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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 03, 2021	2021_715672_0010 (A1)	022054-20, 003581-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Langstaff Square Care Community
170 Red Maple Road Richmond Hill ON L4B 4T8

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order under s. 229 (4) was rescinded due to the outbreak in the home being declared over prior to the inspection. Due to this, the licensee was not required to be following the contact/droplet or isolation precautions for residents in the home when the observations were conducted.

Issued on this 3 rd day of May, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Langstaff Square Care Community
170 Red Maple Road Richmond Hill ON L4B 4T8

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

Amended by JENNIFER BATTEN (672) - (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): March 18, 19, 22 and 23, 2021

The following intakes were completed during this inspection:

One intake related to a resident fall which resulted in an injury.

One intake related to an allegation of improper care of a resident.

During the course of the inspection, a Complaint inspection was conducted concurrently. During that inspection, the following intakes were completed:

One intake related to a complaint received regarding medication administration and fall prevention practices occurring in the home.

One intake related to a complaint received regarding infection prevention and control and visitation practices occurring in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Dietary Manager, IPAC Lead, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, health screeners, maintenance workers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Prevention of Abuse and Neglect, Responsive Behaviours, Pain and Symptom Management and Falls Prevention. The Inspector(s) also observed staff to resident and resident to

resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services

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

- **4 WN(s)**
- **2 VPC(s)**
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the internal Head Injury Routine policy was complied with.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal policy indicated that when a resident was placed on head injury routine assessment, staff were to use a specified form, following the time frames indicated unless specific physician's orders were received which stated otherwise.

Resident #005 sustained a fall which resulted in the resident being placed on head injury routine (HIR). Upon review of the head injury routine assessment, Inspector observed it had not been completed in full, as directed in the internal policy. Inspector then reviewed two other HIR assessments completed for resident #005 and noted that both assessments had not been completed in full and staff had documented on the HIR assessment that the resident was sleeping.

A complaint was received by the Director related to a fall sustained by resident #010 which resulted in the resident being placed on HIR assessment. Upon review of the HIR assessment, Inspector #672 observed it had not been

completed in full, as directed in the internal policy as staff had documented on the HIR assessment that the resident was sleeping. The DOC reviewed the HIRs completed for residents #005 and #010 and verified they had not been completed in full.

Resident #013 sustained a fall which resulted in head injury routine being initiated. Upon review of the HIR assessment, Inspector observed it had not been completed in full, as directed in the internal policy.

Resident #014 sustained an identified number of falls which resulted in head injury routines being initiated. Upon review of the HIR assessments, Inspector observed they had not been completed in full, as directed in the internal policy.

During separate interviews, the DOC and Executive Director verified that the HIR assessments were not fully completed and verified the expectation in the home was for HIR assessments to be completed as per the internal policy.

By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Identified head injury routine assessments for residents #005, #010, #013 and #014; internal head injury routine policy, interviews with DOC and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist residents who required assistance with eating.

During observations in the home, residents #001, #002, #003, #004 and #008, along with two further residents, were served meals and received assistance from staff with their intake while seated in unsafe positions. During separate interviews, PSWs #103, #105, #107, #110, #120 and RPN #104 indicated the residents were not in a safe position for eating or drinking purposes.

During separate interviews, PSWs #105, #107, #110, RPN #104, the DOC and the Executive Director indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted in the home, interviews with PSWs, RPN #104, the DOC and the Executive Director. [s. 73. (1) 10.]

2. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals.

On two specified dates, meal trays were delivered to residents #015 and #019,

without the required staff assistance available to assist with intake. At identified times, the residents were still waiting for assistance with feeding. During separate interviews, PSW #101 indicated staff would routinely provide resident #019 with their meal tray when it became available from the kitchen and staff would enter the resident's room to provide assistance with the intake once they became available, after delivering all of the meal trays to the residents on the unit. PSW #109 indicated meal trays were not supposed to be served to residents who required assistance with their intake until a staff member was available to provide the required assistance, but they had become busy assisting another resident after serving the meal tray to resident #015's room, which caused the delay in the resident receiving the required assistance with their food and fluid intake.

During separate interviews, the Dietary Manager (DM) and Executive Director (ED) indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who needed to be fed their meals when the meals were served posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted, interviews with PSWs, the Dietary Manager and the Executive Director. [s. 73. (2) (b)]

Additional Required Actions:

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

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 no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had their personal items labelled.

During observations made in the home related to resident #005, the resident requested Inspector get a personal item from their shared bathroom and Inspector noted there were an identified number of personal items present in the bathroom without labeling.

Inspector #672 expanded the scope of the inspection to include another shared resident bathroom on the same resident home area (RHA) and noted there were an identified number of personal items in the bathroom without labeling. Inspector then entered another shared resident bathroom on a different RHA in the home and noted there were an identified number of personal items present in the bathroom without labeling.

During separate interviews, PSW #110, RPN #116 and the Executive Director indicated the expectation in the home was for all personal items to be labeled with the resident's name.

Sources: Observations made in the home, interviews with PSW #110, RPN #116 and the Executive Director. [s. 37. (1) (a)]

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 every resident has their personal items labelled, to be implemented voluntarily.

(A1)
The following Non-Compliance has been Revoked / La non-conformité suivante a été révoquée: WN #3

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Issued on this 3 rd day of May, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2021_715672_0010 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022054-20, 003581-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 03, 2021(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Langstaff Square Care Community 170 Red Maple Road, Richmond Hill, ON, L4B-4T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deniese Johnson

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 2063414 Ontario Limited as General Partner of 2063414 Investment LP, 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 # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with section s. 8. (1) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that when a resident is placed on head injury routine, the assessment is completed as required.

Grounds / Motifs :

1. The licensee has failed to ensure that the internal Head Injury Routine policy was complied with.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal policy indicated that when a resident was placed on head injury routine assessment, staff were to use a specified form, following the time frames indicated unless specific physician's orders were received which stated otherwise.

Resident #005 sustained a fall which resulted in the resident being placed on head injury routine (HIR). Upon review of the head injury routine assessment, Inspector observed it had not been completed in full, as directed in the internal policy. Inspector then reviewed two other HIR assessments completed for resident #005 and noted that both assessments had not been completed in full and staff had documented on the HIR assessment that the resident was sleeping.

A complaint was received by the Director related to a fall sustained by resident #010 which resulted in the resident being placed on HIR assessment. Upon review of the HIR assessment, Inspector #672 observed it had not been completed in full, as directed in the internal policy as staff had documented on the HIR assessment that the resident was sleeping. The DOC reviewed the HIRs completed for residents #005 and #010 and verified they had not been completed in full.

Resident #013 sustained a fall which resulted in head injury routine being initiated. Upon review of the HIR assessment, Inspector observed it had not been completed in full, as directed in the internal policy.

Resident #014 sustained an identified number of falls which resulted in head injury routines being initiated. Upon review of the HIR assessments, Inspector observed they had not been completed in full, as directed in the internal policy.

During separate interviews, the DOC and Executive Director verified that the HIR assessments were not fully completed and verified the expectation in the home was for HIR assessments to be completed as per the internal policy.

By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Identified head injury routine assessments for residents #005, #010, #013 and #014; internal head injury routine policy, interviews with DOC and other staff.

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

Severity: There was actual risk of harm to the residents related to the potential for possible head injuries to not be detected.

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

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: A previous WN was issued to the home during Critical Incident System inspection #2020_748653_0015, on August 11, 2020; a previous VPC was issued to the home during Critical Incident System inspection #2019_685648_0020, on October 31, 2019, and a previous Compliance Order was issued to the home during Critical Incident System inspection #2019_263524_0022 on July 16, 2019, which was complied on October 30, 2019. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 15, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. If unsafe positioning is noted, provide immediate redirection and reeducation. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist residents who required assistance with eating.

During observations in the home, residents #001, #002, #003, #004 and #008, along with two further residents, were served meals and received assistance from staff with their intake while seated in unsafe positions. During separate interviews, PSWs #103, #105, #107, #110, #120 and RPN #104 indicated the residents were not in a safe position for eating or drinking purposes.

During separate interviews, PSWs #105, #107, #110, RPN #104, the DOC and the Executive Director indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted in the home, interviews with PSWs, RPN #104, the DOC and the Executive Director. [s. 73. (1) 10.]

2. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals.

On two specified dates, meal trays were delivered to residents #015 and #019, without the required staff assistance available to assist with intake. At identified times, the residents were still waiting for assistance with feeding. During separate interviews, PSW #101 indicated staff would routinely provide resident #019 with their

meal tray when it became available from the kitchen and staff would enter the resident's room to provide assistance with the intake once they became available, after delivering all of the meal trays to the residents on the unit. PSW #109 indicated meal trays were not supposed to be served to residents who required assistance with their intake until a staff member was available to provide the required assistance, but they had become busy assisting another resident after serving the meal tray to resident #015's room, which caused the delay in the resident receiving the required assistance with their food and fluid intake.

During separate interviews, the Dietary Manager (DM) and Executive Director (ED) indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who needed to be fed their meals when the meals were served posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted, interviews with PSWs, the Dietary Manager and the Executive Director.

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

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as more than three residents were observed attempting to eat while in an unsafe position.

Compliance History: Previous areas of noncompliance were issued to the home related to different sub-sections of the legislation within the past 36 months. (672)

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

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 003

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

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

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

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

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

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

Issued on this 3 rd day of May, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JENNIFER BATTEN (672) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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