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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 9, 2019	2019_759502_0018	000907-19, 003294-19, 005094-19, 009936-19	Critical Incident System

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

Deerwood Creek Care Community
70 Humberline Drive ETOBICOKE ON M9W 7H3

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

JULIENNE NGONLOGA (502), SIMAR KAUR (654)

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): July 18, 19, 22, 23, 24, 25, 26, 29, 30 and 31, 2019.

The following intakes were completed in this Critical Incident System Inspection:
- log #000907-19, (CIS #2837-000004-19), and #005094-19, (CIS #2837-000017-19), related to injury with unknown cause,
- log #009936-19, (CIS # 2837-000025-19), related to responsive behaviour.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (DOC), Behaviour Service Ontario Lead, Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Residents, and Resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed residents' health records, staffing schedules, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 was protected from abuse by resident #011.

A Critical Incident System (CIS) report was submitted to the Director related to an alleged abuse of resident #012.

A review of the CIS report and progress notes indicated that on an identified date and time resident #012 complained of pain and stated that resident #011 displayed behaviour toward them. Upon assessment resident #012 had specified injury.

The next day resident #011 told staff that resident #012 went and tried to get something which did not belong to them, so they struck them.

On two occasions after the incident, resident #012 was observed in a common area of the home. When staff inquired why they were not in their room, resident #012 stated that they got out from their room as there were people in the room and they did not know them, and they were afraid of those people.

Review of resident #012's current Minimum Data Set (MDS) assessment indicated that the resident had some difficulty in new situations and that they ambulated independently on the unit.

Review of resident #011's MDS assessment indicated that the resident was moderately cognitively impaired which indicated poor decision-making skills, required cues, and supervision. The MDS assessment also indicated responsive behavior, and that resident #011 ambulated independently on the unit.

The post admission's Dementia Observation System (DOS) Summary for an identified period indicated that resident #011 had specified responsive behaviours and an identified diagnosis.

A review of resident #011's progress notes indicated on more than one occasion resident #011 told their spouse and staff that they wanted to display a specified behaviour toward their roommate because of an identified noise.

On an identified date, resident #011 displayed an identified behaviour and the triggers were identified and included sound, repetitive/disruptive noise from other residents and wandering resident/crowd.

In an interview resident's 1:1 staff #117 indicated that resident #012 was quiet but displayed specific behaviour, which annoyed resident #011, they had reported that to the nurse on duty each time. Resident's 1:1 staff #117 indicated that resident #011 used to complain verbally about the specified behaviour. Currently resident #011 just glares at the resident's 1:1 staff for re-assurance and the resident's 1:1 staff will calm them down and re-direct their focus on something else or take them out of the area.

The PSW #121 indicated that they had suspected that resident #011 displayed an identified behaviour as they did not want other residents entering their room.

Staff #116 indicated resident #011 had a room change as they expressed the desire to display the specified behaviour toward their roommate. Resident #011 was moved in the room with resident #012, stays in their bed but must pass by resident #011's bed area to get in and out of the room. They acknowledged that they did not know what triggered resident #011 the night of the incident mentioned above.

In an interview, ADOC indicated that when the home identified that the noise was a trigger for resident #011's identified behaviour they provided a 1:1 staff for an identified period to keep the resident engaged in activities. They also moved resident #011 to another room with resident #012 as they were a quiet person, did not like to have conversations with the other residents and stays most of the time in their bed.

Staff #116 and the ADOC acknowledged that the home did not assess if other types of noises could trigger resident #011's specified behaviour.

The licensee has failed to ensure that resident #012 was kept safe from abuse by resident #011, as resident #011 had made numerous threats about the identified triggers of their behaviour at specific times. The family and staff 1:1 reported the concerns to nursing staff and no measures were put into place during the specific time to protect resident #012 from abuse. Staff #116 was aware of the risk of resident #012 advising the inspector that they had already moved the resident for previous incidents with another resident. [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. 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 are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A CIS report was submitted to the Director related to an alleged abuse of resident #012.

A review of the CIS and progress notes indicated that on an identified date and time resident #012 complained of pain and that resident #011 displayed responsive behaviour towards them. Upon assessment resident #012 had specified injury.

The next day resident #011 told staff that resident #012 went and tried to get something which did not belong to them, so they struck them.

Review of resident #011's MDS assessment indicated that the resident was moderately cognitively impaired which indicated poor decision-making skills, required cues, and supervision. The MDS assessment also indicated responsive behavior, and that resident #011 ambulated independently on the unit.

The post admission's Dementia Observation System (DOS) Summary for an identified

period indicated that resident #011 had specified responsive behaviour and an identified diagnosis.

A review of resident #011's progress notes indicated on more than one occasion resident #011 told their spouse and staff that they wanted to display a specified behaviour toward their roommate because of an identified noise.

On an identified date resident #011 displayed an identified behaviour and the triggers were identified and included sound, repetitive/disruptive noise from other residents and wandering resident/crowd.

Review of resident #011's current written plan of care indicated interventions to reduce risk of interation with other residents.

In separate interviews PSW #121, RPN #122 and staff #116 indicated that resident #011 has unpredictable behaviour, which is triggered by the noise.

Staff #116 indicated resident #011 had a room change as they had expressed displaying specified behaviour toward their previous roommate. Staff #116 acknowledged that resident #012 could have triggered resident #011's behaviour, but they did not know the trigger of resident #011's behaviour displayed toward resident #012, the night of the incident mentioned above.

The licensee has failed to identify strategies and was aware that resident #011 exhibited physical aggression when hearing repetitive noise. The plan of care included interventions to remove resident #011 from areas of noise, however resident #011's plan of care was not reassessed or revised for behavioural triggers at night to minimize potentially harmful interactions between residents #011 and #012, when they were moved to another room with resident #012, nor were there any interventions in place to mitigate the potential risk of aggression during the specific time. [s. 54. (b)]

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

A CIS report was submitted to the Director related to a fall with injury.

A review of the CIS report indicated that on an identified date and time resident #014 was found lying on the floor in an identified area and had pain. The resident was sent to the hospital the next day after sustaining two additional falls with injury.

A review of resident #014's progress notes indicated three falls with injury within 24-hours in the same identified area.

A review of resident #014's MDS assessment indicated the resident was moderately impaired with poor decision-making skills. They required supervision with one-person assistance for locomotion on the unit.

A review of resident #014's written plan of care under fall risk focus indicated that the resident is moderate to high risk of fall. Review of the PSW #121 and #124's interviews in the home's investigation notes indicated resident #014 used to wander on the unit. PSW #124 indicated that the resident usually had an unsteady gait. Review of the written plan of care created on an identified date noted that there was no specific strategy identified to reduce the resident's risk of fall due to wandering.

A revised written plan of care was completed after resident #014's fall incident and did not identify a specific strategy to reduce the risk of fall due to wandering. In separate interviews with the RPN #122 and the Fall's Prevention Program Co-Lead #102 indicated that after the resident's first fall, no different approaches were considered in the revision of resident #014's plan of care to address their risk of fall.

In an interview, DOC #101 acknowledged that resident #014's plan of care did not identify that different approaches were considered in the revision of their plan of care to address the risk of fall. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A CIS report was submitted to the Director related to resident #010's injury with unknown cause.

Review of the CIS report indicated that the resident was admitted to hospital on an identified date with a specified diagnosis. During their stay in hospital the resident was diagnosed with specified infections.

Record review of the home's line list indicated resident #010 was identified on this list during an identified period.

Review of resident #010's health record indicated that they experienced identified symptoms on the above-mentioned dates.

Review of resident #010's progress notes for the period mentioned above indicated that the resident's signs and symptoms of infection were not monitored on eight occasions during the period identified above.

In an interview, RPN #113 indicated, after reviewing the resident's progress notes, that staff had failed to monitor and document, sign and symptoms of infection for the above-mentioned resident.

In an interview, ADOC #115, who is also the infection prevention and control program lead in the home, indicated that the home's expectation was that residents experiencing symptoms of infection should be monitored every shift, and documentation completed in their progress notes. The ADOC further acknowledged that resident #010 was line listed during the period mentioned above and should have been monitored for symptoms of infection during the day, evening and night shifts. [s. 229. (5) (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 on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 14th day of August, 2019

[redacted]

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

Ministère de la Santé et 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 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) :	JULIENNE NGONLOGA (502), SIMAR KAUR (654)
Inspection No. / No de l'inspection :	2019_759502_0018
Log No. / No de registre :	000907-19, 003294-19, 005094-19, 009936-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 9, 2019
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 :	Deerwood Creek Care Community 70 Humberline Drive, ETOBICOKE, ON, M9W-7H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Ois

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 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

Ministère de la Santé et 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA, 2007.

Specifically the licensee shall ensure that resident #012 and any other resident are protected from abuse by resident #011.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #012 was protected from abuse by resident #011.

A Critical Incident System (CIS) report was submitted to the Director related to an alleged abuse of resident #012.

A review of the CIS report and progress notes indicated that on an identified date and time resident #012 complained of pain and stated that resident #011 displayed behaviour toward them. Upon assessment resident #012 had specified injury.

The next day resident #011 told staff that resident #012 went and tried to get something which did not belong to them, so they struck them.

On two occasions after the incident, resident #012 was observed in a common area of the home. When staff inquired why they were not in their room, resident #012 stated that they got out from their room as there were people in the room and they did not know them, and they were afraid of those people.

Review of resident #012's current Minimum Data Set (MDS) assessment indicated that the resident had some difficulty in new situations and that they

ambulated independently on the unit.

Review of resident #011's MDS assessment indicated that the resident was moderately cognitively impaired which indicated poor decision-making skills, required cues, and supervision. The MDS assessment also indicated responsive behavior, and that resident #011 ambulated independently on the unit.

The post admission's Dementia Observation System (DOS) Summary for an identified period indicated that resident #011 had specified responsive behaviours and an identified diagnosis.

A review of resident #011's progress notes indicated on more than one occasion resident #011 told their spouse and staff that they wanted to display a specified behaviour toward their roommate because of an identified noise.

On an identified date, resident #011 displayed an identified behaviour and the triggers were identified and included sound, repetitive/disruptive noise from other residents and wandering resident/crowd.

In an interview resident's 1:1 staff #117 indicated that resident #012 was quiet but displayed specific behaviour, which annoyed resident #011, they had reported that to the nurse on duty each time. Resident's 1:1 staff #117 indicated that resident #011 used to complain verbally about the specified behaviour. Currently resident #011 just glares at the resident's 1:1 staff for re-assurance and the resident's 1:1 staff will calm them down and re-direct their focus on something else or take them out of the area.

The PSW #121 indicated that they had suspected that resident #011 displayed an identified behaviour as they did not want other residents entering their room.

Staff #116 indicated resident #011 had a room change as they expressed the desire to display the specified behaviour toward their roommate. Resident #011 was moved in the room with resident #012, stays in their bed but must pass by resident #011's bed area to get in and out of the room. They acknowledged that they did not know what triggered resident #011 the night of the incident mentioned above.

In an interview, ADOC indicated that when the home identified that the noise was a trigger for resident #011's identified behaviour they provided a 1:1 staff for an identified period to keep the resident engaged in activities. They also moved resident #011 to another room with resident #012 as they were a quiet person, did not like to have conversations with the other residents and stays most of the time in their bed.

Staff #116 and the ADOC acknowledged that the home did not assess if other types of noises could trigger resident #011's specified behaviour.

The licensee has failed to ensure that resident #012 was kept safe from abuse by resident #011, as resident #011 had made numerous threats about the identified triggers of their behaviour at specific times. The family and staff 1:1 reported the concerns to nursing staff and no measures were put into place during the specific time to protect resident #012 from abuse. Staff #116 was aware of the risk of resident #012 advising the inspector that they had already moved the resident for previous incidents with another resident.

The severity of this non-compliance was determined to be level three as there was actual harm/risk to the resident. The scope was determined to be level one as one of three residents assessed was victim of abuse. The home had a level three compliance history as they had previous non-compliance under a same subsection. As a result of actual harm/risk to the resident, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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 # / Ordre no : 002

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 r. 54 of the LTCHA, 2007.

Specifically, the licensee shall
- Reassess resident #011's interventions at night time to eliminate the risk of resident to resident altercation related to resident #011 trigger of sound, repetitive/disruptive noise and wandering resident.

- Re-evaluate resident #011's accommodation needs based on the triggers identified above.

- Revise the care plan to reflect the above identified interventions.

Grounds / Motifs :

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

A CIS report was submitted to the Director related to an alleged abuse of resident #012.

A review of the CIS and progress notes indicated that on an identified date and time resident #012 complained of pain and that resident #011 displayed

responsive behaviour towards them. Upon assessment resident #012 had specified injury.

The next day resident #011 told staff that resident #012 went and tried to get something which did not belong to them, so they struck them.

Review of resident #011's MDS assessment indicated that the resident was moderately cognitively impaired which indicated poor decision-making skills, required cues, and supervision. The MDS assessment also indicated responsive behavior, and that resident #011 ambulated independently on the unit.

The post admission's Dementia Observation System (DOS) Summary for an identified period indicated that resident #011 had specified responsive behaviour and an identified diagnosis.

A review of resident #011's progress notes indicated on more than one occasion resident #011 told their spouse and staff that they wanted to display a specified behaviour toward their roommate because of an identified noise.

On an identified date resident #011 displayed an identified behaviour and the triggers were identified and included sound, repetitive/disruptive noise from other residents and wandering resident/crowd.

Review of resident #011's current written plan of care indicated interventions to reduce risk of interation with other residents.

In separate interviews PSW #121, RPN #122 and staff #116 indicated that resident #011 has unpredictable behaviour, which is triggered by the noise.

Staff #116 indicated resident #011 had a room change as they had expressed displaying specified behaviour toward their previous roommate. Staff #116 acknowledged that resident #012 could have triggered resident #011's behaviour, but they did not know the trigger of resident #011's behaviour displayed toward resident #012, the night of the incident mentioned above.

The licensee has failed to identify strategies and was aware that resident #011 exhibited physical aggression when hearing repetitive noise. The plan of care

included interventions to remove resident #011 from areas of noise, however resident #011's plan of care was not reassessed or revised for behavioural triggers at night to minimize potentially harmful interactions between residents #011 and #012, when they were moved to another room with resident #012, nor were there any interventions in place to mitigate the potential risk of aggression during the specific time.

The severity of this non-compliance was determined to be level three as there was actual harm/risk to the resident. The scope was determined to be level one as the interaction was with one resident. The home had a level three compliance history as they had previous non-compliance under a same subsection. As a result of actual harm/risk to the resident, a compliance order is warranted. (502)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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
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 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)
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 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 9th day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

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