Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2019	2019_689586_0008 (A1)	002470-19, 009941-19, 010902-19, 010903-19, 010999-19, 011001-19, 011059-19, 011496-19	Critical Incident System

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

Amended by JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Correction to compliance plan due date.

Issued on this 30th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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500 Queensway West SIMCOE ON N3Y 4R4

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

Amended by JESSICA PALADINO (586) - (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): April 23, 24, 25, 26, May 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, 30, 31, June 5, 6, 10 and 11, 2019.

The following Critical Incident System (CIS) Inspections were completed concurrently:

009941-19 - Prevention of Abuse & Neglect;

010902-19 - Prevention of Abuse & Neglect

010903-19 - Prevention of Abuse & Neglect;

010999-1 - Prevention of Abuse & Neglect;

011001-19 - Prevention of Abuse & Neglect;

011059-19 - Prevention of Abuse & Neglect; and,

011496-19 - Prevention of Abuse & Neglect.

The following Follow-Up Inspection was completed concurrently:

002470-19 - Prevention of Abuse & Neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager (NM), Quality Improvement Coordinator (QIC), Resident Assessment Instrument (RAI) Coordinators, Attending Physician, Programs Manager, Behavioural Support Ontario (BSO), Administrative Assistant, Physiotherapist (PT), maintenance staff, restorative staff, dietary staff, ward clerks, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) toured the home, completed observations of the provision of care, medication administration, dining and snack services, resident programs and the homes environment. Inspector(s) reviewed resident clinical records including resident plans of care, policies and procedures, internal investigation notes, quality and improvement systems, staff training records and the staffing mix and payroll records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **1 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 :

The licensee has failed to ensure that resident #020 was protected from abuse.

For the purpose of the definition of 'abuse' in subsection 2 (1) (c) of the Act, 'physical abuse' means, the use of physical force by a resident that causes physical injury to another resident.

A) On an identified date in 2019, PSW #014 was assisting resident #020 during morning care. Resident #020 began showing known resistiveness to care. Resident #019, who was resident #020's roommate and who was in the room at the time, observed the interaction between resident #020 and the PSW and aggressively approached resident #020, and an altercation ensued between the two residents, resulting in injury to resident #020.

A review of resident #020's clinical record identified that the resident had known physical behaviours and in an interview with PSW #014, who worked full time on the resident's home area, there were known triggers between the roommates.

In an interview with the DOC, it was confirmed that the home did not protect resident #020 from physical abuse by resident #019. (583).

B) The licensee has failed to ensure that residents were protected from abuse by resident #015.

Inspection Report #2018_756583_0014, dated December 14, 2018, included compliance order (CO) #006, with a compliance due date of February 1, 2019, outlining resident #015's altercations with co-residents due to physically responsive behaviours.

Resident #015's current plan of care identified that they exhibited physically responsive behaviours toward other residents.

According to resident #015's progress notes, the resident was involved in 21 incidents of aggression toward co-residents, who were not protected from physical abuse by resident #015.

C) The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On December 14, 2018, the following CO #006 from Inspection Report #2018_756583_0014 made under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1), was issued:

1. Ensure that resident #004, resident #027, resident #038, resident #052 and any other residents are not physically abused by co-residents.

2. Develop a protocol/procedure for the observation and assessment of residents who demonstrate responsive behaviours that could potentially trigger altercations between residents.
3. Implement the above noted protocol/procedure for resident #006, resident #041 and any other resident who demonstrates responsive behaviours.
4. Ensure resident #006, resident #041 and any other resident's plans of care are updated in accordance with the above noted assessment, to include care interventions to reduce the risk of altercations between residents.

The compliance due date was February 1, 2019.

Resident #004, #027, #038 and #052's clinical records were reviewed and met the requirement for CO #006 part 1.

In June 2019, a newly revised policy named "III Nursing General, Responsive Behaviours NDM-III-225", was reviewed and met the requirement for CO #006 part 2.

After reviews of resident #006's and #041's clinical records, through interview with RPN #004, who was the lead for the responsive behaviour program, and through interview with front line staff, it was identified the home did not implement a protocol or procedure for resident #006 or #041. In an interview with the DOC it was confirmed that the home's responsive behaviour policy that had been revised was not fully implemented at the time of the inspection. The home failed to complete part 3 and 4 of CO #006. [s. 19.]

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: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of potentially harmful interactions between resident #019 and other residents including, a) failing to identify factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observations, that could potentially trigger such altercations, and b) failing to identify and implement interventions.

On an identified date in 2019, a complex care meeting was held for resident #019 to discuss their responsive behaviours with an interdisciplinary team made up of individuals from specialized external resources, including the Psychogeriatric Resource Consultant, in combination with a few staff from the home. It was documented in the plan of care that several recommendations were made. It was noted that the team identified resident #019 was becoming increasingly responsive and recommendations were made and provided a significant number of approaches to care that staff could utilize.

The following month, a referral was made to another external resource, and specific monitor was initiated for the resident. Otherwise, the remainder of the recommendations (greater than 20) made by the interdisciplinary teams through assessments were not considered or implemented.

A) On an identified date in 2019, it was documented that resident #033 made a complaint to staff about resident #019. Later that same day, it was documented

that resident #033 and resident #019 had an altercation before staff could intervene.

B) On an identified date in 2019, it was documented that when resident #017 went back to their own room, resident #019 was there and an altercation ensued.

In a progress note documented prior to the incident, resident #017's SDM made a complaint to staff about resident #019. It was documented in the progress notes that RPN #023 told resident #017's SDM that they would mitigate and manage this issue.

In interviews with staff if was identified that resident #019 was known to have an identified behaviour that could be triggered.

Resident #019's clinical records were reviewed, and no interdisciplinary assessment could be found to show the home considered factors that were known to exist between resident #019 and #017 and #033 that had the potential to trigger physically responsive behaviours. Resident #019's plan of care did not identify that they had identified behaviours that could be triggered. In an interview with Administrator and DOC, it was confirmed that the home failed to identify this trigger in the plan of care and did not identify or implement any interventions to minimize the risk of potentially harmful interactions between resident #017 and #033.

In an interview with the Administrator and DOC it was identified the home did not have a process as to how recommendations made from specialized resources were reviewed and how it was determined what was implemented into a resident's plan of care and who was responsible. It was confirmed the home failed to co-ordinate assessments and implement techniques and interventions to respond to resident #019's responsive behaviours using an interdisciplinary approach.

The licensee's policy, 'Responsive Behaviours' was reviewed. The home's policy identified specific interventions that would be implemented/trialed and evaluated for effectiveness and implemented in the individuals plan of care when a resident had an "occurrence of an episode of responsive behaviour". It was confirmed the home failed to implement their responsive behaviour policy in relation to resident #019's management of responsive behaviours.

The home failed to ensure steps were taken to minimize the risk of altercations and potential harmful interactions between resident #019 and other residents in the home. [s. 54.]

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 steps were taken to minimize the risk fo portntially harmful interactions between residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

In an interview with the DOC during inspection it was confirmed that a program evaluation for the 2018 Abuse and Neglect Program ('Abuse and Neglect Policy' (ADM-II-245, last revised December 16, 2018) in the home was not completed. [s. 99. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's policy to promote zero tolerance of abuse and neglect of residents was complied with, according to s. 20 (2) (d) regarding mandatory reporting.

The licensee's policy, 'Abuse and Neglect Policy' (ADM-II-245, last revised December 16, 2018) directed all staff to immediately report any witnessed or alleged incident of abuse or neglect to their supervisor in the home on duty at the time of the incident.

According to CIS 2768-000011-19, log #009941-19, on an identified date in 2019, when PSW's #030 and #031 were completing their rounds, PSW #031 physically abused residents #009 and #010. According to interview with PSW #030 and the home's internal investigation notes, they did not report this incident to the Charge RN the following day. PSW #030 confirmed that they did not immediately report the incident of abuse. This was also confirmed by the DOC. [s. 20. (1)]

Issued on this 30th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA PALADINO (586) - (A1)
Inspection No. / No de l'inspection :	2019_689586_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002470-19, 009941-19, 010902-19, 010903-19, 010999-19, 011001-19, 011059-19, 011496-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 30, 2019(A1)
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Cedarwood Village 500 Queensway West, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marci Hutchinson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Maplewood Nursing Home Limited, 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 # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_756583_0014, CO #006;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

(A1)
The licensee failed to comply with the following compliance order CO #001 from inspection #2018_756583_0014 served on December 14, 2018, with a compliance date of February 1, 2019.

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

The licensee shall prepare, submit and implement a written plan to ensure that all residents are protected from abuse by co-residents #015 and #019.

Please submit the written plan for achieving compliance for 2019_689586_0008 to Jessica Paladino, LTCH Inspector, MOHLTC, by email by August 1, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #020 was protected from abuse.

For the purpose of the definition of 'abuse' in subsection 2 (1) (c) of the Act, 'physical abuse' means, the use of physical force by a resident that causes physical injury to another resident.

A) On an identified date in 2019, PSW #014 was assisting resident #020 during morning care. Resident #020 began showing known resistiveness to care. Resident #019, who was resident #020's roommate and who was in the room at the time,

observed the interaction between resident #020 and the PSW and aggressively approached resident #020, and an altercation ensued between the two residents, resulting in injury to resident #020.

A review of resident #020's clinical record identified that the resident had known physical behaviours and in an interview with PSW #014, who worked full time on the resident's home area, there were known triggers between the roommates.

In an interview with the DOC, it was confirmed that the home did not protect resident #020 from physical abuse by resident #019. (583).

B) The licensee has failed to ensure that residents were protected from abuse by resident #015.

Inspection Report #2018_756583_0014, dated December 14, 2018, included compliance order (CO) #006, with a compliance due date of February 1, 2019, outlining resident #015's altercations with co-residents due to physically responsive behaviours.

Resident #015's current plan of care identified that they exhibited physically responsive behaviours and indicated that they were a risk toward other residents.

According to resident #015's progress notes, from February 1 to June 6, 2019, the resident was involved in 21 incidents of aggression toward co-residents, who were not protected from physical abuse by resident #015.

C) The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On December 14, 2018, the following CO #006 from Inspection Report #2018_756583_0014 made under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1), was issued:

1. Ensure that resident #004, resident #027, resident #038, resident #052 and any other residents are not physically abused by co-residents.
2. Develop a protocol/procedure for the observation and assessment of residents

who demonstrate responsive behaviours that could potentially trigger altercations between residents.
3. Implement the above noted protocol/procedure for resident #006, resident #041 and any other resident who demonstrates responsive behaviours.
4. Ensure resident #006, resident #041 and any other resident's plans of care are updated in accordance with the above noted assessment, to include care interventions to reduce the risk of altercations between residents.

The compliance due date was February 1, 2019.

Resident #004, #027, #038 and #052's clinical records were reviewed and met the requirement for CO #006 part 1.

In June 2019, a newly revised policy named "III Nursing General, Responsive Behaviours NDM-III-225", was reviewed and met the requirement for CO #006 part 2.

After reviews of resident #006's and #041's clinical records, through interview with RPN #004, who was the lead for the responsive behaviour program, and through interview with front line staff, it was identified the home did not implement a protocol or procedure for resident #006 or #041. In an interview with the DOC it was confirmed that the home's responsive behaviour policy that had been revised was not fully implemented at the time of the inspection. The home failed to complete part 3 and 4 of CO #006.

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 2 as it related to four of eight residents reviewed. The home had a level 3 compliance history of one or more related non-compliance in the last 36 months that included:
-CO issued December 14, 2018 (2018_756583_0014);
-CO issued February 23, 2016 (2015_188168_0031), complied on February 23, 2017; and,
-Directors Referral (DR) issued February 23, 2017 (2011_573581_0002), complied on June 28, 2017. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 23, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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 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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 30th day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JESSICA PALADINO (586) - (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

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