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

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Public Copy/Copie 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
Oct 13, 2021	2021_872218_0018	014262-21, 014263-21	Critical Incident System

Licensee/Titulaire de permis

Eden House Care Facility Inc.
c/o Ontario Inc. 295 Adelaide Street West, Suite 4007 Toronto ON M5V 0L4

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

Eden House Nursing Home
5016 Wellington County Road 29, R.R. #2 Guelph ON N1H 6H8

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

APRIL RACPAN (218)

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): September 17, 20-23, 27-29, 2021.

The following intakes were completed in this inspection:

-Log #014262-21/Critical Incident System (CIS) Report related to alleged sexual abuse; and
-Log #014263-21/CIS Report related to improper care

Complaint Inspection #2021_872218_0019 was completed concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC)/Infection Prevention and Control (IPAC) Lead, the Behavioural Supports of Ontario (BSO) Lead, Registered staff, a Public Health Inspector, Police authorities, Personal Support Workers (PSWs), and students.

During the course of the inspection, the inspector(s) conducted a tour of the resident home areas (RHAs), observed IPAC practices, resident care provision, resident/staff interactions, and completed resident and staff interviews. The inspector also reviewed clinical health records, posting of required information, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when staff had reasonable grounds to suspect that abuse or improper care of a resident had occurred, that they immediately reported the suspicion to the Director in accordance with s. 24 (1) 2 of the Long-Term Care Homes Act (LTCHA). Pursuant to s. 152 (2), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

On two separate occasions, there was an alleged incident of staff to resident sexual abuse and an alleged incident of improper care towards a resident.

When the Registered Nursing staff became aware of the incidents, they did not inform the management immediately. The management of the home was notified several days following the incidents.

The accused staff member involved in the incidents continued to work at the home for six additional shifts until the home began their investigation and notified the police authorities.

During the inspection, two additional alleged incidents of abuse were identified. The RNs became aware of the incidents on the same days they occurred but were not reported to the Director. A RN said that it was not their responsibility to immediately report any incidents to the Director, and that management staff were responsible for this task. The

RN felt that incidents of abuse and neglect were not something they would report to management depending on the severity and number of occurrences of the incident.

The DOC said that mandatory reporting expectations required staff to immediately report any alleged, suspected or witnessed incidents of abuse or improper care to the RN or management team. During irregular business hours, RNs were responsible for notifying the Director by calling the After Hours hotline.

The home's Abuse and Neglect Prevention program, specific to subsection 2.1 on Mandatory Reporting, emphasized that all staff were required to report any of the matters noted in s. 24 (1) to their supervisor, the Charge Nurse, DOC or Administrator. The policy did not provide staff clear directions on the registered nurses' roles for reporting.

By not reporting the alleged incidents of abuse and improper care immediately to the Director, actions were delayed in response to the incidents, which placed residents at actual risk of harm.

Sources: Abuse and Neglect Prevention Program Subsection 2.1, last reviewed March 2020, CIS Reports, LTCH's investigation records, staff attendance records, multiple interviews with RNs, DOC, and other staff. [s. 24. (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 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 failed to ensure that resident #001 was protected from sexual abuse by a staff member.

For the purpose of this Act and Regulation, “sexual abuse” means any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or by a person other than a licensee or staff member.

A staff member was involved in an alleged incident of sexual abuse towards resident #001, related to the use of a specific electronic device.

The home’s policy on the use of email, internet, and network connections instructed staff that specific electronic devices were not permitted on the unit during work hours. The staff member said they were aware of the home's expectation and policy. The staff member acknowledged that they had an electronic device in their pocket on the day of the incident.

The home did not begin their internal investigation until several days following the incident and the staff member continued to work at the home for six additional shifts.

A police investigation was completed following which the staff member was charged related to the incident. The staff member was removed from employment shortly after.

The home not ensuring that resident #001 was protected from sexual abuse by a staff member placed the resident at risk of harm.

Sources: CIS Report, LTCH’s investigation records, Use of Email, Internet, Network and Information Systems Policy (no date specified), staff member's attendance records, multiple interviews with staff, police enforcement, and others. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 was treated with courtesy, respect and in a way that promoted and respected their dignity.

Following a bath, resident #002 was wrapped in towels because the staff forgot to bring the resident's change of clothes to the tub room. The resident was portered from the tub room to their bedroom, located on the other side of the hallway, wrapped in just towels.

One of the staff members acknowledged that it was inappropriate practice to porter residents in the hallway without being properly clothed, but felt that it was not a big deal at the time.

The staff members were issued disciplinary actions.

Sources: room observations, CIS Report, Point Click Care (PCC) Assessments, LTCH investigation records and disciplinary forms, interviews with staff. [s. 3. (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 resident #002 is treated with courtesy, respect and in a way that promoted and respected their dignity, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care specified in the plan was provided to resident #002 with respect to their responsive behaviours during care.

Resident #002's plan of care specified that if they demonstrated responsive behaviours with certain aspects of care, staff were to utilize the "Stop-and-Go Approach". The BSO Lead said that this intervention was highly effective for resident #002 whenever they demonstrated any type of responsive behaviour.

Resident #002 demonstrated responsive behaviours during care. Instead of using the stop-and-go approach, a specific personal equipment was used on resident #002 so that if they demonstrated behaviours, it would not impact the staff. One of the staff said they did not review resident #002's plan of care and thought the specific equipment was an appropriate and effective intervention for resident #002 when they demonstrated responsive behaviours.

By not ensuring that resident #002's care was provided as specified in their plan with respect to their responsive behaviours, it put them at risk for demonstrating escalating responsive behaviours.

Sources: Resident #002's plan of care, LTCH's investigation records and disciplinary forms, interviews with staff, and the BSO Lead. [s. 6. (7)]

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 the care specified in the plan is provided to resident #002, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to implement a hand hygiene program in accordance with evidence-based practices.

Public Health Ontario (PHO) best practice guidelines states that hand hygiene is required for residents before and after meals with the use of an alcohol-based hand-rub (ABHR) as the preferred method of hand hygiene.

The home’s hand hygiene program did not include hand hygiene procedures for residents post meal services. The home's policy stated that a moistened towelette may be used if visibly soiled, followed by the use of an ABHR.

During a lunch dining service, multiple residents were not encouraged, reminded or assisted with performing hand hygiene after they had finished eating. Some of the residents were being assisted with wiping their hands and faces with moistened towelettes without the use of ABHR.

On another occasion following a lunch dining service, three out of six remaining residents in the dining room were not provided with assistance in performing hand hygiene after they had finished eating. One of the residents was assisted with a moistened towelette to clean their face and hands, without the use of ABHR.

A resident shared that staff did not remind, encourage, or offer them with assistance on hand hygiene before and after eating their meals.

A staff member said that they used moistened towelettes to assist resident’s with hand hygiene in replacement of the use of ABHRs.

The moistened towelettes that were being used had no alcohol concentration in them. It was not the Public Health's recommendation to use moistened towelettes as the primary method of performing hand hygiene.

The IPAC Lead said that the use of moistened towelettes alone was the home's historical practice and acknowledged that their policy did not include guidance on performing hand hygiene post meal services. The IPAC Lead said that their program would be updated in the near future to reflect best practices.

Failure to implement a hand hygiene program that is consistent with best practices placed staff and residents at potential risk of disease transmission.

Sources: multiple observations, PHO: Just Clean Your Hands Long Term Care Home Implementation Guide, PHO Best Practices for Hand Hygiene in All Health Care Settings (April 2014), the home's hand hygiene policy, interviews with a resident, the IPAC Lead, PH Inspector, and other staff. [s. 229. (9)]

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 the home implements a hand hygiene program that is in accordance with evidenced-based practices, to be implemented voluntarily.

Issued on this 20th day of October, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	APRIL RACPAN (218)
Inspection No. / No de l'inspection :	2021_872218_0018
Log No. / No de registre :	014262-21, 014263-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 13, 2021
Licensee / Titulaire de permis :	Eden House Care Facility Inc. c/o Ontario Inc., 295 Adelaide Street West, Suite 4007, Toronto, ON, M5V-0L4
LTC Home / Foyer de SLD :	Eden House Nursing Home 5016 Wellington County Road 29, R.R. #2, Guelph, ON, N1H-6H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Holisek

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 Eden House Care Facility 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

Ordre(s) de l'inspecteur

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

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. 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 or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically, the licensee must:

1) Ensure that any staff who has reasonable grounds to suspect that abuse or improper care of a resident, is immediately reported to the Director.

2) Review and update the home's Mandatory Reporting policy to include clear directions for all staff on their roles for reporting. A written record of the person (s) who reviewed and updated the policy and the date(s) it was completed must be kept.

3) Ensure that all staff receive re-education on the home's updated Mandatory Reporting policy. A written record of this education must be kept and include: the name(s) of the individuals who attended the training, the name(s) of the person (s) who provided the training, the date(s) and content of the training provided, and any other actions taken.

Grounds / Motifs :

1. The licensee failed to ensure that when staff had reasonable grounds to

suspect that abuse or improper care of a resident had occurred, that they immediately reported the suspicion to the Director in accordance with s. 24 (1) 2 of the Long-Term Care Homes Act (LTCHA). Pursuant to s. 152 (2), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

On two separate occasions, there was an alleged incident of staff to resident sexual abuse and an alleged incident of improper care towards a resident.

When the Registered Nursing staff became aware of the incidents, they did not inform the management immediately. The management of the home was notified several days following the incidents.

The accused staff member involved in the incidents continued to work at the home for six additional shifts until the home began their investigation and notified the police authorities.

During the inspection, two additional alleged incidents of abuse were identified. The RNs became aware of the incidents on the same days they occurred but were not reported to the Director. A RN said that it was not their responsibility to immediately report any incidents to the Director, and that management staff were responsible for this task. The RN felt that incidents of abuse and neglect were not something they would report to management depending on the severity and number of occurrences of the incident.

The DOC said that mandatory reporting expectations required staff to immediately report any alleged, suspected or witnessed incidents of abuse or improper care to the RN or management team. During irregular business hours, RNs were responsible for notifying the Director by calling the After Hours hotline.

The home's Abuse and Neglect Prevention program, specific to subsection 2.1 on Mandatory Reporting, emphasized that all staff were required to report any of the matters noted in s. 24 (1) to their supervisor, the Charge Nurse, DOC or Administrator. The policy did not provide staff clear directions on the registered nurses' roles for reporting.

By not reporting the alleged incidents of abuse and improper care immediately to

the Director, actions were delayed in response to the incidents, which placed residents at actual risk of harm.

Sources: Abuse and Neglect Prevention Program Subsection 2.1, last reviewed March 2020, CIS Reports, LTCH's investigation records, staff attendance records, multiple interviews with RNs, DOC, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to residents when the licensee failed to immediately report the allegations of abuse and improper care to the Director.

Scope: This non-compliance was widespread because the licensee did not immediately report four out of four alleged incidents to the Director.

Compliance History: In the last 36 months, the licensee was found to be in non-compliance with s. 24(1) of the LTCHA and two Voluntary Plans of Correction (VPC) and two Written Notifications (WN) were issued to the home. (218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 11, 2021

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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1) Ensure that residents are protected from abuse by staff.

2) Ensure that all staff are re-educated on the home's expectations related to the use of electronic devices and on the home's policy related to the use of email, internet, and network connections.

3) Ensure that all staff are re-education on the home's abuse and neglect program.

4) A documented record of the education is kept and include: the names of the individuals who attended the training, the name(s) of the person(s) who provided the training, the date(s) and content of the training provided, and any other actions taken.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was protected from sexual abuse by a staff member.

For the purpose of this Act and Regulation, "sexual abuse" means any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or by a person other than a licensee or staff member.

A staff member was involved in an alleged incident of sexual abuse towards resident #001, related to the use of a specific electronic device.

The home's policy on the use of email, internet, and network connections instructed staff that specific electronic devices were not permitted on the unit during work hours. The staff member said they were aware of the home's expectation and policy. The staff member acknowledged that they had an electronic device in their pocket on the day of the incident.

The home did not begin their internal investigation until several days following the incident and the staff member continued to work at the home for six additional shifts.

A police investigation was completed following which the staff member was charged related to the incident. The staff member was removed from employment shortly after.

The home not ensuring that resident #001 was protected from sexual abuse by a staff member placed the resident at risk of harm.

Sources: CIS Report, LTCH's investigation records, Use of Email, Internet, Network and Information Systems Policy (no date specified), staff member's attendance records, multiple interviews with staff, police enforcement, and others.

An order was made by taking the following factors into account:

Severity: The licensee not ensuring that resident #003 was protected from sexual abuse placed them at actual risk of harm for sexual exploitation.

Scope: This non-compliance was isolated to one resident being involved in an incident of staff to resident sexual abuse.

Compliance History: In the last 36 months, 16 WNs and 10 VPCs were issued to the home related to different sections of the legislation. (218)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 11, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

Issued on this 13th day of October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : April Racpan

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