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
Sep 24, 2018	2018_685648_0011	006746-18	Critical Incident System

Licensee/Titulaire de permis

Unionville Home Society
4300 Highway #7 MARKHAM ON L3R 1L8

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

Union Villa
4300 Highway #7 Unionville ON L3R 1L8

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

JOVAIRIA AWAN (648)

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): June 08, 11, 12, 13, and 14, 2018

During the course of this inspection, log #006746-18, Critical Incident Report, related to an allegation of resident to resident abuse was inspected.

During the course of the inspection, the inspector reviewed the homes video surveillance logs, investigation notes, which included staff statements, reviewed resident health care records and the home's human resources policy manual.

During the course of the inspection, the inspector(s) spoke with Personal support worker(s) (PSW), registered nurses (RN), and the Director of Nursing (DON).

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident (CI) report, on an identified date, reporting resident to resident abuse which occurred on the identified date at an identified time. A review of the CI report revealed RN#100 was alerted by PSW #101 requesting assistance with resident #001. RN #100 found resident #001 in an identified state in their room with resident #002 present. The RN#100 found resident #001 with identified injuries. Resident #001 and #002 were assessed by the home's physician, the following day, and resident #002 was then sent to the hospital.

A review of resident #001's clinical records identified they were non ambulatory, required total extensive assistance, and were cognitively impaired.

A review of resident #002's clinical records were reviewed and identified known responsive behaviours. Prior to the incident, the resident had been assessed for their identified behaviours and interventions included staff redirection, visits to other areas of the home, and to divert their attention.

A review of resident #002's behaviour monitoring documentation for an identified period of time prior to the reported incident identified a number of instances of an identified responsive behaviour documented for resident #002. Further documentation identified the behaviour was not easily altered for the documented instances.

Resident #002's written plan of care, identified responsive behaviours with interventions to manage behaviours including redirecting and listening to the resident. The plan of care for resident #002 did not identify the identified responsive behaviour related to the reported CI and did not specify interventions to routinely monitor the resident when exhibiting the identified responsive behaviour.

A review of resident #002's progress notes identified resident #002 was found in resident #001's room by PSW #101 on an identified state.

Interviews with all staff on duty at the time of the incident in the identified home area for residents #001 and #002 were conducted during this inspection.

An interview with PSW #105 indicated resident #002 had an identified responsive behaviour. PSW #105 further indicated there were no interventions in place to respond to resident #002's identified behaviour.

Interview with PSW #101 confirmed they were on duty as a PSW on the on the identified shift of the reported incident. PSW #101 stated resident #002 expressed an identified responsive behaviour throughout an identified shift and was observed in this manner prior to the incident with resident #001. PSW #101 reiterated the events of the identified shift as noted in the CI report. PSW #101 saw resident #002 in resident #001's room, and immediately alerted RN #100. PSW #101 assisted RN #100 with care to resident #001 after resident #002 was escorted back to their room. PSW #101 reported RN #100 had advised them to keep a closer eye on resident #002 for the remainder of the shift. PSW #101 stated they monitored the resident more closely for the remainder of the shift. PSW #101 reported resident #001 required total care and was unable to use the call bell prior to the incident.

RN #100 was identified to be on duty for the identified shift as the responding staff to the incident as documented above. Both an interview and a review of RN #100's written statement provided to the home included the following information:

On the identified shift of the reported incident, RN #100 received a call from PSW #101 for assistance as resident #001's was found in a specified state in the presence of resident #002. Both residents were immediately separated by PSW #101.

RN #100 assessed resident #001 and identified injuries as reviewed in the CI report. A number of injuries were identified, assessed, and documented for resident #001 by RN #100 immediately following the incident on the identified date.

Interview with RN #100 reported front line staff were directed to check resident rooms when performing routine hourly monitoring during the identified shift. RN #100 identified resident #002 was known to have identified responsive behaviours. RN #100 reported that resident #001 was found in an identified state, when discovered by them on the date of the reported incident. RN #100 reported they had advised PSW staff on the unit continue monitoring resident #002 after they had been returned to their room, more frequently for the remainder of the identified shift.

Review of the homes investigation materials included video surveillance records as provided by the DON. Video surveillance for the identified shift, was reviewed and logged by the homes DON and reviewed by the inspector. The DOC confirmed the video surveillance log had been reviewed by themselves and the nurse manager to verify the time stamps and observations logged. The video surveillance log identified resident #002 unsupervised and exhibited an identified responsive behaviour on the home area.

Interview with the DON confirmed staff were expected to routinely check residents, including inside resident rooms, to confirm their whereabouts during any shift. Front line staff interviews, review of the homes documentation, and review of the video surveillance was conducted with the DON during the inspection interview. The DON identified awareness of resident #002's identified behaviour prior to this incident, and that the plan of care did not identify this, or include interventions to manage it. The DON acknowledged resident #001 had been injured by resident #002, and the home failed to protect resident #001 from abuse by resident #002.[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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

The MOHLTC received a CI report on an identified date, identifying resident to resident abuse which occurred on an identified date between resident #001 and #002.

As per the CI report, PSW #101 heard the call bell ringing in resident #001's room. PSW

#101 responded to the call bell, and observed resident #002 in resident #001's room and alerted RN #100. Resident #001 was found in a specified state with identified injuries.

A review of resident #002's progress notes prior to the incident, for a specified period of time, identified documentation of instances of resident #002 exhibiting an identified responsive behaviour in the home area.

A review of resident #002's behaviour monitoring documentation for an identified period of time prior to the reported incident indicated a number of instances of an identified behaviour documented for resident #002. Further documentation identified the responsive behaviour was not easily altered for the documented instances.

Resident #002's written plan of care, identified responsive behaviours and included interventions to manage the identified responsive behaviours. The plan of care did not identify an identified responsive behaviour for resident #002 and did not or specify interventions to address the behaviour when exhibited by the resident.

A review of resident #002's progress notes identified resident #002 was found in resident #001's in an identified state.

Interviews with staff on duty in the identified home area for residents #001 and #002 were conducted during this inspection.

PSW #101, was identified as the responding staff to the incident and indicated resident #002 was known to them as a resident that would exhibit an identified responsive behaviour throughout the home area. PSW #101 stated they would monitor resident #002's identified responsive behaviour by an identified intervention when they exhibited the identified behaviour. PSW #101 stated resident #002 exhibited the identified responsive behaviour on the home area the date of the identified incident. Upon review of the incident as for reported to the MOHLTC, PSW #101 stated they had intervened and continued to apply an identified intervention for the remainder of the shift the remainder of the shift on the date of the reported incident. Staff interview with PSW #101 did not identify interventions to prevent resident #002 exhibiting the identified responsive behaviour on the unit.

RN #100 was identified as the charge nurse on duty in the home at the time of the identified incident. RN #100 confirmed they found resident #002 in resident #001's room during the identified shift. RN #100 identified resident #002 exhibited an identified

responsive behaviour, however did not identify interventions to address the identified behaviour.

PSW #105, reported residents known to exhibit an identified behaviour were prevented from doing so by applying an identified intervention. PSW #105 reported they were familiar with resident #002’s behaviours including the identified responsive behaviour. PSW #105 did not identify interventions to prevent resident #002 from exhibited the identified responsive behaviour and confirmed the identified intervention for this behaviour was not applied for resident #002.

RN #106, reported residents with the identified responsive behaviour required an identified intervention. RN #106 identified resident #002 was known to exhibit heightened behaviours including the identified responsive behaviour on the home area identified in the CI. RN #106 did not identify interventions to address resident #002's identified responsive behaviour.

Front line staff interviews, review of the homes documentation as noted above, including resident #002’s written plan of care in place at the time of the incident, and the written plan of care in place prior to the incident, was reviewed with the DON during the inspection interview. The DON acknowledged resident #002’s plan of care did not identify that resident #002 had been assessed for their identified responsive behaviour related to the CI, and that strategies were not developed and implemented for resident #002 prior to the time of the incident.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 24th day of September, 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) :	JOVAIRIA AWAN (648)
Inspection No. / No de l'inspection :	2018_685648_0011
Log No. / No de registre :	006746-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 24, 2018
Licensee / Titulaire de permis :	Unionville Home Society 4300 Highway #7, MARKHAM, ON, L3R-1L8
LTC Home / Foyer de SLD :	Union Villa 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Roxanne Adams

To Unionville Home Society, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19 (1) of the Act.

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by both resident #002 and any other residents with responsive behaviours that put others at risk of harm. The plan must include, but is not limited, to the following:

A description of the training and education that will occur related to the supervision and monitoring of residents with identified responsive behaviours, for all staff having contact with such residents including resident #002, the persons responsible for providing the education, and the dates this training will occur.

Please submit the written plan for achieving compliance for inspection #2018_685648_0011 to Jovairia Awan, LTC Homes Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca by October 25, 2018, to be implemented by December 25, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident (CI) report, on an identified date, reporting resident to resident abuse

which occurred on the identified date at an identified time. A review of the CI report revealed RN#100 was alerted by PSW #101 requesting assistance with resident #001. RN #100 found resident #001 in an identified state in their room with resident #002 present. The RN#100 found resident #001 with identified injuries. Resident #001 and #002 were assessed by the home's physician, the following day, and resident #002 was then sent to the hospital.

A review of resident #001's clinical records identified they were non ambulatory, required total extensive assistance, and were cognitively impaired.

A review of resident #002's clinical records were reviewed and identified known responsive behaviours. Prior to the incident, the resident had been assessed for their identified behaviours and interventions included staff redirection, visits to other areas of the home, and to divert their attention.

A review of resident #002's behaviour monitoring documentation for an identified period of time prior to the reported incident identified a number of instances of an identified responsive behaviour documented for resident #002. Further documentation identified the behaviour was not easily altered for the documented instances.

Resident #002's written plan of care, identified responsive behaviours with interventions to manage behaviours including redirecting and listening to the resident. The plan of care for resident #002 did not identify the identified responsive behaviour related to the reported CI and did not specify interventions to routinely monitor the resident when exhibiting the identified responsive behaviour.

A review of resident #002's progress notes identified resident #002 was found in resident #001's room by PSW #101 on an identified state.

Interviews with all staff on duty at the time of the incident in the identified home area for residents #001 and #002 were conducted during this inspection.

An interview with PSW #105 indicated resident #002 had an identified responsive behaviour. PSW #105 further indicated there were no interventions in place to respond to resident #002's identified behaviour.

Interview with PSW #101 confirmed they were on duty as a PSW on the on the

identified shift of the reported incident. PSW #101 stated resident #002 express an identified responsive behaviour throughout an identified shift and was observed in this manner prior to the incident with resident #001. PSW #101 reiterated the events of the identified shift as noted in the CI report. PSW #101 saw resident #002 in resident #001's room, and immediately alerted RN #100. PSW #101 assisted RN #100 with care to resident #001 after resident #002 was escorted back to their room. PSW #101 reported RN #100 had advised them to keep a closer eye on resident #002 for the remainder of the shift. PSW #101 stated they monitored the resident more closely for the remainder of the shift. PSW #101 reported resident #001 required total care and was unable to use the call bell prior to the incident.

RN #100 was identified to be on duty for the identified shift as the responding staff to the incident as documented above. Both an interview and a review of RN #100's written statement provided to the home included the following information:

On the identified shift of the reported incident, RN #100 received a call from PSW #101 for assistance as resident #001's was found in a specified state in the presence of resident #002. Both residents were immediately separated by PSW #101.

RN #100 assessed resident #001 and identified injuries as reviewed in the CI report. A number of injuries were identified, assessed, and documented for resident #001 by RN #100 immediately following the incident on the identified date.

Interview with RN #100 reported front line staff were directed to check resident rooms when performing routine hourly monitoring during the identified shift. RN #100 identified resident #002 was known to have identified responsive behaviours. RN #100 reported that resident #001 was found in an identified state, when discovered by them on the date of the reported incident. RN #100 reported they had advised PSW staff on the unit continue monitoring resident #002 after they had been returned to their room, more frequently for the remainder of the identified shift.

Review of the homes investigation materials included video surveillance records as provided by the DON. Video surveillance for the identified shift, was reviewed and logged by the homes DON and reviewed by the inspector. The DOC

confirmed the video surveillance log had been reviewed by themselves and the nurse manager to verify the time stamps and observations logged. The video surveillance log identified resident #002 unsupervised and exhibted an identified responsive behaviour on the home area.

Interview with the DON confirmed staff were expected to routinely check residents, including inside resident rooms, to confirm their whereabouts during any shift. Front line staff interviews, review of the homes documentation, and review of the video surveillance was conducted with the DON during the inspection interview. The DON identified awareness of resident #002's identified behaviour prior to this incident, and that the plan of care did not identify this, or include interventions to manage it. The DON acknowledged resident #001 had been injured by resident #002, and the home failed to protect resident #001 from abuse by resident #002.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
• Voluntary plan of correction (VPC) issued April 5, 2016 (2016_251512_0007); (648)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 2018

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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with s. 53. (4) (b) of the O.Reg. 79/10.

The licensee shall prepare, submit and implement a plan to ensure s. 53 (4) (b). The plan must include, but is not limited, to the following:

A process to ensure that an interdisciplinary approach is applied to all residents in the home,including resident #002, identified with responsive behaviours, to ensure strategies are developed, and implemented to respond to these behaviours.

Include all responsible parties, including individuals and/or departments participating in ensuring the process is in place, the disciplines which will participate, the pathways available for interdisciplinary communication, and how the process will be evaluated and reassessed for each resident, including resident #002, where applicable.

Please submit the written plan for achieving compliance for inspection #2018_685648_0011 to Jovairia Awan, LTC Homes Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca by October 25, 2018, to be implemented by December 25, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

The MOHLTC received a CI report on an identified date, identifying resident to resident abuse which occurred on an identified date between resident #001 and #002.

As per the CI report, PSW #101 heard the call bell ringing in resident #001's room. PSW #101 responded to the call bell, and observed resident #002 in resident #001's room and alerted RN #100. Resident #001 was found in a specified state with identified injuries.

A review of resident #002's progress notes prior to the incident, for a specified period of time, identified documentation of instances of resident #002 exhibiting

an identified responsive behaviour in the home area.

A review of resident #002's behaviour monitoring documentation for an identified period of time prior to the reported incident indicated a number of instances of an identified behaviour documented for resident #002. Further documentation identified the responsive behaviour was not easily altered for the documented instances.

Resident #002's written plan of care, identified responsive behaviours and included interventions to manage the identified responsive behaviours. The plan of care did not identify an identified responsive behaviour for resident #002 and did not or specify interventions to address the behaviour when exhibited by the resident.

A review of resident #002's progress notes identified resident #002 was found in resident #001's in an identified state.

Interviews with staff on duty in the identified home area for residents #001 and #002 were conducted during this inspection.

PSW #101, was identified as the responding staff to the incident and indicated resident #002 was known to them as a resident that would exhibit an identified responsive behaviour throughout the home area. PSW #101 stated they would monitor resident #002's identified responsive behaviour by an identified intervention when they exhibited the identified behaviour. PSW #101 stated resident #002 exhibited the identified responsive behaviour on the home area the date of the identified incident. Upon review of the incident as for reported to the MOHLTC, PSW #101 stated they had intervened and continued to apply an identified intervention for the remainder of the shift the remainder of the shift on the date of the reported incident. Staff interview with PSW #101 did not identify interventions to prevent resident #002 exhibiting the identified responsive behaviour on the unit.

RN #100 was identified as the charge nurse on duty in the home at the time of the identified incident. RN #100 confirmed they found resident #002 in resident #001's room during the identified shift. RN #100 identified resident #002 exhibited an identified responsive behaviour, however did not identify interventions to address the identified behaviour.

PSW #105, reported residents known to exhibit an identified behaviour were prevented from doing so by applying an identified intervention. PSW #105 reported they were familiar with resident #002's behaviours including the identified responsive behaviour. PSW #105 did not identify interventions to prevent resident #002 from exhibited the identified responsive behaviour and confirmed the identified intervention for this behaviour was not applied for resident #002.

RN #106, reported residents with the identified responsive behaviour required an identified intervention. RN #106 identified resident #002 was known to exhibit heightened behaviours including the identified responsive behaviour on the home area identified in the CI. RN #106 did not identify interventions to address resident #002's identified responsive behaviour.

Front line staff interviews, review of the homes documentation as noted above, including resident #002's written plan of care in place at the time of the incident, and the written plan of care in place prior to the incident, was reviewed with the DON during the inspection interview. The DON acknowledged resident #002's plan of care did not identify that resident #002 had been assessed for their identified responsive behaviour related to the CI, and that strategies were not developed and implemented for resident #002 prior to the time of the incident.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1. The home had a level 2 history of non compliance.
(648)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 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 24th day of September, 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 : Jovairia Awan

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