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
May 25, 2021	2021_882760_0015	020394-20, 024840-20, 001648-21, 002838-21, 002839-21, 002840-21, 002841-21, 002842-21, 003377-21, 007268-21	Critical Incident System

Licensee/Titulaire de permis

Tendercare Nursing Homes Limited
20 High Park Blvd. Toronto ON M6R 1M7

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

Tendercare Living Centre
1020 McNicoll Avenue Scarborough ON M1W 2J6

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

JACK SHI (760), ROMELA VILLASPIR (653)

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): May 12, 13, 14, 17, 18, 19, 2021.

The following intakes were completed in this critical incident inspection:

Four logs were related to a fall;
One log was related to an unsafe transfer;

One log related to follow up to Compliance Order (CO) #001, LTCHA s. 6 (7), related to nutrition and hydration, issued under inspection #2021_823653_0001, on February 11, 2021, with a compliance date of March 25, 2021, was inspected;

One log related to follow up to CO #002, O. Reg 79/10 s. 229 (4) related to infection control and prevention, issued under inspection #2021_823653_0001, on February 11, 2021, with a compliance date of February 26, 2021, was inspected;

One log related to follow up to CO #003, O. Reg 79/10 s. 68 (2) related to nutrition and hydration, issued under inspection #2021_823653_0001, on February 11, 2021, with a compliance date of March 25, 2021, was inspected;

One log related to follow up to CO #004, O. Reg 79/10 s. 26 (4) related to nutrition and hydration, issued under inspection #2021_823653_0001, on February 11, 2021, with a compliance date of March 25, 2021, was inspected;

One log related to follow up to CO #005, O. Reg 79/10 s. 73 (2) related to dining and meal service, issued under inspection #2021_823653_0001, on February 11, 2021, with a compliance date of March 25, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with a resident, a screener, the Registered Dietitian (RD) the Nurse Practitioner (NP), an Agency Registered Nurse (ARN), Registered Nurses (RN), Agency Registered Practical Nurses (ARPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Associate Director of Cares (ADOC) and the Director of Care (DOC).

During the course of the inspection, the inspectors toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:

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

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

- **5 WN(s)**
- **3 VPC(s)**
- **1 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
O.Reg 79/10 s. 229. (4)	CO #002	2021_823653_0001	760
O.Reg 79/10 s. 26. (4)	CO #004	2021_823653_0001	760
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_823653_0001	653
O.Reg 79/10 s. 68. (2)	CO #003	2021_823653_0001	653
O.Reg 79/10 s. 73. (2)	CO #005	2021_823653_0001	653

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents were assessed using a clinically appropriate assessment instrument, when their pain was not relieved by initial interventions.

According to the progress notes, a resident sustained a fall and started to complain of pain the following day. An RN had provided an intervention for the resident, but it was not effective, and they were sent to the hospital afterwards. According to the home's pain management policy, a clinical pain assessment tool is to be completed whenever a resident is experiencing new pain. A review of the resident's records did not produce this pain assessment tool, in accordance with the home's policy. The RN stated they could not recall completing a pain assessment on the resident, but that this was the responsibility of the Registered Practical Nurse (RPN). The Associate Director of Care (ADOC) stated that based on the symptoms of pain that this resident experienced, the clinical pain assessment tool should have been completed. There was potential risk to the resident, because the failure to complete a pain assessment, using the home's clinical tool on the resident may result in missed opportunities to implement pain management interventions, prior to their hospital transfer.

Sources: The home's "Pain Identification and Management" policy dated December 2020; A resident's electronic records including their completed assessments and progress notes; Interviews with an RN, the ADOC and other staff. [s. 52. (2)]

2. A review of the progress notes indicated that the resident sustained an unwitnessed fall. The following day, the resident was experiencing pain symptoms and they were sent to the hospital shortly after. A review of the resident's chart indicated that a clinical pain assessment tool was not completed, related to the pain they were experiencing at that time. The RPN stated they may have missed completing the clinical pain assessment tool for the resident. The ADOC stated that because the resident was experiencing new pain after their fall, a pain assessment should have been completed for the resident, using the clinical tool, from the home's policy. There was potential risk to the resident, as the failure to complete a pain assessment utilizing the home's clinical tool may have resulted in missed opportunities to provide pain interventions for the resident.

Sources: The home's "Pain Identification and Management" policy dated December 2020; a resident's electronic records including their completed assessments and progress notes; Interviews with an RPN, the ADOC and other staff. [s. 52. (2)]

3. A review of the progress notes indicated that a resident had sustained a fall and

shortly after, they started to complain of pain. Interventions were rendered for the resident by the attending physician; however, they were ineffective, and later, the resident was diagnosed with an injury. The ADOC reviewed the resident's health records and acknowledged that the resident's pain was not assessed using a clinically appropriate assessment instrument, when their pain was not relieved by the initial interventions.

Sources: Review of Critical Incident Systems (CIS) report and progress notes; Interviews with the ADOC and other staff. [s. 52. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, regarding wearing the required eye protection.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak in LTCHs. As part of this directive, dated May 4, 2021, all staff and essential visitors are required to wear appropriate eye protection when they are within 2 metres of a resident as part of provision of direct care and/or when they interact with a resident in an indoor area.

An observation was made in the home and a visitor in the home was providing direct assistance to a resident in their room. The visitor did not have any eye protection worn. The ADOC stated that this visitor should have worn eye protection when they were assisting the resident. There was potential risk to the resident, as the failure to wear the

eye protection may risk transmission of infectious agents.

Sources: Review of Directive #3, dated May 4, 2021; Observation in the home; Interviews with a visitor, the ADOC and other staff. [s. 5.]

2. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, regarding active screening of all staff, visitors, and anyone else entering the home for COVID-19.

As per the version of Directive #3 dated May 4, 2021, all LTCHs must implement and ensure ongoing compliance to active screening of all persons (including Staff, Visitors, and Residents Returning to the Home), specifically, all individuals must be actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the LTCH. The COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, Version 4, dated May 5, 2021, was linked to this updated Directive.

On one occasion, the screener did not actively screen Inspector #653 upon entry to the home. The inspector also noted that the home’s screening tool was modified from version three of the Ministry of Health: COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes. During an interview, the Director of Care (DOC) stated that they were in the process of updating the screening tool in accordance with Directive #3. The DOC further indicated that the expectation was for the screener to actively screen people upon entry, by asking each question and reading out the symptoms as listed out in the screening tool. The DOC stated that the screeners were considered as the home’s first line of defense, and the associated risk to not actively screening people was the potential to bring in virus to the home.

Sources: Review of COVID-19 Directive #3 dated May 4, 2021, Ministry of Health COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes Version 4 – May 5, 2021, the home’s screening tool; Inspector #653’s observation; Interview with the DOC. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that the staff used safe transferring techniques when assisting a resident.

An interview with a PSW indicated they witnessed a resident about to fall, but the PSW intervened to bring the resident onto the floor. An RPN had come to assess the resident and afterwards, the RPN and PSW transferred the resident off the floor. The ADOC stated the transfer made by the RPN and PSW did not follow the home's policy and confirmed they did not use safe transferring techniques with this resident.

Sources: Review of CIS report, and progress notes; Interviews with a PSW, an RPN, the ADOC and other staff. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of the progress notes and interview with an RPN indicated that a resident was about to fall but a PSW intervened to bring the resident onto the floor. The RPN confirmed they did not conduct a post-fall assessment. The ADOC stated that in accordance to the home's policy, this resident did have a fall and a post-fall assessment should have been completed by the RPN. The ADOC further acknowledged that the risk associated to not conducting a post-fall assessment was a potential for unidentified injury, and further falls due to lack of post fall analysis.

Sources: Review of a CIS report, and progress notes; Interviews with an RPN, the ADOC and other staff. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
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).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was notified within one business day regarding a resident, who was hospitalized and had a significant change to their status.

A CIS report was submitted a number of days after a resident went to the hospital and was diagnosed with an injury. The ADOC stated that the incident should have been reported to the Director on the day that the resident went to the hospital.

Sources: A CIS report; Interview with the ADOC and other staff. [s. 107. (3)]

2. The licensee failed to ensure that a PSW was mentioned in the CIS report, involved in the fall of a resident.

A CIS report indicated that a PSW was involved in an unwitnessed fall incident with a resident. The CIS report did not mention who the name of this PSW was. The ADOC confirmed that the name of the PSW was not in the report and should have been.

Sources: A CIS report; Interview with the ADOC and other staff. [s. 107. (4)]

3. The licensee failed to ensure that an agency RPN was mentioned in the CIS report, related to a fall that a resident sustained.

A CIS report indicated that a resident sustained an unwitnessed fall. An agency RPN confirmed they were the one who initially responded and assessed the resident. A review of the CIS report did not mention this agency RPN’s name. The DOC confirmed that the names of all staff involved in a critical incident should be mentioned in the report.

Sources: A CIS report; Interview with an agency RPN, the DOC and other staff. [s. 107. (4)]

Issued on this 25th day of May, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760), ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2021_882760_0015
Log No. / No de registre :	020394-20, 024840-20, 001648-21, 002838-21, 002839-21, 002840-21, 002841-21, 002842-21, 003377-21, 007268-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 25, 2021
Licensee / Titulaire de permis :	Tendercare Nursing Homes Limited 20 High Park Blvd., Toronto, ON, M6R-1M7
LTC Home / Foyer de SLD :	Tendercare Living Centre 1020 McNicoll Avenue, Scarborough, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Francis Martis

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Tendercare Nursing Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 52(2) of O. Reg. 79/10.

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

Grounds / Motifs :

1. The licensee has failed to ensure that three residents were assessed using a clinically appropriate assessment instrument, when their pain was not relieved by initial interventions.

According to the progress notes, a resident sustained a fall and started to complain of pain the following day. An RN had provided an intervention for the resident, but it was not effective, and they were sent to the hospital afterwards. According to the home's pain management policy, a clinical pain assessment tool is to be completed whenever a resident is experiencing new pain. A review of the resident's records did not produce this pain assessment tool, in accordance with the home's policy. The RN stated they could not recall completing a pain assessment on the resident, but that this was the responsibility of the Registered Practical Nurse (RPN). The Associate Director of Care (ADOC) stated that based on the symptoms of pain that this resident experienced, the clinical pain assessment tool should have been completed. There was potential risk to the resident, because the failure to complete a pain assessment, using the home's clinical tool on the resident may result in missed opportunities to implement pain management interventions, prior to their hospital transfer.

Sources: The home's "Pain Identification and Management" policy dated December 2020; A resident's electronic records including their completed assessments and progress notes; Interviews with an RN, the ADOC and other staff. (760)

2. A review of the progress notes indicated that the resident sustained an unwitnessed fall. The following day, the resident was experiencing pain symptoms and they were sent to the hospital shortly after. A review of the resident's chart indicated that a clinical pain assessment tool was not completed, related to the pain they were experiencing at that time. The RPN stated they may have missed completing the clinical pain assessment tool for the resident. The ADOC stated that because the resident was experiencing new pain after their fall, a pain assessment should have been completed for the resident, using the clinical tool, from the home's policy. There was potential risk to the resident, as the failure to complete a pain assessment utilizing the home's clinical tool may have resulted in missed opportunities to provide pain interventions for the resident.

Sources: The home's "Pain Identification and Management" policy dated December 2020; a resident's electronic records including their completed assessments and progress notes; Interviews with an RPN, the ADOC and other staff. (760)

3. A review of the progress notes indicated that a resident had sustained a fall and shortly after, they started to complain of pain. Interventions were rendered for the resident by the attending physician; however, they were ineffective, and later, the resident was diagnosed with an injury. The ADOC reviewed the resident's health records and acknowledged that the resident's pain was not assessed using a clinically appropriate assessment instrument, when their pain was not relieved by the initial interventions.
Sources: Review of Critical Incident Systems (CIS) report and progress notes; Interviews with the ADOC and other staff.

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

Severity: There was potential risk of harm to the residents, as the failure to

complete the pain assessment in accordance to the home's clinical tool may result in missed opportunities to implement effective pain management interventions.

Scope: This non-compliance was widespread as three out of three residents were noted not to have been assessed using a clinically appropriate assessment instrument.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 12, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 25th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

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