Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 16, 2018 | 2018_712665_0004 | 005116-18 | Critical Incident System |

## Licensee/Titulaire de permis

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

JOY IERACI (665)

## 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): March 15, 16, 19, 20 and 21, 23, 2018.**

**The Critical Incident System (CIS) #C533-000005-18 was inspected related to an injury for which a resident was taken to hospital.**

**During the course of the inspection, the inspector conducted interviews with staff, resident and substitute decision maker, staff and resident interactions observations, reviewed clinical health records, training records, relevant home policies and procedures and other pertinent documents.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Quality Lead (QL), Facilities Manager (FM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Maker (SDM), resident and police constable.**

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

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

- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a Critical Incident System (CIS) report #C533-000005-18, to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in2018, for an incident that occurred between resident #001 and resident #002. The CIS report, indicated resident #001 was found with injury to an identified area of the body. Resident #001 was transferred to hospital and resident #002 was escorted out of the home by an identified authority the same day.

Review of the clinical records revealed resident #001 and resident #002 were related. Resident #001 was admitted to the home on an identified date in 2016, and resident #002 was admitted to the home on an identified date in 2017. Five months later, resident #002 was united in the same room with resident #001.

Interviews with Registered Nurse (RN) #103, Registered Practical Nurses (RPNs) #101 and #105 and the Director of Care (DOC), indicated resident #001 was not cognitively aware and the substitute decision maker (SDM) was an identified family member who made health care decisions. The staff indicated resident #002 was cognitively aware and was able to make health care decisions, and the home would also communicate with the same SDM noted above regarding health care decisions.

Interviews with Personal Support Workers (PSWs) #102, #104 and #109, RPNs #101 and #105, RN #103 and the DOC, indicated resident #002 was a caring person to resident #001. The DOC indicated resident #001 was pampered and was dependent on resident #002. The staff revealed resident #002 would let the nursing staff know when resident #001 required anything.

Interview with the SDM confirmed resident #002's feelings towards resident #001.

Review of the clinical records revealed resident #002 was concerned about an identified bodily function of resident #001 since prior to admission to the home, and on two identified occasions in 2018, resident #002 performed an identified procedure on resident #001 related to the identified bodily function.

Interview with the SDM confirmed resident #002 was concerned about the identified bodily function of resident #001 and was aware that resident #002 would perform the identified procedure on resident #001. The SDM indicated they told resident #002 their action will hurt resident #001.

Review of the clinical records revealed resident #001's identified medical diagnosis had

progressed and there was a decline in an identified area of health for resident #001 on an identified date in 2018. The home had a care conference on an identified date in 2018, to discuss resident #001's health status. The care conference was attended by resident #001's SDMs, resident #002, the registered dietitian, DOC, the physician and RPN #101. An identified intervention was discussed to address resident #001's identified area of health concern and the family decided not to pursue the identified intervention and the home was to ensure resident #001 was comfortable.

Review of resident #002's clinical records revealed a consult letter dated on an identified date in 2016, from an identified clinic. The letter revealed the staff at an identified hospital had an identified health care concern regarding resident #002. The letter further indicated that resident #001 was hospitalized for an identified period of months for their identified diagnosis and slowly improved. While resident #001 was hospitalized, resident #002 talked about what they would do to resident #001 and then to self. The identified physician indicated resident #002 presented with an identified issue on the background of resident #001's decline in health status.

Interview with the Facilities Manager RN #103 revealed they were the RN who admitted resident #002 to the home and was not aware of the consult letter from the identified clinic for resident #002, until March 16, 2018, after the inspector reviewed resident #002's chart. The RN indicated they were surprised by what they read about resident #002 and showed the consult letter to the DOC. The RN stated if the home knew about the consult letter, the home would have referred resident #002 to external consultants for an assessment, resident #002 would have been monitored for an identified health care focus, safety checks would have been initiated and the information would have been added to the plan of care.

Interview with the DOC revealed they were not aware of the letter until the Facilities Manager RN #103 showed the letter to them. The DOC indicated if they had known about the letter, resident #002 would have been referred to an identified external consultant for an assessment and would bring it to the attention of the SDM.

On an identified date in 2018, review of the progress notes for residents #001 and #002 revealed RN #106 heard a loud sound coming from the west side of the identified resident home area and saw resident #002 being brought down the hallway by PSW #102. The PSW informed the RN that resident #001 had an identified injury. The RN ran into resident #001's room and found the resident in bed with eyes open with injury to an identified area of the body, and observed two identified sharp objects on the bedside

table of resident #001. According to the progress notes, resident #002 informed the RN and the PSW of a letter in resident #002's bedside table. The letter was written in an identified language and the PSW read the letter which explained why resident #002 injured resident #001 and resident #002's plan was to injure self thereafter.

The progress notes indicated resident #001 returned to the home from hospital on an identified date in 2018 with treatment orders. The head to toe assessment upon resident #001's return from hospital revealed the resident sustained five identified injuries to the identified area of the body.

Observations conducted on March 15, 16 and 19, 2018, revealed the injury to resident #001.

Review of the progress notes on an identified date in 2018, for resident #002 revealed the resident left the home with an identified authority and was released to the care of their family, but was admitted to hospital due to an identified medical condition. Another progress note on an identified date in 2018, indicated the identified authority had implemented a restriction for resident #002 towards resident #001.

Interview with PSW #102 revealed on the identified date and time in 2018, the PSW heard a noise and voice and went to check where the sound was coming from. The noise was coming from the room where residents #001 and #002 resided. The room was locked from the inside and the PSW pushed the door open with their body. The door was blocked with a chair and resident #002's mobility aide. When the PSW entered the room, the PSW saw resident #002 screaming what they have done. Resident #002 was standing by their bed, holding an identified sharp object and observed a second identified sharp object on resident #002's bed. The PSW stated when they went to see resident #001, they observed an identified injury from an identified area of the body. The PSW asked resident #002 what happened, and resident #002 told the PSW, that resident #001 communicated a message to resident #002 that evening and resident #002 wrote a letter. The PSW read the letter written in an identified language and the letter indicated that resident #002 will do a particular act to resident #001 and after that resident #002 will do the same act to self. The PSW stated they left the room to get RN #106 and resident #002 followed behind. PSW #102 acknowledged the incident was an act of physical abuse by resident #002 to resident #001.

Interview with RN #106 revealed a loud sound was heard while they were at an identified area of the resident home area. The RN saw PSW #102 come out of resident #001's and

#002's room. PSW #102 informed the RN that resident #001 had an identified injury. Upon entering the room, the RN observed the injury to resident #001's identified area of the body and an identified substance on another area of the body of resident #001. The RN requested PSW #102 to perform an identified intervention on resident #001's injury and proceeded to call 911. As per the RN, resident #002 returned to the room and sat on the bed and asked the resident what they have done to resident #001. Resident #002 pointed at their bedside table drawer and indicated a letter was in the drawer. PSW #106 read the letter written in an identified language and translated the letter. RN #106 acknowledged the incident was considered to be physical abuse by resident #002 to resident #001.

Interview with the SDM indicated they brought one of the two identified sharp objects from home to perform a particular task for both residents. The identified sharp object was stored in resident #002's bedside drawer since admission. The SDM was not aware if the staff were aware of the object.

Interviews with RPNs #105 and #101 and RN #106 revealed they were not aware of the identified sharp object that was brought in by the SDM and indicated the SDM would bring items to the home for resident #002.

Interview with the DOC indicated the other identified sharp object was an object used during an identified activity of daily living. The DOC indicated resident #002 received the identified sharp object during the identified activity of daily living in the home as the resident was cognitively aware.

Interviews with the DOC and Executive Director (ED) acknowledged the incident that occurred on an identified date in 2018, was considered to be physical abuse by resident #002 to resident #001. The licensee failed to ensure that resident #001 was protected from abuse by resident #002. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**
**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**
**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
**(c) identifies measures and strategies to prevent abuse and neglect;**
**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
**(e) identifies the training and retraining requirements for all staff, including,**
**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

Review of the home's current policy on Zero Tolerance for Abuse and Neglect with a last review date of January 18, 2016, did not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

Interview with the ED, indicated that residents who have been abused or neglected or allegedly abused or neglected are provided support but acknowledged the home's policy on Zero Tolerance for Abuse and Neglect did not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [s. 96. (a)]

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**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 is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

Review of the home's current policy on Zero Tolerance for Abuse and Neglect revealed it was created on February 6, 2014, and published on January 18, 2016. The policy was last reviewed on January 18, 2016, and the next review was scheduled for January 18, 2018.

Interview with the ED, indicated the home's policy on Zero Tolerance for Abuse and Neglect was reviewed and evaluated every two years and confirmed the last review was conducted on January 18, 2016. The ED indicated the review of the policy was scheduled for January 18, 2018, but has not been completed. The ED acknowledged the home did not evaluate the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of residents at least once in every calendar year. [s. 99. (b)]

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**Issued on this 25th day of April, 2018**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JOY IERACI (665) |
| **Inspection No. / No de l'inspection :** | 2018_712665_0004 |
| **Log No. / No de registre :** | 005116-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Apr 16, 2018 |
| **Licensee / Titulaire de permis :** | Kristus Darzs Latvian Home<br>11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6 |
| **LTC Home / Foyer de SLD :** | Kristus Darzs Latvian Home<br>11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lauma Stikuts |

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

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

Specifically, the licensee must prepare, submit and implement a plan to ensure that resident #001 is protected from abuse by resident #002. The plan must include, but is not limited, to the following:

1) Update the plan of care for resident #001 and resident #002 to include interventions and/or strategies to protect resident #001 from abuse by resident #002.

2) Update the plan of care for resident #002 to include pertinent information from the the identified consult letter, and any strategies and/or interventions required as a result of this information.

3) Develop an on-going auditing process to ensure that the room/s for resident #001 and resident #002 are free from any objects that may put resident #001 at risk of harm and include who will be responsible for doing the audits and evaluating the results. The home is required to maintain a documentation record of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

4) Develop a process to ensure that all documents received as part of the resident admission package, and any consultation letters received during a resident's stay in the home, are reviewed and any strategies and/or interventions required as a result of this information be included in the plan of care, as applicable. Conduct on-going audits of this process and maintain documentation record of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Please submit the written plan for achieving compliance for, 2018_712665_0004 to Joy Ieraci, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by April 30, 2018.

Please ensure that the submitted written plan does not contain any personal information/personal health information.

**Grounds / Motifs :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a Critical Incident System (CIS) report #C533-000005-18, to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2018, for an incident that occurred between resident #001 and resident #002. The CIS report, indicated resident #001 was found with injury to an identified area of the body. Resident #001 was transferred to hospital and resident #002 was escorted out of the home by an identified authority the same day.

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Interview with the DOC revealed they were not aware of the letter until the Facilities Manager RN #103 showed the letter to them. The DOC indicated if they had known about the letter, resident #002 would have been referred to an identified external consultant for an assessment and would bring it to the attention of the SDM.

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and #002 revealed RN #106 heard a loud sound coming from the west side of the identified resident home area and saw resident #002 being brought down the hallway by PSW #102. The PSW informed the RN that resident #001 had an identified injury. The RN ran into resident #001's room and found the resident in bed with eyes open with injury to an identified area of the body, and observed two identified sharp objects on the bedside table of resident #001. According to the progress notes, resident #002 informed the RN and the PSW of a letter in resident #002's bedside table. The letter was written in an identified language and the PSW read the letter which explained why resident #002 injured resident #001 and resident #002's plan was to injure self thereafter.

The progress notes indicated resident #001 returned to the home from hospital on an identified date in 2018 with treatment orders. The head to toe assessment upon resident #001's return from hospital revealed the resident sustained five identified injuries to the identified area of the body.

Observations conducted on March 15, 16 and 19, 2018, revealed the injury to resident #001.

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Interview with PSW #102 revealed on the identified date and time in 2018, the PSW heard a noise and voice and went to check where the sound was coming from. The noise was coming from the room where residents #001 and #002 resided. The room was locked from the inside and the PSW pushed the door open with their body. The door was blocked with a chair and resident #002's mobility aide. When the PSW entered the room, the PSW saw resident #002 screaming what they have done. Resident #002 was standing by their bed, holding an identified sharp object and observed a second identified sharp object on resident #002's bed. The PSW stated when they went to see resident #001, they observed an identified injury from an identified area of the body. The PSW asked resident #002 what happened, and resident #002 told the PSW, that resident #001 communicated a message to resident #002 that evening and resident #002 wrote a letter. The PSW read the letter written in an identified

language and the letter indicated that resident #002 will do a particular act to resident #001 and after that resident #002 will do the same act to self. The PSW stated they left the room to get RN #106 and resident #002 followed behind. PSW #102 acknowledged the incident was an act of physical abuse by resident #002 to resident #001.

Interview with RN #106 revealed a loud sound was heard while they were at an identified area of the resident home area. The RN saw PSW #102 come out of resident #001's and #002's room. PSW #102 informed the RN that resident #001 had an identified injury. Upon entering the room, the RN observed the injury to resident #001's identified area of the body and an identified substance on another area of the body of resident #001. The RN requested PSW #102 to perform an identified intervention on resident #001's injury and proceeded to call 911. As per the RN, resident #002 returned to the room and sat on the bed and asked the resident what they have done to resident #001. Resident #002 pointed at their bedside table drawer and indicated a letter was in the drawer. PSW #106 read the letter written in an identified language and translated the letter. RN #106 acknowledged the incident was considered to be physical abuse by resident #002 to resident #001.

Interview with the SDM indicated they brought one of the two identified sharp objects from home to perform a particular task for both residents. The identified sharp object was stored in resident #002's bedside drawer since admission. The SDM was not aware if the staff were aware of the object.

Interviews with RPNs #105 and #101 and RN #106 revealed they were not aware of the identified sharp object that was brought in by the SDM and indicated the SDM would bring items to the home for resident #002.

Interview with the DOC indicated the other identified sharp object was an object used during an identified activity of daily living. The DOC indicated resident #002 received the identified sharp object during the identified activity of daily living in the home as the resident was cognitively aware.

Interviews with the DOC and Executive Director (ED) acknowledged the incident that occurred on an identified date in 2018, was considered to be physical abuse by resident #002 to resident #001. The licensee failed to ensure that resident #001 was protected from abuse by resident #002.

The severity of this issue was determined to be a level three as there was actual harm to resident #001. Resident #001 sustained injury to an identified area of the body and required transfer to hospital for treatment. The scope of the issue was a level one as it was isolated to resident #001 who was reviewed. The home had a level two history of one or more unrelated non-compliance in the last 36 months.
(665)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 30, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

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

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

**Issued on this  16th  day of April, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Joy Ieraci

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office