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

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
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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
Jan 28, 2022	2021_548756_0019 (A2)	008207-21, 008579-21, 010960-21, 011771-21, 011912-21, 015096-21	Critical Incident System

Licensee/Titulaire de permis

Maxville Manor
80 Mechanic Street Maxville ON K0C 1T0

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

Maxville Manor
80 Mechanic Street West Maxville ON K0C 1T0

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

Amended by LISA CUMMINGS (756) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This licensee inspection report has been revised to reflect an approved extension of the Compliance Due Date to February 28, 2022. The Critical Incident System inspection #2021_548756_0019 was completed on October 20, 2021.

A copy of the revised report is attached.

Issued on this 28th day of January, 2022 (A2)

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

Long-Term Care Operations Division
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Maxville Manor
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Long-Term Care Home/Foyer de soins de longue durée

Maxville Manor
80 Mechanic Street West Maxville ON K0C 1T0

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

Amended by LISA CUMMINGS (756) - (A2)

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): October 6-8, 12-15, 18-20, 2021.

During the course of the Critical Incident (CI) Inspection, the following intakes were completed:

- Log #011771-21 (CI #3000-000008-21), log #011912-21 (CI #3000-000009-21), and log #010960-21 (CI #3000-000007-21) regarding allegations of resident to resident sexual abuse

- Log #008207-21 (CI #3000-000004-21), and log #008579-21 (CI #3000-000005-21) regarding allegations of staff to resident abuse

- Log #015096-21 (CI #3000-000011-21) regarding a fall that caused injury and required a transfer to hospital

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Unit Managers, a Physician, a Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity staff, Housekeeping staff, and residents.

During the course of the inspection, the inspectors made observations related to resident care and services, dining and infection prevention and control, reviewed resident healthcare records, reviewed staff training records, reviewed internal investigation notes, reviewed the licensee's Falls Prevention and Management policy, and reviewed the licensee's Zero Tolerance for Abuse and Neglect policy.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to protect several residents from sexual abuse.

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

Incidents of inappropriate behaviour occurred between resident #002 and #001 on two separate days and between resident #002 and 001 on one day. An RPN stated they separated the residents in all instances because they identified the situations as sexual abuse as the residents could not consent. Resident #002 had interventions in place.

The following month, resident #002 was seated in a room with resident #006 who had an item of clothing removed. The NP stated resident #006 could not remove this item of clothing themselves. The residents were separated and resident #002 continued to have interventions in place.

Later that month, resident #002 engaged in sexual behaviours with resident #001. Another RPN did not separate the residents as they thought the Substitute Decision Makers had consented on the resident's behalf. The Physician had previously provided direction that these two residents could engage in a relationship based on their assessment. However, when interviewed, the physician acknowledged that due to medical diagnoses the resident's capacity to consent could fluctuate. Progress notes for resident #002 on two days leading up to this incident described the resident as being confused and the progress note detailing this incident identified that the resident thought they had surgery the day prior, however this had not occurred.

When interviewed the NP stated that none of the residents on the resident home area had the capacity to consent to a sexual relationship. The NP also stated they increased resident #002's medication as a result of behaviours and further interventions continued to be in place.

The following month, there were two incidents of inappropriate behaviours between resident #002 and #004. A third RPN stated the residents were separated on both occasions because they could not consent to these situations.

Sources: resident healthcare records, Zero Tolerance of Abuse and Neglect policy, interviews with staff. [s. 19. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that their Abuse and Neglect policy was complied with.

There were two incidents of inappropriate behaviour between resident #002 and #001. Both incidents were not reported to the Director or to the Substitute Decision Makers (SDM), and were not immediately investigated as required by the abuse policy.

Resident #002 acted inappropriately towards resident #005 and the incident was not reported to the Director or the SDMs, and was not immediately investigated.

Resident #002 was seated in a room with resident #006 who had an item of clothing removed. The incident was not reported to the Director, to the SDMs and was not immediately investigated.

There were two incidents of inappropriate behaviour between resident #002 and #004. These incidents were not reported to the Director, to the SDMs and were not immediately investigated.

Sources: The licensee's Abuse and Neglect policy, resident healthcare records and interviews with staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of resident abuse were immediately investigated.

The incidents between resident #001 and #002, the incident between resident #005 and #002, and the incident between resident #006 and #002 were identified as abuse by an RPN, however these incidents were not immediately investigated.

The incidents between resident #002 and #004 were identified as abuse by another RPN, however these incidents were not immediately investigated.

Sources: Resident healthcare records, interviews with staff. [s. 23. (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 alleged, suspected or witnessed incident of abuse of a resident is immediately investigated, to be implemented voluntarily.

WN #4: 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 the Director was immediately notified of incidents of resident to resident sexual abuse.

A CI report was submitted to the Director related to an allegation of resident to resident sexual abuse for an incident that occurred the previous afternoon.

Documentation on the day of the incident identified that a resident had acted inappropriately towards another resident. An RN confirmed that the Director was notified the following day.

Sources : Critical Incident System report, licensee’s policy zero tolerance for abuse and neglect, resident healthcare record, interview with staff [s. 24. (1)]

2. The Director was not notified of inappropriate touching and behaviours between resident #002 and residents #001, #004, #005, and #006 that occurred on six separate days.

The DOC confirmed these incidents were not reported to them and therefore were not reported to the Director.

Sources: resident healthcare records, Zero Tolerance of Abuse and Neglect policy, interviews with the DOC and others. [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 to ensure that a person who has reasonable grounds to suspect that sexual abuse
occurred or may occur shall immediately report the suspicion and the information upon
which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001, #002, #004, #005, and #006's Substitute Decision-Makers (SDM) were notified of all alleged, suspected or witnessed incidents of sexual abuse.

The two incidents between resident #001 and #002, the incident between resident #005 and #002, and the incident between resident #006 and #002 were identified as incidents of sexual abuse by an RPN. The SDM's of the residents were not notified within 12 hours of these incidents occurring.

The two incidents between resident #002 and #004 were identified as sexual abuse by another RPN who confirmed that the SDM's of the residents were not notified within 12 hours of these incidents occurring.

Sources: Resident healthcare records, interviews with staff. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker is notified of any alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the infection prevention and control (IPAC) program, specifically universal mask wearing.

As per the Chief Medical Officer of Health Directive #3 for Long Term Care Homes, all staff must wear a medical mask for the entire duration of their shift, both indoors and outdoors, regardless of their immunization status. Masks must not be removed when staff are interacting with residents and/or in designated resident areas.

A shift report was observed on a resident home area and the staff present in the dining room for the shift report had removed their medical masks. The dining room was open to the resident home area and there were residents walking by. Further observations were conducted on the resident home area where three PSW's were observed to have their medical masks lowered exposing their nose and mouth. One of the PSW's was again observed a few days later with their medical mask lowered exposing their nose and mouth while speaking with a resident in the hallway.

The DOC confirmed that as per the IPAC policy and Directive #3, staff are to wear a medical mask when on resident home areas, including during shift report and in the hallways.

Sources: observations of resident home areas, Chief Medical Officer of Health Directive #3 for Long Term Care Homes, interviews with staff. [s. 229. (4)]

Issued on this 28th day of January, 2022 (A2)

[redacted]

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 LISA CUMMINGS (756) - (A2)
Inspection No. / No de l'inspection :	2021_548756_0019 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008207-21, 008579-21, 010960-21, 011771-21, 011912-21, 015096-21 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 28, 2022(A2)
Licensee / Titulaire de permis :	Maxville Manor 80 Mechanic Street, Maxville, ON, K0C-1T0
LTC Home / Foyer de SLD :	Maxville Manor 80 Mechanic Street West, Maxville, ON, K0C-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amy Porteous

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 Maxville Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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 :

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 Long-Term Care Homes Act, 2007.

Specifically, the licensee shall ensure residents #001, #002, #004, #005, and #006 are protected from sexual abuse by completing the following:

A) Ensure that all staff providing direct care to residents complete education on the Abuse and Neglect policy, including the definition of sexual abuse, the duty under section 24 to make mandatory reports, the duty under section 23 to investigate, and the duty under regulation 97 to notify Substitute Decision-Makers.

B) Ensure that residents #001, #002, #004, #005, and #006 plans of care are reviewed and revised to ensure that abuse prevention interventions are identified.

C) Ensure that residents #001, #002, #004, #005, and #006 are assessed for the capacity to consent to taking part in sexual acts with another resident at each incidence of occurrence.

D) A written record must be kept of everything required under (a), (b) and (c).

Grounds / Motifs :

1. The licensee has failed to protect several residents from sexual abuse.

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

Incidents of inappropriate behaviour occurred between resident #002 and #001 on two separate days and between resident #002 and 001 on one day. An RPN stated they separated the residents in all instances because they identified the situations as sexual abuse as the residents could not consent. Resident #002 had interventions in place.

The following month, resident #002 was seated in a room with resident #006 who had an item of clothing removed. The NP stated resident #006 could not remove this item of clothing themselves. The residents were separated and resident #002 continued to have interventions in place.

Later that month, resident #002 engaged in sexual behaviours with resident #001. Another RPN did not separate the residents as they thought the Substitute Decision Makers had consented on the resident's behalf. The Physician had previously provided direction that these two residents could engage in a relationship based on their assessment. However, when interviewed, the physician acknowledged that due to medical diagnoses the resident's capacity to consent could fluctuate. Progress notes for resident #002 on two days leading up to this incident described the resident as being confused and the progress note detailing this incident identified that the resident thought they had surgery the day prior, however this had not occurred.

When interviewed the NP stated that none of the residents on the resident home area had the capacity to consent to a sexual relationship. The NP also stated they increased resident #002's medication as a result of behaviours and further interventions continued to be in place.

The following month, there were two incidents of inappropriate behaviours between resident #002 and #004. A third RPN stated the residents were separated on both occasions because they could not consent to these situations.

Sources: resident healthcare records, Zero Tolerance of Abuse and Neglect policy, interviews with staff. [s. 19. (1)]

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

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to the residents as the incidents involved either non-consensual touching or the lack of an assessment of the residents capacity to consent to the situation at that time.
Scope: This non-compliance was widespread as seven of the nine incidents reviewed met the LTCHA definition of sexual abuse.
Compliance History: Previous non-compliance was left for a different subsection.
(756)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2022(A2)

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

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

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

Issued on this 28th day of January, 2022 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LISA CUMMINGS (756) - (A2)

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

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