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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2014	2014_159178_0005	T-400-14	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CAREFREE LODGE
306 FINCH AVENUE EAST, NORTH YORK, ON, M2N-4S5

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 14, 17, 18, 19, 24, April 3, 7, 16, 17, 22, 28, 29, May 2, 2014

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Acting Director of Care, Nurse Manager, registered staff, Social Service Worker (counselor), personal care assistants (PCAs), Coroner, investigating police detective.

During the course of the inspection, the inspector(s) reviewed resident and home records, observed resident # 1's room and bed.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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 ensure that resident # 1 was not neglected by staff when the resident became wedged between the bed frame and bed rail and died on an identified date.

Staff interviews and record review confirm the following:
Resident # 1 was considered at risk for self-harm and therefore was to be monitored and observed every 30 minutes. On the night of the resident's death, the resident was not consistently monitored every 30 minutes as per the plan of care. On that night, the resident was not observed between the time of 11 pm and 1230 am. At 1230 am the resident was found hanging partially out of the bed, with his/her neck caught between the side rail and the bed. The resident's hand was warm, however the resident did not appear to be breathing and no radial or carotid pulse could be detected. The resident was not assessed for other signs of life, including an apical pulse, blood pressure, presence of reflex activity, or reaction of the pupils.
Staff determined that the resident had not had a level of intervention specified by his/her substitute decision maker (SDM) so the staff considered the resident to be Level 4. According to staff interviews and home records, when a resident is designated as level 4 it means that aggressive intervention is to be provided, including cardio pulmonary resuscitation (CPR) in the case of a witnessed cardiac arrest, advanced life supports offered, with possible admission to an intensive care unit.
Staff called 911 and initiated an Emergency Code Blue within the home and as a result several staff members attended the scene. However the resident was not removed from between the bed frame and bed rail, and no first aid or cardio-pulmonary resuscitation (CPR) was attempted until paramedics arrived approximately ten minutes later. Once the paramedics arrived the resident was removed from between the bed frame and bed rails and CPR was initiated by the Registered Nurse in charge and taken over by the paramedics. [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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 1 was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident when a side rail was in use.

Staff interviews, record review and observations within the long term care home (LTCH) confirm the following facts:
Resident # 1 had a quarter side rail on one side of his/her bed, which was raised when the resident was in bed. Staff interviews confirm that prior to using this bed system, the resident was not assessed and his/her bed system was not evaluated in accordance with evidence-based practices in order to minimize risk to the resident when the side rail was in use.
On an identified date, the resident was found with his/her head in between the mattress and the side rail, and his/her lower body dangling over the side of the bed. When asked what he/she was doing, the resident responded that he/she wanted to kill him/herself.
After this incident the resident was assessed to be at risk for self-harm. As a result, the plan of care was changed to include more frequent monitoring, the bed was placed in the lowest position and a falls mat was placed beside the bed. The resident's room was also assessed for items which might enable the resident cause self-harm. However, the home still did not assess the resident and evaluate his/her bed system in accordance with evidence-based practices in order to minimize risk to the resident when the side rail was in use.
Approximately one week later the resident was found face up in bed, with his/her lower body out of the bed, and his/her neck trapped in between the bed deck and the bottom of the side rail. The resident was without vital signs. Resuscitation was attempted but was unsuccessful. [s. 15. (1) (a)]

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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.

Staff interviews and record review confirm that the primary physician for resident # 1 was not informed by home staff that the resident had expressed a wish to end his/her life.
Staff interviews confirm that resident # 1 had expressed to various staff members, the desire to end his/her life. This information was not communicated to the resident's primary physician. The Admission Health Examination, completed by the resident's primary physician after the resident had expressed to staff the desire to end his/her life, does not include mention of the resident's suicidal wishes and does not note or address any psychological concerns in the targeted review of systems. [s. 6. (4) (a)]

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

Staff interviews and record review confirm that resident # 1 was considered at risk for self harm and therefore was to be monitored and observed every 30 minutes. Staff interviews confirm that the resident was not consistently monitored every 30 minutes as per the plan of care. Staff interviews confirm that on an identified date, the resident was not observed between the time of 11 pm and 1230 am. At 1230 am on the identified date, the resident was found hanging partially out of the bed, with his/her neck caught between the side rail and the bed, and with no vital signs present. [s. 6. (7)]

3. The licensee has failed to ensure that staff were kept aware of the contents of resident # 1's plan of care.
Staff interviews and record review confirm that as a result of the resident's suicidal ideations, resident # 1's plan of care required that the resident be monitored every 30 minutes to ensure his/her safety.
Staff interviews with various front line staff members who would be responsible for this monitoring, confirmed that some were not aware that the frequency of resident # 1's monitoring was to be every 30 minutes. Two identified personal care workers believed that the resident was to be monitored every hour. A third personal care worker and an identified registered staff member were not aware of the required frequency of monitoring resident # 1. [s. 6. (8)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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, particularly in respect to the residents' psychological needs and identified safety risks
-staff is kept aware of residents' plans of care, particularly in respect to managing residents' identified safety risks, and preventing harm to residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no staff performs their responsibilities before receiving training in emergency and evacuation procedures.

The home provides training in the following emergency procedures annually: Fire In-service, Codes Black, Orange and Blue, Code White, and Code Yellow. Staff interviews and record review confirm that an identified registered nurse (RN) did not receive training in the handling of a Code Blue either at the time of orientation, or at any point in 2011, 2012 or 2013. The identified registered nurse was the RN in charge at the time of resident # 1's death, and was called to the scene by the personal care assistant who found the resident not breathing, and hanging partially out of his bed, with his/her neck caught between the side rail and the bed. [s. 76. (2) 8.]

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 no staff performs their responsibilities before receiving training in emergency and evacuation procedures, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Record review and staff interviews confirm that the enhanced monitoring of resident # 1 was not consistently documented.
Resident # 1 was considered at risk for self-harm and therefore the plan of care called for the resident to be monitored and observed more frequently than usual, specifically every 30 minutes. Staff interviews confirm that when resident # 1 was monitored, the registered staff was expected to document on the Monitoring Record the time the resident was observed and his/her actions.
Review of the resident's records confirms that resident # 1's Monitoring Record was not consistently completed during the period he/she was receiving enhanced monitoring.
On the evening before resident # 1 died, there is no documentation on the resident's Monitoring Record between 4 pm and 1030 pm, although the plan of care stated the resident was to be monitored every half hour. Staff interviews confirmed that the resident was monitored and observed several times during the evening, although there is no documentation indicating specifically when the resident was monitored, or what his/her actions were at the time. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program is evaluated annually and updated in accordance with evidence-based practices or prevailing practices.
Record review and interview with the home's acting Administrator confirmed that the home's responsive behaviour program was not evaluated and updated for the year 2013. [s. 53. (3) (b)]

Issued on this 10th day of June, 2014

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

(178)

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178)
Inspection No. / No de l'inspection :	2014_159178_0005
Log No. / Registre no:	T-400-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 9, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CAREFREE LODGE 306 FINCH AVENUE EAST, NORTH YORK, ON, M2N-4S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alice Marak

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

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

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 shall prepare, submit and implement a plan to ensure that residents are not neglected by staff, specifically during a medical emergency, and that care is provided to any resident experiencing a medical emergency as directed by the resident's Level of Intervention.
The plan will be submitted via email to susan.lui@ontario.ca by July 15, 2014

Grounds / Motifs :

1. The licensee has failed to ensure that resident # 1 was not neglected by staff when he became wedged between his bed frame and bed rail and died on March 13, 2014.

Staff interviews and record review confirm the following:
Resident # 1 was considered at risk for self-harm and therefore was to be monitored and observed every 30 minutes. On the night of the resident's death, the resident was not consistently monitored every 30 minutes as per the plan of care. On that night, the resident was not observed between the time of 11 pm and 1230 am. At 1230 am the resident was found hanging partially out of the bed, with his neck caught between the side rail and the bed. The resident's hand was warm, however the resident did not appear to be breathing and no radial or carotid pulse could be detected. The resident was not assessed for other signs of life, including an apical pulse, blood pressure, presence of reflex activity, or reaction of the pupils.
Staff determined that the resident had not had a level of intervention specified by his/her substitute decision maker (SDM), so the staff considered the resident to be Level 4. According to staff interviews and home records, when a resident is designated as level 4 it means that aggressive intervention is to be provided, including cardio pulmonary resuscitation (CPR) in the case of a witnessed cardiac arrest, advanced life supports offered, with possible admission to an intensive care unit.
Staff called 911 and initiated an Emergency Code Blue within the home and as a result several staff members attended the scene. However the resident was not removed from between the bed frame and bed rail, and no first aid or cardio-pulmonary resuscitation (CPR) was attempted until paramedics arrived approximately ten minutes later. Once the paramedics arrived the resident was removed from between the bed frame and bed rails and CPR was initiated by the Registered Nurse in charge and taken over by the paramedics. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2014

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
The plan shall be submitted via email to susan.lui@ontario.ca by June 30, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that resident # 1 was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident when a side rail was in use.
Staff interviews, record review and observations within the long term care home (LTCH) confirm the following facts:
Resident # 1 had a quarter side rail on one side of the bed, which was raised when the resident was in bed. Staff interviews confirm that prior to using this bed system, the resident was not assessed and his/her bed system was not evaluated in accordance with evidence-based practices in order to minimize risk to the resident when the side rail was in use.
On March 5, 2014, the resident was found with his/her head in between the mattress and the side rail, and his/her lower body dangling over the side of the bed. When asked what he/she was doing, the resident responded that he/she wanted to kill him/herself.
After this incident the resident was assessed to be at risk for self-harm. As a result, the plan of care was changed to include more frequent monitoring, his/her bed was placed in the lowest position and a falls mat was placed beside the bed. The resident's room was also assessed for items which might enable the resident to cause self-harm. However, the home still did not assess the resident and evaluate his/her bed system in accordance with evidence-based practices in order to minimize risk to the resident when the side rail was in use.
Approximately one week later the resident was found face up in bed, with his/her lower body out of the bed, and his/her neck trapped in between the bed deck and the bottom of the side rail. The resident was without vital signs. Resuscitation was attempted but was unsuccessful.
(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to residents as specified in the plan, particularly in respect to managing residents' safety risks and prevention of harm to residents.
The plan shall be submitted by July 15, 2014 via email to susan.lui@ontario.ca.

Grounds / Motifs :

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

Staff interviews and record review confirm that resident # 1 was considered at risk for self harm and therefore was to be monitored and observed every 30 minutes. Staff interviews confirm that the resident was not consistently monitored every 30 minutes as per the plan of care. Staff interviews confirm that on an identified date, the resident was not observed between the time of 11pm and 1230am. At 1230am on the identified date, the resident was found hanging partially out of the bed, with his/her neck caught between the side rail and the bed, and with no vital signs present. (178)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 9th day of June, 2014

Signature of Inspector / Signature de l'inspecteur : Susan Lui (178)

Name of Inspector / Nom de l'inspecteur : SUSAN LUI

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