Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
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130, avenue Dufferin 4ème étage
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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
Jun 30, 2021	2021_605213_0016 (A1)	003819-21, 004742-21, 008664-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Glendale Crossing
3030 Singleton Avenue London ON N6L 0B6

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This licensee inspection report has been revised to reflect a change to a due date within compliance order #001 and a change to the compliance due date for compliance order #002. The Critical Incident System inspection #2021_605213_0016 was completed June 8 to 16, 2021. A copy of the revised report is attached.

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

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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Jun 30, 2021	2021_605213_0016 (A1)	003819-21, 004742-21, 008664-21	Critical Incident System

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The Village of Glendale Crossing
3030 Singleton Avenue London ON N6L 0B6

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended 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 8, 9, 10, 11, 14, 15, 16, 2021.

The following intakes were completed during this critical incident inspection:

Log #003819-21, a critical incident report related to alleged resident to resident abuse

Log #004742-21, a critical incident report related to alleged resident to resident abuse

Log #008664-21, a critical incident report related to a fall

Inspector Loma Puckerin (#705241) was also present during this inspection.

This inspection was completed concurrently while in the home also completing follow-up inspection #2021_886630_0022 related to catheter care.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Acting Director of Nursing, the Director of Recreation, the Director of Environmental Services, the Assistant Director of Care, a Neighbourhood Coordinator, two Pharmacists, Registered Nurses, Registered Practical Nurses, the Resident Assessment Instrument Coordinator, the Personal Expressions Resource Team/Responsive Behaviours Team Lead, a Kinesiologist, the Social Services Worker, Registered Practical Nurses, Personal Support Workers, a Housekeeper, residents and family members.

The inspectors also made observations and reviewed health records, policies and procedures, internal investigation records, and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 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 protect resident #002, #006 and #013 from abuse by resident #001.

The home reported eight Critical Incident System (CIS) reports involving resident #001 abuse toward other residents over a three year period of time including toward resident #002 and resident #006.

There were four different incident reports of resident #001 abuse toward resident #014, #006, #013 and #002, documented in Point Click Care (PCC) over a nine month period of time. The incident reports all stated at the top of the form "Incident Report. To be completed by the registered team leader when an incident occurs involving a resident/visitor/team member. REPORT TO YOUR LEADERSHIP TEAM AND CHARGE NURSE AS SOON AS AN INCIDENT OCCURS". There were no dates or indications if the Director of Nursing, the General Manager or the charge nurse were notified that the incidents occurred. The reports all indicated that a physician was notified when the incident occurred.

Three residents were abused by resident #001 after the home was aware that there was a risk of resident #001 abusing residents as there had been multiple incidents dating back over a three year period of time. Residents continued to be afraid of resident #001 and did not feel safe in the home.

Sources: Two CIS reports, incident reports in PCC, health records including progress notes, assessments and care plans for seven residents, interviews with the General Manager, the Acting Director of Nursing, the Personal Expressions Resource Team Lead, the Social Services Worker and four PSWs, interviews with residents, and observations of residents. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the New Orders Policy as part of the Medication Management System was implemented.

O. Reg 79/10 s. 114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

O. Reg 79/10 s. 114 (3) (a) requires that the written polices and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Specifically, staff did not fully implement or comply with the pharmacy CareRx New Orders policy #5.1 with a revised date of August 15, 2018.

Sources: A critical incident report, health records for a resident, observations of a resident, interviews with a Registered Nurse, the acting Director of Nursing, the Consultant Pharmacist and Pharmacist. [s. 114. (3) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by another resident had occurred, they immediately reported the suspicion and the information upon which it was based to the Director.

The home reported a Critical Incident System (CIS) report, regarding abuse of resident #002 by resident #001. In reviewing the progress notes for resident #001, as well as incident reports documented in Point Click Care (PCC), an incident occurred four months earlier, whereby resident #001 was observed abusing resident #013. The report indicated that the Medical Director was notified when the incident occurred. The incident report also stated at the top of the form "Incident Report. To be completed by the registered team leader when an incident occurs involving a resident/visitor/team member. REPORT TO YOUR LEADERSHIP TEAM AND CHARGE NURSE AS SOON AS AN INCIDENT OCCURS". There was no date or indication if the Director of Nursing, the General Manager or the charge nurse were notified that the incident occurred.

The General Manager said that they were unaware that the incident of abuse and were not sure why it was not reported.

Sources: A critical incident report, an incident report in PCC, progress notes and assessments for two residents, interview with the General Manager. [s. 24. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone occurs, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of an investigation of suspected resident to resident abuse.

The home reported a Critical Incident System (CIS) report to the Director, indicating that a resident reported to the home that another resident hit them resulting in pain the day before. The CIS was not amended after the original submission with the results of the investigation including the condition of the resident, or whether the alleged incident of resident to resident abuse was determined to be founded or unfounded.

The Director was unaware of the severity of the incident when the report regarding resident to resident physical abuse was not amended with the results and outcome.

Sources: A Critical Incident System (CIS) report, health records for two residents, interviews with the ADON and the GM. [s. 23. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that plan of care for a resident was based on an interdisciplinary assessment of the physical functioning and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming; specifically bathing.

A family member of a resident shared that the resident's preference for bathing was a tub bath, but they only received showers. The plan of care for resident stated: Bathing - Type = shower.

A Resident was not receiving bathing assistance in the method of their choice and their plan of care was not based on an interdisciplinary assessment related to bathing equipment, it was based on a concern from nursing staff related to safety.

Sources: Health records for a resident, observations of a resident, interviews with a PSW, a Kinesiologist, a Neighbourhood Coordinator and a family member. [s. 26. (3) 7.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Inspectors observed a partial bottle of liquid Becto Daily Disinfectant on the counter of an unlocked resident laundry room. This was brought to the attention of a staff member who removed the product and said it was a potentially hazardous substance to residents. The Material Safety Data Sheet (MSDS) for this product showed it was a "corrosive poison." The Director of Environmental Services (DES) said this disinfectant was to be kept locked in the housekeepers carts in the housekeepers room as it was a hazardous material. The DES said they were not sure why the product was in that room as staff were aware that the expectation in the home was to not leave this cleaning product in an unlocked common area.

Sources: Observations, the MSDS for Betco Daily Disinfectant Dual; interviews with the DES and other staff. [s. 91.]

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

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RHONDA KUKOLY (213) - (A1)
Inspection No. / No de l'inspection :	2021_605213_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003819-21, 004742-21, 008664-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 30, 2021(A1)
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Glendale Crossing 3030 Singleton Avenue, London, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Awde

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Schlegel Villages Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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 :

(A1)
The licensee must comply with s. 19 (1) of the LTCHA.
Specifically, the licensee must:
1. Complete an interdisciplinary assessment of resident #001 by July 7, 2021, to determine appropriate triggers, strategies and interventions, resident monitoring and documentation required to prevent resident #001 from sexually abusing other residents. The assessment must also include if one to one staffing/monitoring is required in order to prevent resident #001 from sexually abusing other residents.
2. Review and revise resident #001's plan of care to include the strategies and interventions to prevent sexual abuse of other residents as identified in the interdisciplinary assessment, by July 7, 2021.
3. Immediately implement any and all strategies and interventions, resident monitoring and documentation identified in the resident #001's revised plan of care.
4. Further review resident #001's plan of care on a weekly basis and revise as required, for a three month period of time to ensure that other residents are protected from sexual abuse from resident #001.
5. Keep a record of all assessments completed and plan of care reviews and revisions, including the dates completed, who participated, outcomes of the review and discussion, and changes made.

Grounds / Motifs :

1. The licensee has failed to protect resident #002, #006 and #013 from abuse by resident #001.

The home reported eight Critical Incident System (CIS) reports involving resident #001 abuse toward other residents over a three year period of time including toward resident #002 and resident #006.

There were four different incident reports of resident #001 abuse toward resident #014, #006, #013 and #002, documented in Point Click Care (PCC) over a nine month period of time. The incident reports all stated at the top of the form "Incident Report. To be completed by the registered team leader when an incident occurs involving a resident/visitor/team member. REPORT TO YOUR LEADERSHIP TEAM AND CHARGE NURSE AS SOON AS AN INCIDENT OCCURS". There were no dates or indications if the Director of Nursing, the General Manager or the charge nurse were notified that the incidents occurred. The reports all indicated that a physician was notified when the incident occurred.

Three residents were abused by resident #001 after the home was aware that there was a risk of resident #001 abusing residents as there had been multiple incidents dating back over a three year period of time. Residents continued to be afraid of resident #001 and did not feel safe in the home.

Sources: Two CIS reports, incident reports in PCC, health records including progress notes, assessments and care plans for seven residents, interviews with the General Manager, the Acting Director of Nursing, the Personal Expressions Resource Team Lead, the Social Services Worker and four PSWs, interviews with residents, and observations of residents.

An order was made by taking the following factors into account:
Severity: There was minimal harm related to the sexual abuse of residents #002 and #006; however, the residents were still afraid of resident #001 and did not feel safe. There was also risk of sexual abuse occurring again as interventions were not effective in preventing resident #001 from sexually abusing other residents. The severity is determined to be a level 2, minimal harm and minimal risk.
Scope: 3 out of 3 residents were sexually abused after the home was aware that the risk of resident #001 sexually abusing other residents was present. The scope is determined to be a level 3, widespread.
Compliance history: The home has a history of non-compliance related to this subsection of the legislation. A compliance order was issued September 6, 2019

2020, in inspection #2019_778563_0030 and was complied October 17, 2019. A compliance order was also issued August 1, 2018, in inspection #2018_605563_0013 and was complied January 14, 2019. The compliance history is determined to be a level 3, previous non-compliance to the same subsection. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2021

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: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must comply with s. 114 (3)(a) of O. Reg. 79/10.
Specifically, the licensee must:
1. Review and revise if necessary, the home's policy related to processing orders and indications for use of medications. This review must be interdisciplinary, including a minimum of the Pharmacist, the Medical Director and the Director of Nursing.
2. If revisions are made to the policy, provide training to all relevant staff, including but not limited to, all registered nursing staff, physician's writing orders in the home and pharmacists processing orders in the home. A record of such training must be kept to include the training provided and date completed, to ensure that all applicable staff have completed the training.
3. Complete a review of residents #001,#009 and #010's medication orders, to ensure that they are compliant with the home's policy related to processing orders and indications for use of medications.

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

Grounds / Motifs :

1. The licensee has failed to ensure the New Orders Policy as part of the Medication Management System was implemented.

O. Reg 79/10 s. 114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

O. Reg 79/10 s. 114 (3) (a) requires that the written polices and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Specifically, staff did not fully implement or comply with the pharmacy CareRx New Orders policy #5.1 with a revised date of August 15, 2018.

Sources: A critical incident report, health records for a resident, observations of a resident, interviews with a Registered Nurse, the acting Director of Nursing, the Consultant Pharmacist and Pharmacist.

An order was made by taking the following factors into account:
Severity: There was no negative outcome related to the indications for use not being included in medication orders. There was risk of harm with registered nursing staff not being able to complete the eight rights of medication administration. The severity is determined to be a level 2, minimal risk.
Scope: 3 out of 3 residents' medication orders were reviewed. 3 out of 3 residents did not have indications for use for several regular scheduled medications. 2 out of 3 residents did not have indications for use for one or more PRN (use as needed) medications. The scope is determined to be a level 3, widespread.
Compliance history: The home has a history of non-compliance related to this subsection of the legislation and the medication management system. A compliance order was issued November 17, 2020, in inspection #2020_722630_0029 and was complied March 8, 2021. The compliance history is determined to be a level 3, previous non-compliance to the same subsection. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Order(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
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:

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
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.

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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 revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

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

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by RHONDA KUKOLY (213) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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