Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2019	2019_595110_0011	021283-19	Complaint

Licensee/Titulaire de permis

Yee Hong Centre for Geriatric Care
2311 McNicoll Avenue SCARBOROUGH ON M1V 5L3

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

Yee Hong Centre - Scarborough Finch
60 Scottfield Drive SCARBOROUGH ON M1S 5T7

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 7, 9, 13, 14, 15 and 18, 2019.

Complaint related to an injury of unknown origin; failure to report and responding to complainant.

During this inspection the inspector completed record reviews along with resident observations.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Resident Care (ADRC), Registered Nurse (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Physiotherapist Aide (PTA), Personal Support Workers (PSW).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 Ministry of Long Term Care received a complaint, stating resident #001 had been

transferred to the hospital and returned with a change in health status due to an unknown cause and that weeks prior the home reported unexplained areas of altered skin integrity on resident #001's body.

For the purposes of the Act and Regulations, O. Reg. 79/10, s. 5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A record review of progress notes identified that resident #001 was transferred to the hospital on the identified date referred to as Day 14 and returned with a diagnosis defined as a significant change in the resident's health status. A further review identified a progress note weeks prior, referred to as Day 1, that staff had reported seeing areas of altered skin integrity on an area resident #001's body.

A record review of the Home Area 'Shift Report' identified documented comments on Day 1 related to the areas of altered skin integrity and requesting the nurse practitioner to assess.

A review of the resident's written plan of care, identified the resident was provided with therapeutic treatment by physiotherapy, as tolerated, two times per week.
A record review of the physiotherapy attendance sheet for an identified period confirmed that resident #001 received therapeutic treatment twice a week.

An interview with physiotherapy aide (PTA) #111 confirmed that resident #001 received therapeutic exercises twice a week and they provided the resident's therapy treatment. The PTA revealed that on Day 2, following the identified documentation related to areas of altered skin integrity they worked along with co-worker PTA #110 to provide resident #001 treatment. PTA #111 shared that on this day when providing treatment resident #001's face was not comfortable; their face was sour, so they stopped. The PTA shared that resident #001 was non verbal. PTA #111 shared they thought the nurses and PSWs would have known and did not share their observations.

A telephone interview with PTA #110 stated they did see resident #001 on Day 2 of the identified week and saw a change in the resident's health status and told co worker PTA #111 not to do any exercises because of the change.

The licensee failed to take action when resident #001 was observed to be uncomfortable

with physiotherapy treatment and was identified with a change in health status on Day 2.

An interview with PTA #104 confirmed they provided physiotherapy treatment to resident #001 one of the two days each week. The PTA shared that days later, on Day 9, they tried to complete the treatrment and the resident reacted. The PTA stated the resident said “ah, ah, ah” and was yelling and not in their normal way. The PTA stated that they looked at an identified area and there appeared to be a change in status. The PTA shared that they asked the resident if they felt pain and the resident nodded their head yes. When asked by Inspector if they had reported this observation, the PTA shared they had informed PT #117, and informed them not to do anything further for resident #001 at this time.

Physiotherapist (PT) #117 was unavailable for an interview during this inspection.

An interview with interim PT #101 revealed that they were replacing PT #117 and started on an identified date, Day 11. PT #101 shared they had no awareness of any concerns related to resident #001 when they started working at the home.

A review of follow-up notes written by PT #117 to replacement PT #101 was requested. The notes did not include documentation related to resident #001's health status.

The licensee failed to take action regarding resident #001's change in health status.

A record review identified a Minimum Data Set (MDS) quarterly assessment by physiotherapist #117 on an identified date, Day 11. The documentation included a concern regarding resident #001 health status and that PT #117 had explained to the charge nurse that the resident needed to be referred to the physician.

A further interview with PT #117 confirmed that they did assess resident #001 on Day 11 and identified a change in the resident’s health status. The PT shared that they had spoken with RN #106 and RPN #105 after their observations and assessment.

In separate interviews with RN #106 and RPN #105, both staff could not recall a conversation with PT #117 on Day 11.

The licensee failed to take action regarding resident #001's change in health status.

In separate interviews with PSWs, #112, #113, #114, #115 and #116 who had

documented providing ADL dressing care to resident #001 at one point between Day 1 and Day 13 all revealed no awareness of resident #001's change in health status.

A record review identified that on Day 13, documentation by PT #101 stated that resident #001 was showing signs of a change in health status and questioned an injury. The PT recommended the nurse to follow-up and physician to assess.

An interview with PT #101 confirmed their assessment findings on Day 13 and stated they had spoken with RPN #105. The PT shared that RPN #105 asked them to place a note in the doctors book if they had concerns. The PT shared that someone prior should have identified resident #001's change in health status.

An interview with RPN #105 confirmed a conversation with PT #101 on Day 13 and stated that they had assessed the resident and did not identify a concern.

A record review of a progress note on Day 13 identified that RPN #107 during an identified assessment reported that resident #001 had a change in their health status and was transferred to the hospital.

A late entry progress note on Day 15 by RPN #105 documented that on Day 13 the PT reported the resident's change in health status and that they assessed the resident and recommended monitoring the resident. The RPN documented the PT placed a note for the doctor to assess.

A final record review included a review of the an identified hospital record on Day 14 . The record included comments of an areas of altered skin integrity on resident #001's body and a diagnosis of a significant change in health status.

An interview with the DOC identified the pattern of inaction towards resident #001's change in health status as it was presented. [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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

According to O. reg 79/10, s. 107 (7) a "significant change" is defined as a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition and requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

The Ministry of Long Term Care received a complaint stating resident #001 had been transferred to the hospital and returned with a changed in health status due to an

unknown cause and that weeks prior the home reported unexplained areas of altered skin integrity on resident #001's body.

A record review of progress notes identified that resident #001 was transferred to the hospital and returned with a diagnosis of a significant change in health status.

A review of the resident's health record following the resident's return from hospital identified changes to the resident's plan of care.

An interview with physiotherapist (PT) #101 confirmed resident #001's transfer status and plan of care had changed upon return from the hospital and diagnosis.

An interview with ADRC #109 confirmed awareness that resident #001 had been transferred to hospital and returned with a diagnosis of change in health status. The ADRC shared that the resident's activities of daily living (ADL's) had not changed and therefore the incident report had not been forwarded to the Ministry.

As a result of non-compliance being identified the sample size was expanded to include two additional residents, #002 and #003.

The Inspector requested a list of residents, who in the past 3 months, were transferred to hospital with a similar identified diagnosis. A report was provided entitled "ED Transfer Tracking Tool Year 2019". The report included resident #002 and resident #003 both of which returned from the hospital with a significant change in health status.

A review of the resident #002 and #003's health record following their return from hospital identified changes to the resident's plan of care.

An interview with the DOC confirmed that the incidents involving the three identified resident should have been reported to the Director and that there was some misunderstanding around the definition of "significant change". [s. 107. (3)]

Additional Required Actions:

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

Issued on this 31st day of December, 2019

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) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2019_595110_0011
Log No. / No de registre :	021283-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 12, 2019
Licensee / Titulaire de permis :	Yee Hong Centre for Geriatric Care 2311 McNicoll Avenue, SCARBOROUGH, ON, M1V-5L3
LTC Home / Foyer de SLD :	Yee Hong Centre - Scarborough Finch 60 Scottfield Drive, SCARBOROUGH, ON, M1S-5T7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Chee

To Yee Hong Centre for Geriatric Care, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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 the LTCHA, 2007, s. 19 (1).
The licensee is ordered to:
1. Educate all staff on the O.Reg. 79/10, s.5 definition of "neglect" the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The education shall include a review of the complaint findings related to resident #001 and acknowledge the pattern of inaction.
2. Maintain a record of education for review by the Inspector.

Grounds / Motifs :

1. The Ministry of Long Term Care received a complaint, stating resident #001 had been transferred to the hospital and returned with a change in health status due to an unknown cause and that weeks prior the home reported unexplained areas of altered skin integrity on resident #001's body.

For the purposes of the Act and Regulations, O. Reg. 79/10, s. 5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A record review of progress notes identified that resident #001 was transferred to the hospital on the identified date referred to as Day 14 and returned with a diagnosis defined as a significant change in the resident's health status. A further review identified a progress note weeks prior, referred to as Day 1, that staff had reported seeing areas of altered skin integrity on an area resident

#001's body.

A record review of the Home Area 'Shift Report' identified documented comments on Day 1 related to the areas of altered skin integrity and requesting the nurse practitioner to assess.

A review of the resident's written plan of care, identified the resident was provided with therapeutic treatment by physiotherapy, as tolerated, two times per week.
A record review of the physiotherapy attendance sheet for an identified period confirmed that resident #001 received therapeutic treatment twice a week.

An interview with physiotherapy aide (PTA) #111 confirmed that resident #001 received therapeutic exercises twice a week and they provided the resident's therapy treatment. The PTA revealed that on Day 2, following the identified documentation related to areas of altered skin integrity they worked along with co-worker PTA #110 to provide resident #001 treatment. PTA #111 shared that on this day when providing treatment resident #001's face was not comfortable; their face was sour, so they stopped. The PTA shared that resident #001 was non verbal. PTA #111 shared they thought the nurses and PSWs would have known and did not share their observations.

A telephone interview with PTA#110 stated they did see resident #001 on Day 2 of the identified week and saw a change in the resident's health status and told co worker PTA #111 not to do any exercises because of the change.

The licensee failed to take action when resident #001 was observed to be uncomfortable with physiotherapy treatment and was identified with a change in health status on Day 2.

An interview with PTA #104 confirmed they provided physiotherapy treatment to resident #001 one of the two days each week. The PTA shared that days later, on Day 9, they tried to complete the treatrment and the resident reacted. The PTA stated the resident said "ah, ah, ah" and was yelling and not in their normal way. The PTA stated that they looked at an identified area and there appeared to be a change in status. The PTA shared that they asked the resident if they felt pain and the resident nodded their head yes. When asked by Inspector if

they had reported this observation, the PTA shared they had informed PT #117, and informed them not to do anything further for resident #001 at this time.

Physiotherapist (PT) #117 was unavailable for an interview during this inspection.

An interview with interim PT #101 revealed that they were replacing PT #117 and started on an identified date, Day 11. PT #101 shared they had no awareness of any concerns related to resident #001 when they started working at the home.

A review of follow-up notes written by PT #117 to replacement PT #101 was requested. The notes did not include documentation related to resident #001's health status.

The licensee failed to take action regarding resident #001's change in health status.

A record review identified a Minimum Data Set (MDS) quarterly assessment by physiotherapist #117 on an identified date, Day 11. The documentation included a concern regarding resident #001 health status and that PT #117 had explained to the charge nurse that the resident needed to be referred to the physician.

A further interview with PT #117 confirmed that they did assess resident #001 on Day 11 and identified a change in the resident's health status. The PT shared that they had spoken with RN #106 and RPN #105 after their observations and assessment.

In separate interviews with RN #106 and RPN #105, both staff could not recall a conversation with PT #117 on Day 11.

The licensee failed to take action regarding resident #001's change in health status.

In separate interviews with PSWs, #112, #113, #114, #115 and #116 who had documented providing ADL dressing care to resident #001 at one point between Day 1 and Day 13 all revealed no awareness of resident #001's change in

health status.

A record review identified that on Day 13, documentation by PT #101 stated that resident #001 was showing signs of a change in health status and questioned an injury. The PT recommended the nurse to follow-up and physician to assess.

An interview with PT #101 confirmed their assessment findings on Day 13 and stated they had spoken with RPN #105. The PT shared that RPN #105 asked them to place a note in the doctors book if they had concerns. The PT shared that someone prior should have identified resident #001's change in health status.

An interview with RPN #105 confirmed a conversation with PT #101 on Day 13 and stated that they had assessed the resident and did not identify a concern.

A record review of a progress note on Day 13 identified that RPN #107 during an identified assessment reported that resident #001 had a change in their health status and was transferred to the hospital.

A late entry progress note on Day 15 by RPN #105 documented that on Day 13 the PT reported the resident's change in health status and that they assessed the resident and recommended monitoring the resident. The RPN documented the PT placed a note for the doctor to assess.

A final record review included a review of the an identified hospital record on Day 14 . The record included comments of an areas of altered skin integrity on resident #001's body and a diagnosis of a significant change in health status.

An interview with the DOC identified the pattern of inaction towards resident #001's change in health status as it was presented.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001.
The scope of this issue was a Level 1 or isolated.
The home had a level 2 compliance history as there was previous non compliance to a different subsection.

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

(110)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
   i. a breakdown or failure of the security system,
   ii. a breakdown of major equipment or a system in the home,
   iii. a loss of essential services, or
   iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

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

The licensee must be compliant with the LTCHA, 2007, r. 107. (3).
The licensee is ordered to complete the following:
1. Review the current reporting practices in the home as required by the legislation.
2. Corrective action shall be taken for any areas identified in the review which may have prevented reporting to the Director as required by the legislation.
3. Educate all registered staff and management on the home's reporting procedures and any changes made to the procedures warranted by the home's review. The education must include the reporting requirements under O. Reg 79/10. S 107 (3) and must include the definition of significant change under O. Reg 79/10, s. 107 (7).
4. Develop an auditing system to ensure the Director is notified of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A record shall be kept of all documents for review by an Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

According to O. reg 79/10, s. 107 (7) a "significant change" is defined as a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition and requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

The Ministry of Long Term Care received a complaint stating resident #001 had been transferred to the hospital and returned with a changed in health status due to an unknown cause and that weeks prior the home reported unexplained areas of altered skin integrity on resident #001's body.

A record review of progress notes identified that resident #001 was transferred

to the hospital and returned with a diagnosis of a significant change in health status.

A review of the resident's health record following the resident's return from hospital identified changes to the resident's plan of care.

An interview with physiotherapist (PT) #101 confirmed resident #001's transfer status and plan of care had changed upon return from the hospital and diagnosis.

An interview with ADRC #109 confirmed awareness that resident #001 had been transferred to hospital and returned with a diagnosis of change in health status. The ADRC shared that the resident's activities of daily living (ADL's) had not changed and therefore the incident report had not been forwarded to the Ministry.

As a result of non-compliance being identified the sample size was expanded to include two additional residents, #002 and #003.

The Inspector requested a list of residents, who in the past 3 months, were transferred to hospital with a similar identified diagnosis. A report was provided entitled "ED Transfer Tracking Tool Year 2019". The report included resident #002 and resident #003 both of which returned from the hospital with a significant change in health status.

A review of the resident #002 and #003's health record following their return from hospital identified changes to the resident's plan of care.

An interview with the DOC confirmed that the incidents involving the three identified resident should have been reported to the Director and that there was some misunderstanding around the definition of "significant change".

The severity of this issue was determined to be a level 1 as there was no harm or no risk.
The scope of this issue was a Level 3 or Widespread as three out of three resident's reviewed were not reported.
The home had a level 2 compliance history as there was previous non

compliance to a different subsection.
(110)

2.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 12th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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