Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2018	2018_580568_0011	017267-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

DOROTHY GINTHER (568), GLORIA KOVACH (697), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 17, 18, 19, 20, 23, 24, 25, 27, 30, 31, 2018 and August 1, 2018.

The following intakes were completed in conjunction with the Resident Quality Inspection:
Followup to CO #001 from inspection #2018_742527_0007 log #016755-18 related to abuse;
Critical Incident System (CIS) #2887-000007-18 log #004664-18, CIS #2887- 000018-18 log #012042-18, CIS #2887-000012-18 log #005461-18 related to responsive behaviours;
CIS #2887-000022-18 log #014619-19, CIS #2887-000016-18 log #009557-18, CIS 2887 -000011-18 log #005000-18 related to falls;
CIS #2887-000025-18 log #017644-18 related to abuse;
CIS #2887-000027-18 log #018828-18 related to incident of choking;
Complaint IL-57781-CW log #016383-18 related to temperatures in the home;
Complaint IL-57244-CW log #011946-18 related to falls prevention and pain management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, RAI Coordinator, Director of Food Services, Environmental Services Manager, Registered Dietitian, Physiotherapist, maintenance staff, Scheduler, Registered Nurses, Registered Practical Nurses, student nurses, Personal Support Workers, Housekeepers, a Residents' Council representative, residents and their families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, medication incidents; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_742527_0007	568

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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A Critical Incident System (CIS) report and the home's investigation for the incident identified that on a specified date there was an altercation between two residents resulting in injury to one of the residents. Staff were uncertain if the interventions identified in the resident's plan of care were in place at the time of the incident.

Under the section "outcome/current status" on the CIS report it was documented that one of the resident's continued to exhibit responsive behaviours.

Review of the clinical record showed that the identified resident was being monitored with respect to responsive behaviours at the time of the incident.

A second CIS report and subsequent investigation by the home documented an altercation between the identified resident and another resident on a specified date. The immediate actions taken to prevent recurrence stated that the identified resident would be closely monitored by staff. Progress notes documented a prior altercation between the same two residents.

The plan of care for the identified resident documented that the resident exhibited responsive behaviours. A number of interventions had been put in place to address the

resident's behaviours and to mitigate the risk of harm to other residents.

Progress notes for the identified resident documented a history of responsive behaviours involving staff and residents.

Review of the electronic Medication Administration Record (eMAR) identified that the resident had been prescribed and administered medication to assist in managing their responsive behaviours.

A medical consultation note documented that the resident had a history of responsive behaviours and there was a potential risk to others.

During interviews with PSWs, registered staff, and the Behaviour Support Ontario (BSO) RN they said that the identified resident had a history of responsive behaviours and that strategies had been put in place to manage these behaviours. When the BSO RN was asked if the interventions had been effective, the RN stated they were not fully successful. When asked what alternative interventions had been tried, the RN said that they had implemented a short-term strategy which was successful in mitigating risk of harm to other residents, but it was not kept in place.

The Director of Care (DOC) said they were aware of the identified resident's ongoing responsive behaviours and altercations with other residents. When asked why the short term strategy was not implemented on a longer term basis, they said the resident's responsive behaviours were not consistent.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions. [s. 54. (b)]

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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

a) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) in relation to an incident that causes injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The plan of care for the resident at the time of the incident identified the resident as being at risk for falls. Several interventions were put in place to mitigate the risk of falls and injury.

A PSW said they recalled the incident as outlined in the CIS report. They said that when they observed the resident at the time of the incident more than one of the interventions identified in the plan of care to mitigate the risk of falls was not in place.

The Director of Care (DOC) said that the resident was a risk to fall based on their risk assessment. When asked if interventions were in place to mitigate the risk of falls at the time of the identified incident, the DOC said that based on their investigation, specified interventions in the plan of care were not implemented at the time of the incident.

b) During the Resident Quality Inspection (RQI) it was identified that a resident was underweight according to their body mass index (BMI) and there were no nutritional interventions identified for weight gain.

Review of the resident's clinical record provided details of the resident's BMI and weight range over the last five months. The admission Dietary Assessment identified the resident as a nutritional risk related to a number of factors. The plan of care stated that the resident was to receive specified nutritional interventions.

The Registered Dietitian stated that the resident was a nutritional risk in relation to their

weight and BMI. The RD said that their plan was to maintain the resident's weight by implementing specific nutritional interventions. When asked how the PSWs were made aware of individual resident's specific nutritional interventions, the RD said that it would be documented in the resident's plan of care / kardex and on the diet sheets on the nourishment cart.

Review of the diet book found on the nourishment cart identified that specified nutritional interventions were in place for the resident. During an observation of a nourishment pass it was noted that staff did not offer the resident the specific nutritional intervention. The staff member said they were not aware the resident was to receive the specified nutritional intervention and had not checked the diet book.

The licensee failed to ensure that the resident received their specialized nourishment as outlined in the resident's plan of care. [s. 6. (7)]

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 care set out in the plan of care was provided to the resident as specified in he plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Prevention of Abuse & Neglect of a Resident" stated that if any employee or volunteer witnessed an incident, or had any knowledge of an incident, that constituted resident abuse or neglect; all staff were to immediately inform the Executive Director (ED) and / or Charge Nurse in the home. The Charge Nurse would immediately report to the Director (MOHLTC) with the ED or designate, if available.

A CIS report was submitted to the MOHLTC on a specified date for an incident that took place one day prior. The CIS stated that there was an altercation between two residents resulting in injury to one of the residents.

In an interview with registered staff they confirmed that they were working at the time of the incident as the Charge Nurse had responded to the incident in question. The registered staff said they did not investigate the incident at the time nor did they report the incident of alleged abuse to management in the home or the MOHLTC.

The DOC stated that it was expected that staff immediately report any alleged or witnessed incidents of abuse or neglect to the charge nurse, assistant DOC, ED or DOC. If there was no management staff in the home then the charge nurse would report to the after-hours line. With respect to the incident in question, the DOC said they believed that management did not become aware of the incident until the following day as it had not been immediately reported by the charge nurse.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse ad neglect of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

On a specified date a resident to resident altercation took place in the home which resulted in injury to one of the residents.

The CIS report documented that a call had been made to the after hours Long Term Care (LTC) reporting line the day of the incident. Documentation indicated that the substitute decision maker (SDM) had been notified of the incident.

A review of the home's investigation documentation showed that the investigation was initiated almost three weeks after the incident.

The DOC said their process for investigations included completing a CIS report, completing a huddle, speaking to the resident if possible and speaking to staff involved. The DOC acknowledged there was a delay with the investigation for this incident.

The licensee has failed to ensure that the alleged incident of abuse involving two residents was immediately investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported, is immediately investigated: (i) Abuse of a resident by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that corrective action was taken as necessary for all medication incidents and adverse drug reactions after being reviewed and analyzed.

A Medication incident documented that a resident was administered another resident's medication. It was reported that there were several medications given in error. Progress notes on the date of the incident stated a medication error occurred due to confusion on names of residents.

The medication incident was discussed with the DOC and they acknowledged that the resident was given the wrong medication because of a confusion between the two names. When asked what interventions were put in place following the incident, the DOC said that they had implemented a specific strategy to avoid the same type of incident.

During a medication administration observation it was noted that the specified strategy to prevent confusion between resident names was not in place. The DOC acknowledged that the specified strategy, as stated in the action plan, had not been implemented.

The licensee failed to ensure that corrective actions were taken with respect to a medication incident involving residents. [s. 135. (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 corrective action is taken as necessary for all medication incidents and adverse drug reactions after being reviewed and analyzed, to be implemented voluntarily.

WN #6: 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 residents were protected from abuse by anyone.

The following is further evidence to support the order issued on May 29, 2018, during a critical incident inspection 2018_742527_0007 to be complied June 29, 2018.

Review of a CIS report and the home's investigation into the incident identified that on a specified date there was an altercation between two residents resulting in an injury to one of the residents.

The plan of care for the identified resident documented that the resident exhibited responsive behaviours which involved residents and staff. Interventions had been implemented to address the resident's responsive behaviours and mitigate the risk to other residents.

A medical consultation note documented that the resident had a history of responsive behaviours and there was a potential risk to others.

A second CIS report and subsequent investigation by the home documented an altercation between the identified resident and another resident on a specified date. The immediate actions taken to prevent recurrence stated that the identified resident would be closely monitored by staff. Progress notes identified a previous altercation between the same two residents.

Progress notes for the identified resident documented a history of responsive behaviours involving staff and residents.

In interviews with two PSWs and a registered staff they said that the identified resident exhibited responsive behaviours and they utilized specific interventions to try to manage these behaviours.

The BSO / RN told the Inspector that strategies / interventions had been put in place to manage the identified resident's responsive behaviours, but acknowledged that the interventions were not always effective in preventing harm to other residents.

The Licensee failed to ensure that residents were protected from abuse by anyone. [s. 19. (1)]

Issued on this 5th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), GLORIA KOVACH (697), JANETM EVANS (659)
Inspection No. / No de l'inspection :	2018_580568_0011
Log No. / No de registre :	017267-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 2, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Hawthorn Woods Care Community 9257 Goreway Drive, BRAMPTON, ON, L6P-0N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Adam Kertesz

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s. 54 (b) of O. Reg 79/10.

Specifically the licensee must:
Ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #045 and other residents, by identifying and implementing interventions. Consideration should be given to internal and external resources which might supplement care and mitigate the risk of harm to other residents.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A Critical Incident System (CIS) report and the home's investigation for the incident identified that on a specified date there was an altercation between two residents resulting in injury to one of the residents. Staff were uncertain if the interventions identified in the resident's plan of care were in place at the time of the incident.

Under the section "outcome/current status" on the CIS report it was documented that one of the resident's continued to exhibit responsive behaviours.

Review of the clinical record showed that the identified resident was being monitored with respect to responsive behaviours at the time of the incident.

A second CIS report and subsequent investigation by the home documented an altercation between the identified resident and another resident on a specified date. The immediate actions taken to prevent recurrence stated that the identified resident would be closely monitored by staff. Progress notes documented a prior altercation between the same two residents.

The plan of care for the identified resident documented that the resident exhibited responsive behaviours. A number of interventions had been put in place to address the resident's behaviours and to mitigate the risk of harm to other residents.

Progress notes for the identified resident documented a history of responsive behaviours involving staff and residents.

Review of the electronic Medication Administration Record (eMAR) identified that the resident had been prescribed and administered medication to assist in managing their responsive behaviours.

A medical consultation note documented that the resident had a history of responsive behaviours and there was a potential risk to others.

During interviews with PSWs, registered staff, and the Behaviour Support Ontario (BSO) RN they said that the identified resident had a history of responsive behaviours and that strategies had been put in place to manage these behaviours. When the BSO RN was asked if the interventions had been effective, the RN stated they were not fully successful. When asked what alternative interventions had been tried, the RN said that they had implemented a short-term strategy which was successful in mitigating risk of harm to other residents, but it was not kept in place.

The Director of Care (DOC) said they were aware of the identified resident's ongoing responsive behaviours and altercations with other residents. When asked why the short term strategy was not implemented on a longer term basis, they said the resident's responsive behaviours were not consistent.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The severity of the issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 2, pattern, with two out of three incidents. The home had a level 3 compliance history as they had one or more related non-compliance in the last 36 months which included:
Voluntary Plan of Correction (VPC) issued May 29, 2018 (2018_742527_0007)
VPC issued March 22, 2017 (2017_449619_0003)
VPC issued June 30, 2016 (2016_431527_0010)

(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 09, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 2nd day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Dorothy Ginther

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