

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée 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
Nov 30, 2021	2021_617148_0020 (A1)	010968-21, 011382-21, 011758-21, 012123-21, 012252-21, 012736-21, 013028-21, 013033-21, 013184-21, 013185-21, 014273-21	Critical Incident System

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville,
the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 Brockville ON K6V 5T1

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

St. Lawrence Lodge
1803 County Road, #2 East Postal Bag #1130 Brockville ON K6V 5T1

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

Amended by AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

**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**

Acting Administrator Lisa Harper requested extension of CDD to January 28 2022. The report has been updated to reflect this request.

Issued on this 30th day of November, 2021 (A1)

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

Original report signed by the inspector.

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
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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 (ID #) /
Nom de l'inspecteur (No) :** Amended by AMANDA NIXON (148) - (A1)

**Inspection No. /
No de l'inspection :** 2021_617148_0020 (A1)

**Appeal/Dir# /
Appel/Dir#:**

**Log No. /
No de registre :** 010968-21, 011382-21, 011758-21, 012123-21,
012252-21, 012736-21, 013028-21, 013033-21,
013184-21, 013185-21, 014273-21 (A1)

**Type of Inspection /
Genre d'inspection :** Critical Incident System

**Report Date(s) /
Date(s) du Rapport :** Nov 30, 2021(A1)

**Licensee /
Titulaire de permis :** The Corporations of the United Counties of Leeds
and Grenville, the City of Brockville, the Town of
Gananoque and the Town of Prescott
c/o St. Lawrence Lodge, 1803 County Road 2,
Brockville, ON, K6V-5T1

**LTC Home /
Foyer de SLD :** St. Lawrence Lodge
1803 County Road, #2 East, Postal Bag #1130,
Brockville, ON, K6V-5T1

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** Carolyn Zacharuk

To The Corporations of the United Counties of Leeds and Grenville, the City of
Brockville, the Town of Gananoque and the Town of Prescott, you are hereby required
to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # /**No d'ordre:** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

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

Order / Ordre :

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

Specifically the licensee shall ensure that four residents are protected from abuse by completing the following:

- 1) Review and revise the policy to promote zero tolerance of abuse and neglect related to the procedures for reporting of abuse of residents;
- 2) Provide training to an RN, an RPN and four PSWs on the revised policy to promote zero tolerance of abuse and neglect of residents,
- 3) Ensure that managers, including the Acting Administrator, are trained on the definition of abuse and action to be taken, including immediate investigation, when information is known that meets such definitions,
- 4) A record of all training and re-training provided, including the dates and the persons who attended shall be maintained.

Grounds / Motifs :

1. The licensee failed to protect three residents from abuse by a PSW .

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A PSW was involved with four separate incidents of alleged abuse over the course of

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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

six days, involving four residents.

An RPN and a PSW reported concerns to the Acting Administrator, regarding the care provided by the PSW, approximately two weeks before the first incident. The RPN and PSW reported general concerns with the PSW's care and services on a home area, noting that the PSW can be too loud, uses poor language with residents and may not be suited to long-term care. The Acting Administrator indicated that after these concerns were brought forward, the PSW was to be scheduled to work in other home areas; no further action was taken. The PSW continued to work on the same home area where the first three incidents occurred.

An RPN reported the first three incidents to the Acting Administrator. Upon receiving the information, the Acting Administrator indicated that the PSW would be reassigned to another home area with follow up to occur the next day. Although there is evidence to suggest that the Manager of Human Resources was made aware of the information and scheduling personnel were directed to reassign the PSW, no further action was taken and the licensee can not demonstrate that any follow up occurred for the next two days. On the third day, the PSW was involved with a subsequent incident of alleged abuse on another home area.

The licensee failed to take appropriate and immediate action when information was known of alleged abuse; the PSW was subsequently involved in additional incidents of alleged abuse.

As indicated by WN #2, staff failed to comply with the policy to promote zero tolerance of abuse and neglect of residents, specifically as it relates to immediate reporting. The policy to promote zero tolerance of abuse and neglect was last updated May 2019 and indicated the following statement "Any employee who witnesses or suspects abuse or neglect of a resident by another employee must report the incident immediately". The policy does not provide for clear direction as to whom this report is to be made and only address the abuse of an employee toward a resident.

As it relates to the protection of residents from abuse, the licensee failed to: (1) ensure that the Director was immediately informed of suspected abuse (WN #3); (2) ensure that resident SDMs were made aware of the results of the investigation (WN #4); and (3) ensure that the results of the investigation are reported to the Director

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term
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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

(WN #7).

An order was made by taking the following factors into account: Severity: There was actual risk of harm to three residents, as appropriate and immediate action was not taken to protect residents. Scope: The scope of this non-compliance was identified as widespread as all three of the alleged incidents of abuse, involving the same PSW, failed to take appropriate and immediate action. Compliance History: In the last 36 months, the licensee has had no previous non-compliance of LTCHA section 19.

Sources: Documents of the licensee's investigation file, Critical Incident Reports and interviews with an RPN, PSWs and Acting Administrator. [s. 19. (1)] (148)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jan 28, 2022(A1)

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

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l'article 154 de la *Loi de 2007 sur les
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2007, chap. 8

**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
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term
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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
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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 révision
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 30th day of November, 2021 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

Amended by AMANDA NIXON (148) - (A1)

Order(s) of the Inspector

Pursuant to section 153 and/or
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2007, chap. 8

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

Ottawa Service Area Office

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**Long-Term Care Operations Division
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Division des opérations relatives aux
soins de longue durée
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**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** Amended by AMANDA NIXON (148) - (A1)

**Inspection No. /
No de l'inspection :** 2021_617148_0020 (A1)

**Appeal/Dir# /
Appel/Dir#:**

**Log No. /
No de registre :** 010968-21, 011382-21, 011758-21, 012123-21,
012252-21, 012736-21, 013028-21, 013033-21,
013184-21, 013185-21, 014273-21 (A1)

**Type of Inspection /
Genre d'inspection :** Critical Incident System

**Report Date(s) /
Date(s) du Rapport :** Nov 30, 2021(A1)

**Licensee /
Titulaire de permis :** The Corporations of the United Counties of Leeds
and Grenville, the City of Brockville, the Town of
Gananoque and the Town of Prescott
c/o St. Lawrence Lodge, 1803 County Road 2,
Brockville, ON, K6V-5T1

**LTC Home /
Foyer de SLD :** St. Lawrence Lodge
1803 County Road, #2 East, Postal Bag #1130,
Brockville, ON, K6V-5T1

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** Carolyn Zacharuk

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Brockville, the Town of Gananoque and the Town of Prescott, you are hereby required
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Order # /**No d'ordre:** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

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

Order / Ordre :

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

Specifically the licensee shall ensure that four residents are protected from abuse by completing the following:

- 1) Review and revise the policy to promote zero tolerance of abuse and neglect related to the procedures for reporting of abuse of residents;
- 2) Provide training to an RN, an RPN and four PSWs on the revised policy to promote zero tolerance of abuse and neglect of residents,
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Grounds / Motifs :

1. The licensee failed to protect three residents from abuse by a PSW .

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A PSW was involved with four separate incidents of alleged abuse over the course of

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An RPN and a PSW reported concerns to the Acting Administrator, regarding the care provided by the PSW, approximately two weeks before the first incident. The RPN and PSW reported general concerns with the PSW's care and services on a home area, noting that the PSW can be too loud, uses poor language with residents and may not be suited to long-term care. The Acting Administrator indicated that after these concerns were brought forward, the PSW was to be scheduled to work in other home areas; no further action was taken. The PSW continued to work on the same home area where the first three incidents occurred.

An RPN reported the first three incidents to the Acting Administrator. Upon receiving the information, the Acting Administrator indicated that the PSW would be reassigned to another home area with follow up to occur the next day. Although there is evidence to suggest that the Manager of Human Resources was made aware of the information and scheduling personnel were directed to reassign the PSW, no further action was taken and the licensee can not demonstrate that any follow up occurred for the next two days. On the third day, the PSW was involved with a subsequent incident of alleged abuse on another home area.

The licensee failed to take appropriate and immediate action when information was known of alleged abuse; the PSW was subsequently involved in additional incidents of alleged abuse.

As indicated by WN #2, staff failed to comply with the policy to promote zero tolerance of abuse and neglect of residents, specifically as it relates to immediate reporting. The policy to promote zero tolerance of abuse and neglect was last updated May 2019 and indicated the following statement "Any employee who witnesses or suspects abuse or neglect of a resident by another employee must report the incident immediately". The policy does not provide for clear direction as to whom this report is to be made and only address the abuse of an employee toward a resident.

As it relates to the protection of residents from abuse, the licensee failed to: (1) ensure that the Director was immediately informed of suspected abuse (WN #3); (2) ensure that resident SDMs were made aware of the results of the investigation (WN #4); and (3) ensure that the results of the investigation are reported to the Director

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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

(WN #7).

An order was made by taking the following factors into account: Severity: There was actual risk of harm to three residents, as appropriate and immediate action was not taken to protect residents. Scope: The scope of this non-compliance was identified as widespread as all three of the alleged incidents of abuse, involving the same PSW, failed to take appropriate and immediate action. Compliance History: In the last 36 months, the licensee has had no previous non-compliance of LTCHA section 19.

Sources: Documents of the licensee's investigation file, Critical Incident Reports and interviews with an RPN, PSWs and Acting Administrator. [s. 19. (1)] (148)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jan 28, 2022(A1)

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
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2007, chap. 8

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The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
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Director
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Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
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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:

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

**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
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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l'article 154 de la *Loi de 2007 sur les
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2007, chap. 8

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 révision
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 30th day of November, 2021 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

Amended by AMANDA NIXON (148) - (A1)

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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

Ottawa Service Area Office