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

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

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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2019	2019_730593_0023 (A1)	004798-19, 005001-19, 006672-19, 010220-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Medex
1865 Baseline Road OTTAWA ON K2C 3K6

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

Amended by GILLIAN CHAMBERLIN (593) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension was granted and the CDD was changed to October 25, 2019. A change was made in the last paragraph of the grounds, resident #001 was changed to resident #002.

Issued on this 25th day of September, 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*

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Extendicare Medex
1865 Baseline Road OTTAWA ON K2C 3K6

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

Amended by GILLIAN CHAMBERLIN (593) - (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): July 15 - 18, 22 - 24, 2019.

Log #004798-19 (CIS 2579-000008-19) was inspected related to resident to resident alleged abuse.

Log #006672-19 (CIS 2579-000016-19) was inspected related to staff to resident alleged abuse.

Log's #005001-19 (CIS 2579-000011-19) and #010220-19 (CIS 2579-000020-19) were inspected related to falls resulting in hospitalization and a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records and licensee policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 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. 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 :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as per the plan.

A critical incident report (CIS) was submitted to the Ministry of Long-Term Care (MLTC) reporting the witnessed sexual abuse of resident #003 by resident #002. It was reported in the CIS that resident #002 was sitting with resident #003 on the couch, when they reached over and touched resident #003 inappropriately. Resident #003 immediately pushed resident #002 away and said "no" loudly. Staff intervened immediately and separated both residents.

Inspector #593 reviewed resident #002's progress notes and found two additional documented incidents of sexual abuse towards residents in the home since the initial incident:

• Resident #002 was found sitting with resident #003 with their hands underneath resident #003's shirt and touching them inappropriately.

• Resident #006 was sitting in the lounge, resident #002 walked to resident #006 and touched them inappropriately.

A review of resident #002's plan of care document (dated prior to the first incident), found the following related to responsive behaviours of a sexual nature:

Focus- Sexually inappropriate touching towards staff and co-residents related to dementia.
Interventions- Early warning signs: If staff see resident holding hands with staff or co-residents, redirect resident to stop, and relocate resident, ie. move to a different chair, or direct them to their room or dining room. Staff to avoid seating resident next to specific residents.

A review of resident #002's plan of care document (dated after the first two incidents), found the following related to responsive behaviours of a sexual nature:

Focus- Sexually inappropriate touching towards staff and co-residents related to dementia.
Interventions- Early warning signs: If staff see resident holding hands with staff or co-residents, redirect resident to stop, and relocate resident, ie, move to a

different chair, or direct them to their room or dining room. Staff to avoid seating resident next to specific residents. If resident is sitting next to a specific resident, relocate resident to another seat, remove them from the area or relocate resident.

Interventions- Behaviours, ensure resident sits far from specific co-residents when is unsupervised.

A review of resident #002's plan of care document (dated after the third incident), found the following related to behaviours of a sexual nature:

Focus- Sexually inappropriate touching towards staff and co-residents related to dementia.
Interventions- Early warning signs: If staff see resident holding hands with staff or co-residents, redirect resident to stop, and relocate resident, ie, move to a different chair, or direct them to their room or dining room. Staff to avoid seating them next to specific residents. If resident is sitting next to a specific resident, relocate resident to another seat, remove them from the area or relocate resident.

During an interview with Inspector #593, July 23, 2019, PSW #106 indicated that they were familiar with resident #002 however unsure if they were to be monitored or kept away from specific residents in the home. The PSW was unsure about what was in resident #002's plan of care regarding their responsive behaviours of a sexual nature.

During an interview with Inspector #593, July 22, 2019, PSW #109 indicated that they witnessed and intervened during the second incident. PSW #109 further indicated that they were unaware of the responsive behaviours of a sexual nature of resident #002 and were unaware of any interventions to manage this.

During an interview with Inspector #593, July 22, 2019, RPN #110 indicated that they were called for assistance by PSW #109 after an incident occurred involving residents #002 and #003. RPN #110 stated, "I think they (resident #002) had done it before and I can't confirm that. For sure, if we knew, we could have watched them more closely". At the time of the second incident, RPN #110 indicated that they did not even know about a previous incident involving the two residents. RPN #110 added that there were no interventions implemented until resident #002 was moved to another floor after the second incident.

During an interview with Inspector #593, July 23, 2019, RN #105 indicated that

resident #002 has had one incident of sexual abuse since moving to another floor. The RN added that it was opportunity, if they (resident #002) was seated close to a specific resident, they will reach out and try to touch the resident. They added that there were no specific directions to keep resident #002 away from specific residents on the unit.

During an interview with Inspector #593, July 18, 2019, RN #108 indicated that before the move to another floor, there were safety checks implemented including a 1:1 for a short period of time. The 1:1 was to intervene and the safety checks were supposed to be every 15 minutes however realistically, they were every 30 minutes as these checks were challenging on the evening and night shifts due to staff to resident ratios.

During an interview with Inspector #593, July 24, 2019, the DOC indicated that resident #002 was targeting resident #003 which is why they moved resident #002 to another floor. After the first incident, resident #002 was on hourly monitoring but less than a month later, a second incident occurred. After resident #002 was moved to another floor, there was a 1:1 in place in response to the move, and then this was changed to hourly safety checks. The DOC indicated that there were no specific interventions about keeping resident #002 away from specific residents or additional monitoring when seated around specific residents.

Resident #002 has had three documented incidents of sexual abuse toward two residents in the home. It was known that resident #002 showed interest in resident #003 and there were documented interventions to monitor resident #002 around residents, including to intervene if behaviours progressed. After resident #002 was moved to another floor, a third incident occurred with a different resident. Furthermore, some staff were unaware of such behaviours with resident #002 and other staff who provided regular care to resident #002 were unaware of interventions to manage responsive behaviours of a sexual nature including during the first incident, where resident #002 was seated next to resident #003 before they reached over and touched them inappropriately and the second incident, where resident #002 was holding hands with resident #003 and staff did not intervene until resident #002 started to touch resident #003 inappropriately. As such, the licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as per the plan. (log #004798-19) [s. 6. (7)]

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 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 has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to resident #003, has immediately

reported the suspicion and the information upon which it is based to the Director.

A critical incident report (CIS) was submitted to the Ministry of Long-Term Care (MLTC), reporting the alleged sexual abuse of resident #003. It was reported in the CIS that resident #003 was sitting on the couch and resident #002 was sitting close to resident #003 with their hand up the resident's shirt and appeared to be touching them inappropriately. A resident brought this interaction to the attention of staff members, who intervened.

As per the CIS, the incident occurred at 1800 hours; however was not reported to the Director until the following day at 1255 hours.

During an interview with Inspector #593, July 24, 2019, the DOC indicated that the Manager on Call was not called when this incident occurred nor was the after hours pager. If the manager on call had been notified, we would have gone through the decision tree over the phone and this incident would have been reported to the Director immediately.

As such, the licensee has failed to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident, has immediately reported the suspicion and the information upon which it is based to the Director. (log #005819-19) [s. 24. (1)]

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to resident #001, has immediately reported the suspicion and the information upon which it is based to the Director.

A critical incident report (CIS) was submitted to the Ministry of Long-Term Care (MLTC), reporting the alleged sexual abuse of resident #001. It was reported in the CIS that resident #001 said a nurse came into their room when they were sleeping and touched them inappropriately.

As per the CIS, the incident occurred at 2200 hours; however was not reported to the Director until the following day at 0902 hours. The following was documented in the CIS: RN #104 spoke with resident #001 during the night and reported to the day RN.

During an interview with Inspector #593, July 23, 2019, RN #104 indicated that they did not report the accusations to the manager on call, they were informed the following day by the DOC that the incident was reportable to the MLTC and the police had to called.

During an interview with Inspector #593, July 24, 2019, the DOC indicated that RN #104 should have called the manager on call as they were serious allegations and then the MLTC could have been informed right away. We would have gone through the decision tree over the phone and then reported immediately.

As such, the licensee has failed to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident, has immediately reported the suspicion and the information upon which it is based to the Director. (log #006672-19) [s. 24. (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 ensuring that 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 which it is based to the Director. 2. Abuse of a resident by anyone or neglect of a resident by the licensee that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

Issued on this 25th day of September, 2019 (A1)

[redacted]

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 GILLIAN CHAMBERLIN (593) - (A1)
Inspection No. / No de l'inspection :	2019_730593_0023 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004798-19, 005001-19, 006672-19, 010220-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 25, 2019(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Medex 1865 Baseline Road, OTTAWA, ON, K2C-3K6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tina Nault

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 Extendicare (Canada) Inc., 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007.

The licensee must ensure that:

1. The care documented in the plan of care for resident #002 and other residents in the home with responsive behaviours of a sexual nature, is provided to the residents as per the plan.

2. Registered nursing staff and direct care staff, who work on resident #002's floor and all other staff who interact with resident #002 and other residents with responsive behaviours of a sexual nature, are aware of their responsive behaviours and the documented plan of care addressing the responsive behaviours.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as per the plan.

A critical incident report (CIS) was submitted to the Ministry of Long-Term Care (MLTC), February 28, 2019 reporting the witnessed sexual abuse of resident #003 by resident #002, February 27, 2019. It was reported in the CIS that resident #002 was sitting with resident #003 on the couch, when they reached over and touched resident #003's breast. Resident #003 immediately pushed resident #002 away and said "no" loudly. Staff intervened immediately and separated both residents.

Inspector #593 reviewed resident #002's progress notes and found two additional documented incidents of sexual abuse towards residents in the home since the February 27, 2019 incident:

• March 13, 2019- Resident #002 was found sitting with resident #003 with their hands underneath resident #003's shirt and touching their breasts.

• June 17, 2019- Resident #006 was sitting in the lounge, resident #002 walked to resident #006 and touched their left breast.

A review of resident #002's plan of care document dated January 15, 2019, found the following related to responsive behaviours of a sexual nature:

Focus- Sexually inappropriate touching towards staff and co-residents related to dementia.
Interventions- Early warning signs: If staff see resident holding hands with staff or co-residents, redirect resident to stop, and relocate resident, ie. move to a different chair, or direct them to their room or dining room. Staff to avoid seating resident next to women.

A review of resident #002's plan of care document dated April 15, 2019, found the following related to responsive behaviours of a sexual nature:

Focus- Sexually inappropriate touching towards staff and co-residents related to dementia.
Interventions- Early warning signs: If staff see resident holding hands with staff or co-residents, redirect resident to stop, and relocate resident, ie, move to a different chair, or direct them to their room or dining room. Staff to avoid seating resident next to women. If resident is sitting next to a woman, relocate resident to another seat, remove them from the area or relocate female resident.
Interventions- Behaviours, ensure resident sits far from female co-residents when is unsupervised.

A review of resident #002's plan of care document dated July 02, 2019, found the following related to behaviours of a sexual nature:

Focus- Sexually inappropriate touching towards staff and co-residents related to dementia.
Interventions- Early warning signs: If staff see resident holding hands with staff or co-residents, redirect resident to stop, and relocate resident, ie, move to a different chair, or direct them to their room or dining room. Staff to avoid seating them next to women. If resident is sitting next to a woman, relocate resident to another seat, remove them from the area or relocate female resident.

During an interview with Inspector #593, July 23, 2019, PSW #106 indicated that they were familiar with resident #002 however unsure if they were to be monitored or kept away from female residents in the home. The PSW was unsure about what was in resident #002's plan of care regarding their responsive behaviours of a sexual nature.

During an interview with Inspector #593, July 22, 2019, PSW #109 indicated that they witnessed and intervened during the second incident occurring March 13, 2019. PSW #109 further indicated that they were unaware of the responsive behaviours of a sexual nature of resident #002 and were unaware of any interventions to manage this.

During an interview with Inspector #593, July 22, 2019, RPN #110 indicated that they were called for assistance by PSW #109 after an incident occurred March 13, 2019 involving residents #002 and #003. RPN #110 stated, "I think they (resident #002) had done it before and I can't confirm that. For sure, if we knew, we could have watched them more closely". At the time of the second incident, RPN #110 indicated that they did not even know about a previous incident involving the two residents. RPN #110 added that there were no interventions implemented until resident #002 was moved to the third floor after the second incident.

During an interview with Inspector #593, July 23, 2019, third floor RN #105 indicated that resident #002 has had one incident of sexual abuse toward female resident's since moving to the third floor. The RN added that it was opportunity, if they (resident #002) was seated close to a female resident, they will reach out and try to touch the female resident. They added that there were no specific directions to keep resident #002 away from female residents on the unit.

During an interview with Inspector #593, July 18, 2019, second floor RN #108

indicated that before the move to the third floor, there were safety checks implemented including a 1:1 for a short period of time. The 1:1 was to intervene and the safety checks were supposed to be every 15 minutes however realistically, they were every 30 minutes as these checks were challenging on the evening and night shifts due to staff to resident ratios.

During an interview with Inspector #593, July 24, 2019, the DOC indicated that resident #002 was targeting resident #003 which is why they moved resident #002 to the third floor. After the first incident, resident #002 was on hourly monitoring but less than a month later, a second incident occurred. After resident #002 was moved to the third floor, there was a 1:1 in place in response to the move, and then this was changed to hourly safety checks. The DOC indicated that there were no specific interventions about keeping resident #002 away from female residents or additional monitoring when seated around female residents.

Resident #002 has had three documented incidents of sexual abuse toward two female residents in the home. It was known that resident #002 showed interest in resident #003 and there were documented interventions to monitor resident #002 around female residents, including to intervene if behaviours progressed. After resident #002 was moved to the third floor, a third incident occurred with a different female resident. Furthermore, some staff were unaware of such behaviours with resident #002 and other staff who provided regular care to resident #002 were unaware of interventions to manage responsive behaviours of a sexual nature including during the first incident, where resident #002 was seated next to resident #003 before they reached over and touched their breasts and the second incident, where resident #002 was holding hands with resident #003 and staff did not intervene until resident #002 started to touch resident #003's breasts. As such, the licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as per the plan. (log #004798-19)

The decision to issue this compliance order was based on the severity of the issue, responsive behaviours of a sexual nature towards residents in the home as well as the scope of the issue, three documented incidents of sexual abuse towards residents in the home. The home had a level three compliance history as they had previous non-compliance to the same sub-section.

(593)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 25, 2019(A1)

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

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 25th day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by GILLIAN CHAMBERLIN (593) - (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 : Ottawa Service Area Office