhibited with responsive behaviour and causing injury to resident #008. [s. 19. (1)]

2. A review of CIS report revealed that resident #010 exhibiting with responsive behaviour and causing injury to resident #011. Resident #011 reported to the staff that he/she was the recipient of an identified responsive behaviours by resident #010. The incident was not witnessed by anyone. PSW #115 observed resident #011 with an injury on his/her identified body part. Resident #011 was sent to the hospital and returned with a treatment for the injury. The home conducted investigation and from a review of the video footage the incident was confirmed that resident #010 had exhibited an identified responsive behaviour towards resident #011 and caused him/her an injury.

A review of resident #010's written plan of care revealed that the resident had responsive behaviour.

Interview with PSW #115 revealed that resident #010 demonstrates unpredictable responsive behaviour towards residents and staff.

Interview with RN #116 revealed that on the day of the incident PSW #115 reported to

him/her about resident #011's injury, and resident #011 confirmed that it was caused by resident #010. Resident #011 was sent to the hospital and required a treatment for the injury.

Interview with the Director of Care (DOC) revealed that the home did not have video footage saved for this incident, however confirmed that after viewing the video, resident #010 had been had exhibited an identified responsive behaviour towards resident #011 and causing him/her injury.

The inspector interviewed the Project Specialist of Just Culture of Collaborative Safety. The goal of this approach from Just Culture is to identify where the LTC Homes' systems and staff are vulnerable for errors to occur and work towards optimizing reliability in those areas. Analysis of adverse events focuses on identifying root causes and risks, not fault. Efforts are made to ensure that appropriate systems and processes are in place. Interview with Project Specialist of Just Culture of Collaborative Safety revealed that he/she was involved in the investigation of the above mentioned incident, and created notes of the video while reviewing camera footage. He/she confirmed that resident #010 had exhibited an identified responsive behaviour towards resident #011 and compromised his/her safety. [s. 19. (1)]

3. A review of the CIS report revealed that resident #010 exhibited an identified responsive behaviour towards resident #012 on an identified body part, when PSW #117 was providing care to resident #012. This caused resident #012 injury.

A review of resident #010 and #012's written plan of care revealed that they had responsive behaviour towards residents and staff.

Interview with PSW #117 reveled that he/she witnessed the incident and could not initiate any intervention because the incident happened so fast. Resident #012 exhibited with an identified responsive behaviour at PSW #117 and because of that resident #010 approached quickly besides resident #012 and exhibited an identified responsive behaviour towards him/her.

Interview with RN #118 revealed that PSW #117 witnessed the incident and as a result of the incident, resident #012's sustained an injury.

A review of the home's policy, entitled, "Zero Tolerance of Abuse and Neglect Program", reviewed July 2017, indicated, all residents have the right to live in a home environment

that is free from any form of abuse in all circumstance.

Interview with the DOC confirmed that resident #010 had exhibited an identified responsive behaviour toward resident #012 and caused him/her injury.

The severity of the non-compliance and the severity of the harm were actual harm. The scope of the non-compliance was isolated.
A review of the compliance history revealed that Compliance Order (CO) was issued during inspection # 2016_168202_0022, dated November 24, 2016, related to the Long-Term Care Homes Act, 2007, s. 19. [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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A review of the CIS report indicated an incident that caused injury to resident #013 for which the resident was hospitalized and resulted in a significant change in the resident's health status. The resident was observed with an injury on an identified body part. Two days later the resident was observed with an altered skin integrity an identified body part. The resident was transferred to the hospital for further assessment. The assessment results identified the injury to the above mentioned identified body part.

A review of the resident's written plan of care revealed that the resident was able to maneuver his/her wheelchair around the unit.

A review of the video footage revealed that the resident was pushed by housekeeping staff #145 into the identified area in the home. The resident had his/her identified body

part jeopardized during this transportation. Housekeeping staff #145 did not recognize the resistance and continued transporting the resident pushing his/her wheelchair.

A review of the another video footage captured on the same day later in the time revealed that the staff continued to push the resident while in his/her wheelchair with the resident's having improper positioning of his/her body part having resistance during the transport.

A review of progress note documented in the same evening revealed that at night the resident was identified with altered skin integrity with unknown cause. The resident was sent to the hospital and the results of the hospital assessment revealed the resident sustained an injury.

Interview with the resident's Substitute Decision Maker (SDM) revealed that he/she requested to remove an identified part from the wheelchair, earlier when the resident was self-propelling him/herself. He/she observed non-nursing staff such as dietary and house-keeping pushing the resident's wheelchair.

Interview with PSW #117 and #141 revealed that the resident stopped self-propelling him/herself for a month prior to him/her sustaining the injury and required one person to push his/her wheelchair. At that time, the resident did not have an identified part on his/her wheelchair, as it was removed earlier because he/she was able to self-propel. PSW #117 and #141 indicated that sometimes house- keeping and dietary staff help staff moving residents by pushing their wheelchairs, however they do not have access to resident's plan of care and not the best people to push residents' wheelchair to maintain residents' safety.

Interview with RN #130 revealed that the resident was not able to self-propel while in his/her wheelchair a month prior to the incident, and had no identified part on his/her wheelchair. The best practice to maintain the resident's safety was to have the identified part placed on the wheelchair. As a part of the home's investigation for the incident, while reviewing the camera footage the home identified that the resident's safety was jeopardized while staff pushed him/her.

Interview with House-keeping staff #145 revealed that he/she did not realize that the resident's safety was jeopardized during a transfer. The home did conduct the investigation and provide education about using wheelchair to all staff.

A review of the home's investigation notes revealed that as per the video footage the resident was pushed by the housekeeping staff, as a result the improper transportation the resident sustained an injury. The home completed education for all staff on transporting residents in wheelchairs.

Interview with the DOC, and Project Specialist of "Just Culture of Collaborative Safety" revealed that the resident's safety was compromised during the incident, as the resident pushed by the housekeeping staff and the resident was not positioned properly and sustained injury.

Interview with Occupational Therapist (OT) revealed that the identified part was removed from the resident's wheelchair based on the family request. The resident was able to self-propel in the past, however house-keeping staff are not the best people to push the residents' wheelchairs in order to maintain residents' safety as they do not have access to residents' plan of care.

Interview with Physiotherapist (PT) revealed that the resident should have the identified part on the wheelchair when the resident is not self-propel and pushed by the staff. After reviewing the video footage PT indicated that the way the staff pushed the resident's wheelchair is not acceptable, it was unsafe positioning of the resident's body part, and pushing the resident without having the identified part on the wheelchair is a safety issue.

The severity of the non-compliance and the severity of the harm were actual harm. The scope of the non-compliance was isolated. [s. 36.]

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A complaint was received at Ministry of Health and Long-term Care (MOHLTC) in regards to personal care not provided to a resident. Observation of residents revealed resident #011's identified area of the body and appeared to be required care. According to the personal care flow sheets for an identified care measure for the period of four months revealed an identified care measure was only provided twice.

A review of the progress notes for the same period did not reveal why identified care measure of resident #011 had not been provided, which approaches were tried and if the family was informed.

A review of the written plan of care did not indicate a goal and interventions for resident #011's identified care measure.

An interview with evening registered staff RN #132 revealed resident #011 is resistive to care, but it is easy to manage if he/she is approached several times. RN #132 was not

aware that PSWs did not document in flow sheets for two months about resident #011's identified care measure nor that they have challenges with providing his/her identified care measure.

Interview with PSW #115 revealed he/she has tried to provide the care measure to resident #011, but has been unsuccessful.

Interview with PSW #130 revealed he/she attempted many times to provide the identified care measure to resident #011 but he/she was successful only one time. PSW #130 indicated that registered staff has been notified about this and they are aware of it.

Interview with day registered nurse RN #130 revealed unawareness that PSWs were having difficult time with providing the identified care measure to resident #011. RN #130 indicated that activation staff is providing the identified care measure as part of the activity program and during the conversation with the inspector the same activity took place.

Observation of the group activity program revealed activation staff #131 was performing an identified care measure of resident #011 while there was a relaxing ambient and music was going on. Resident #011 seemed calm and allowed the care measure to be provided. Interview with activation staff #131 revealed he/she was not aware that PSWs had problems with resident #011's identified care measure and that if he/she knew about that he/she would make sure he/she involved resident in the program. Further he/she indicated that he/she does not use a regular assisting tool as part of the activity but has an alternative.

A review of the clinical record, interview with staff #129, #132, #130, #131, and #115 and DOC confirmed there was no communication between the PSWs and registered staff and nursing department staff and activation staff in order for resident #011's written plan of care to be updated in regards to the identified care measure interventions. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident had been reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the Resident Quality Inspection (RQI), resident #001 triggered related to incidence of worsening bowel or bladder continence.

The inspector attempted to interview resident #001, however, the resident was not interviewable. He/she had a severe cognitive impairment.

Record review of resident #001's written plan of care indicated that the resident required assistance for toileting related to decreased strength and balance. The written plan of care directed staff to assist the resident to go to the bathroom at certain hours, three times a day. It was also indicated that the resident use an identified intervention for comfort while on the toilet.

The resident was frequently incontinent of bowel and bladder and wore an incontinence product, and was being assisted by the Personal Support Workers (PSWs) to go to the toilet to provide incontinent care.

Interview with PSW #112 confirmed that the resident was incontinent of both bladder and bowel, and that the staff check him/her every two hours and changed him/her as needed. The PSW further indicated that the resident's health had declined weeks prior to the interview. The resident's health had declined and PSW #112 confirmed that the resident's written plan of care had not been updated, as it still indicated that the resident had to be toileted.

Interview with Registered Practical Nurse (RPN) #111 confirmed that the resident's written plan of care had not been revised as it did not reflect the current condition of the resident in regards to his/her continence care and bowel management. The RPN further indicated that the resident's health condition had recently declined. The resident was no longer being toileted in the bathroom, and staff were changing his/her brief in bed.

Interview with the DOC acknowledged that resident #001's written plan of care had not been revised and that the home's expectation was for the registered staff to revise the written plan of care at the time that the condition had changed. [s. 6. (10) (b)]

3. During stage one of the RQI, resident #007 triggered related to worsening skin integrity.

Record review of the resident's Resident Assessment Instrument-Minimum Data Set (RAI-MDS), revealed he/she had an identified type of impaired skin integrity.

Review of resident #007's health records revealed the following:
A review of the Treatment Administration Record (eTAR) directed staff to apply treatment

once daily and change the treatment once daily.

-Written plan of care revealed that resident #007 had an impaired skin integrity and staff were directed to get him/her up for the meal for 2 to 3 hours and then return to bed.

During an observation on an identified day, between certain time periods revealed the resident's presence in the bed room, Registered Practical Nurse (RPN) #111 provided a treatment different than the one listed into the resident's plan of care, while being assisted by another registered staff.

Interview with RPN #111 confirmed that the registered staff had been having difficulties in completing treatment for the resident's impaired skin integrity and the treatment was changed. He/she also mentioned that the resident no longer gets up for a meal. RPN #111 acknowledged that the resident's plan of care had not been revised when the plan was no longer necessary.

Interview with the DOC acknowledged the above-mentioned discrepancies and that resident #007's plan of care had not been revised in regards to his/her skin and wound care. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that,
- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other
- the resident had been reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following: 1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act.

The MOHLTC received a complaint on August 24, 2015, regarding inappropriate reason for refusal of admission by the home, and the home taking more than five days to complete the refusal letter.

Interview with the Community Care Access Centre (CCAC) Placement Coordinator, revealed that the identified application was sent to the home on May 27, 2015, and refusal letter was received by CCAC on August 13, 2015, the home took more than five days to send the refusal letter.

A review of the date of the application and the refusal letter revealed that the application was dated May 29, 2015 and the refusal letter was dated August 13, 2015.

Interview with the DOC revealed that the home should have responded to the appropriate placement co-ordinator within five days. [s. 162. (3) 1.]

2. Interview with the DOC revealed that the home received application for applicant #002 on February 16, 2017, and the verbal response was given to the placement coordinator on March 20, 2017. The written refusal letter was sent on July 18, 2017. [s. 162. (3) 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 that subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following: 1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 48 (1) 1, Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls, and the risk of injury.

Review of the home's policy titled "Post Fall Management Policy and Procedures" policy #F2 dated February 1, 2017, indicated the following:
"Any staff member who witnesses a resident fall or finds a resident on the floor or ground

must:
-Not move the resident.
-Notify the registered staff immediately.
-Maintain the resident in a safe position until a registered nursing staff assesses the resident".

The home submitted CIS report related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Review of progress note, revealed that resident #021 had a fall in an identified room and the PSW transferred the resident to his/her bedroom first before calling the RN. The RN attended to the resident in his/her bedroom and noted an injury. The resident was then transferred to the hospital for further assessment as per the SDM's request.

The inspector attempted to interview resident #001, however, the resident was not interviewable due to severe cognitive impairment.

Interview with PSW #126 stated that he/she had recently resigned from the home. The PSW confirmed the above-mentioned incident and stated that after the fall, resident #021 had been transported to his/her bedroom first prior to being assessed by the RN. The PSW confirmed that he/she did not comply with the home's policy in this situation.

Review of the home's investigation notes revealed that after the fall, the resident attempted to get up and PSW #126 assisted him/her off the floor and walked him/ her to his/her room and placed the resident on the bed. It was at that moment that the PSW realized the resident had an injury and called the registered staff.

Interview with RN #127 confirmed the above-mentioned incident and stated that the PSW did not inform him/her immediately about the fall, instead, the PSW transported resident #021 to the bedroom and then he/she called the RN for help.

Interview with the DOC, acknowledged the above-mentioned incident and that the home's policy had not been complied with. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that an applicant's admission to the home was approved after a review of the assessments and information provided by the placement co-ordinator, unless (a) the home lacks the physical facilities necessary to meet the applicant's care requirements (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The MOHLTC received a complaint on August 24, 2015, regarding inappropriate admission refusal by the home.

Interview with the CCAC Placement Supervisor revealed that the home refused applicant #001's application by providing an inappropriate reason. The application was sent on May 27, 2015, and refusal letter was received on August 13, 2015, the home took more than five days to send the refusal letter. The refusal reason is inappropriate and there were no grounds for withholding the application indicated in the letter from the home. The CCAC Placement Supervisor indicated that the applicant #001 is living in the community and still willing to move in the home.

A review of applicant #001's refusal letter dated August 13, 2015, revealed the reason for the refusal was the home' inability to meet the applicant's needs due to smoking safety.

A review of the CCAC application for applicant #001 revealed that the resident smokes an identified number of cigarettes per day outside of the building and required two staff to assist for transfer. The CCAC notes further indicated that the resident uses a wheelchair and is self-sufficient and can travel nine meters outside the facility. The resident agreed to a smoking cessation program if he/she can no longer smoke safely.

Interview with the Administrator revealed that the home is challenged in maintaining the resident's safety with smoking, he/she confirmed that as per the legislation it was not an appropriate reason for bed refusal. [s. 44. (7)]

2. The licensee has failed to ensure that if the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval.

The MOHLTC received a complaint on August 24, 2015, regarding inappropriate admission refusal by the home, the home taking more than five days to respond for the application.

Interview with the CCAC Placement Supervisor revealed that the application was sent for applicant #001 on May 27, 2015, and refusal letter was sent on August 13, 2015, the home took more than five days to send the refusal letter. CCAC Placement Supervisor indicated that the letter did not include a detail explanation on the home withholding the application.

A review of the refusal letter sent for applicant #001 indicated smoking safety, a reason for refusal of the application. The letter did not contain the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; and an explanation of how the supporting facts justify the decision to withhold approval. [s. 44. (9)]

3. Interview with the CCAC Placement Supervisor revealed that the home's refusal letter did not include a detailed explanation on the home withholding the application.

A review of the refusal letter sent for applicant #002 indicated smoking safety, a reason for refusal of the application. The letter did not contain the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; and an explanation of how the supporting facts justify the decision to withhold approval.

Interview with the DOC revealed the home had a huge back log of refusal letters due to higher volume of applications and therefore a written response was delayed. [s. 44. (9)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copy of the inspection report for the past two years for the long-term care home was posted in the home.

During the tour of the home on September 6, 2017, the inspector reviewed the "Inspection Reports, Orders & Decisions" binder located on the main floor near the elevators. It was noted that Inspection Report #2016_356618_0002, Report Date: February 3, 2016, was not included in the binder. During an interview, the Administrator acknowledged that the above-mentioned inspection report was not included in the binder as required. [s. 79. (3) (k)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction had been reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the home's medication incidents for the past three months revealed a medication incident involving resident #026. The medication incident report indicated that resident #026 had two treatments applied him/ her for four days, and had no adverse effects. The physician's order directed registered staff to apply the treatment every 7 days and remove the old treatment before applying the new one.

Review of the medication incident report, progress notes, and interview with the SOC, confirmed that the resident was not notified of the medication incident.

Resident #026 was discharged from the home, and could no longer be interviewed.

Interview with the SOC acknowledged that resident #026 was not informed of the medication incident as required. He/she further indicated that at the time the resident was cognitively intact and should have been informed of the medication incident. [s. 135. (1) (b)]

Issued on this 19th day of October, 2017

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

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), ROMELA VILLASPIR (653), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2017_524500_0002
Log No. / No de registre :	021329-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 12, 2017
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	YORK REGION NEWMARKET HEALTH CENTRE 194 EAGLE STREET, NEWMARKET, ON, L3Y-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Salonen Mackay

To The Regional Municipality of York, 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)

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 :

Upon receipt of this order the licensee shall,

1). Prepare, develop, and implement a plan to protect all residents on the unit from resident #010's responsive behaviour.
2). Manage resident #008, and #012's behavioral issues which may trigger resident #010'sresponsive behaviour.
3). Conduct weekly meetings with all staff working on the unit including all departments, and supervisors/managers of those departments to identify all possible triggers which can exhibit resident #010's responsive behaviour.
4). Provide opportunity to the above mentioned staff to participate in the discussion to identify triggers, and in the development and implementation of strategies to manage those triggers.
5). Keep a record of all possible triggers and strategies identified in the above mentioned meetings in regards to resident #010's responsive behaviors.
6). Keep records of minutes of the above mentioned meetings and a list of staff who attended those meetings.
7). Conduct weekly audits by the lead of the Responsive Behaviour Program to evaluate the implementation of the identified strategies to manage resident #010's identified behaviour.
8). Have interdisciplinary team meetings to discuss the outcome identified during the above mentioned audits and an action plan for each outcome. The licensee to ensure to keep minutes of these meetings.
9). Educate all staff working on the unit by creating a case study scenario for incidents involving resident #010, due to his/her responsive behaviors.
10). Include Resident to Resident abuse case scenarios in the home's mandatory training education.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone.

A review of the CIS report revealed that resident #010 exhibited an identified responsive behaviour towards resident #012 on an identified body part, when PSW #117 was providing care to resident #012. This caused resident #012 injury.

A review of resident #010 and #012's written plan of care revealed that they had responsive behaviour towards residents and staff.

Interview with PSW #117 reveled that he/she witnessed the incident and could not initiate any intervention because the incident happened so fast. Resident #012 exhibited with an identified responsive behaviour at PSW #117 and because of that resident #010 approached quickly besides resident #012 and exhibited an identified responsive behaviour towards him/her.

Interview with RN #118 revealed that PSW #117 witnessed the incident and as a result of the incident, resident #012's sustained an injury.

A review of the home's policy, entitled, "Zero Tolerance of Abuse and Neglect Program", reviewed July 2017, indicated, all residents have the right to live in a home environment that is free from any form of abuse in all circumstance.

Interview with the DOC confirmed that resident #010 had exhibited an identified responsive behaviour toward resident #012 and caused him/her injury. [s. 19. (1)] (500)

2. A review of CIS report revealed that resident #010 exhibiting with responsive behaviour and causing injury to resident #011. Resident #011 reported to the staff that he/she was the recipient of an identified responsive behaviours by resident #010. The incident was not witnessed by anyone. PSW #115 observed resident #011 with an injury on his/her identified body part. Resident #011 was sent to the hospital and returned with a treatment for the injury. The home conducted investigation and from a review of the video footage the incident was confirmed that resident #010 had exhibited an identified responsive behaviour towards resident #011 and caused him/her an injury.

A review of resident #010's written plan of care revealed that the resident had responsive behaviour.

Interview with PSW #115 revealed that resident #010 demonstrates unpredictable responsive behaviour towards residents and staff.

Interview with RN #116 revealed that on the day of the incident PSW #115 reported to him/her about resident #011's injury, and resident #011 confirmed that it was caused by resident #010. Resident #011 was sent to the hospital and required a treatment for the injury.

Interview with the Director of Care (DOC) revealed that the home did not have video footage saved for this incident, however confirmed that after viewing the video, resident #010 had been had exhibited an identified responsive behaviour towards resident #011 and causing him/her injury.

The inspector interviewed the Project Specialist of Just Culture of Collaborative Safety. The goal of this approach from Just Culture is to identify where the LTC Homes' systems and staff are vulnerable for errors to occur and work towards optimizing reliability in those areas. Analysis of adverse events focuses on identifying root causes and risks, not fault. Efforts are made to ensure that appropriate systems and processes are in place. Interview with Project Specialist of Just Culture of Collaborative Safety revealed that he/she was involved in the investigation of the above mentioned incident, and created notes of the video while reviewing camera footage. He/she confirmed that resident #010 had exhibited an identified responsive behaviour towards resident #011 and compromised his/her safety. [s. 19. (1)] (500)

3. A review of Critical Incident System (CIS) report revealed that resident #008 approached resident #010 in the identified area and ask for help. Resident #010 became upset and made a contact with resident #008's identified part of the body, later on resident #008 was identified with an impaired skin integrity on the same part of the body.

A review of resident #008's written plan of care revealed that the resident had identified types of responsive behaviour and staff were directed to distract the resident.

A review of resident #010's written plan of care revealed that the resident had

identified types of responsive behaviour.

A review of the progress note revealed resident #008 sustaining an impaired skin integrity on an identified part of the body after the occurrence of the above mentioned incident.

Interview with Activations #113 revealed that he/she witnessed the above mentioned incident.

Interview with RPN #114, RN #146, and Supervisor of Care (SOC) #107 revealed the above mentioned incident happened and resident #010 exhibited with responsive behaviour and causing injury to resident #008.

The severity of the non-compliance and the severity of the harm were actual harm.
The scope of the non-compliance was isolated.
A review of the compliance history revealed that Compliance Order (CO) was issued during inspection # 2016_168202_0022, dated November 24, 2016, related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)] (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Upon receipt of this order the licensee shall:

1). Prepare, develop, and implement a plan to ensure that all staff in the home involved in direct resident care have been trained on the safe transportation of residents while in the wheelchair.
2). Assess all residents for their ability to self-propel using a wheelchair on a quarterly basis and at the time of significant change in their health status and document these assessments in the residents' plan of care.
3). Assess the requirement of residents for a foot rest on their wheel-chairs during the above mentioned assessments and include it in the residents' written plan of care.
4). Assign a staff member who is a member of the regulatory profession to complete the above mentioned assessments.
4). Conduct and keep a record of monthly audits for completion of the above mentioned assessments and its inclusion in the residents' written plan of care.
5). Have an interdisciplinary team meetings to discuss the outcome identified during the above mentioned audits and develop an action plan for each outcome. The licensee to ensure to keep minutes of these meetings.

Grounds / Motifs :

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

A review of the CIS report indicated an incident that caused injury to resident #013 for which the resident was hospitalized and resulted in a significant change in the resident's health status. The resident was observed with an injury on an identified body part. Two days later the resident was observed with an altered

skin integrity an identified body part. The resident was transferred to the hospital for further assessment. The assessment results identified the injury to the above mentioned identified body part.

A review of the resident's written plan of care revealed that the resident was able to maneuver his/her wheelchair around the unit.

A review of the video footage revealed that the resident was pushed by housekeeping staff #145 into the identified area in the home. The resident had his/her identified body part jeopardized during this transportation. Housekeeping staff #145 did not recognize the resistance and continued transporting the resident pushing his/her wheelchair.

A review of the another video footage captured on the same day later in the time revealed that the staff continued to push the resident while in his/her wheelchair with the resident's having improper positioning of his/her body part having resistance during the transport.

A review of progress note documented in the same evening revealed that at night the resident was identified with altered skin integrity with unknown cause. The resident was sent to the hospital and the results of the hospital assessment revealed the resident sustained an injury.

Interview with the resident's Substitute Decision Maker (SDM) revealed that he/she requested to remove an identified part from the wheelchair, earlier when the resident was self-propelling him/herself. He/she observed non-nursing staff such as dietary and house-keeping pushing the resident's wheelchair.

Interview with PSW #117 and #141 revealed that the resident stopped self-propelling him/herself for a month prior to him/her sustaining the injury and required one person to push his/her wheelchair. At that time, the resident did not have an identified part on his/her wheelchair, as it was removed earlier because he/she was able to self-propel. PSW #117 and #141 indicated that sometimes house- keeping and dietary staff help staff moving residents by pushing their wheelchairs, however they do not have access to resident's plan of care and not the best people to push residents' wheelchair to maintain residents' safety.

Interview with RN #130 revealed that the resident was not able to self-propel while in his/her wheelchair a month prior to the incident, and had no identified

part on his/her wheelchair. The best practice to maintain the resident's safety was to have the identified part placed on the wheelchair. As a part of the home's investigation for the incident, while reviewing the camera footage the home identified that the resident's safety was jeopardized while staff pushed him/her.

Interview with House-keeping staff #145 revealed that he/she did not realize that the resident's safety was jeopardized during a transfer. The home did conduct the investigation and provide education about using wheelchair to all staff.

A review of the home's investigation notes revealed that as per the video footage the resident was pushed by the housekeeping staff, as a result the improper transportation the resident sustained an injury. The home completed education for all staff on transporting residents in wheelchairs.

Interview with the DOC, and Project Specialist of "Just Culture of Collaborative Safety" revealed that the resident's safety was compromised during the incident, as the resident pushed by the housekeeping staff and the resident was not positioned properly and sustained injury.

Interview with Occupational Therapist (OT) revealed that the identified part was removed from the resident's wheelchair based on the family request. The resident was able to self-propel in the past, however house-keeping staff are not the best people to push the residents' wheelchairs in order to maintain residents' safety as they do not have access to residents' plan of care.

Interview with Physiotherapist (PT) revealed that the resident should have the identified part on the wheelchair when the resident is not self-propel and pushed by the staff. After reviewing the video footage PT indicated that the way the staff pushed the resident's wheelchair is not acceptable, it was unsafe positioning of the resident's body part, and pushing the resident without having the identified part on the wheelchair is a safety issue.

The severity of the non-compliance and the severity of the harm were actual harm. The scope of the non-compliance was isolated. [s. 36.] (500)

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

Ministére 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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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