Ontario

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

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

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

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


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

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

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
Télécopieur: (416) 327-4486


## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 13, 2019 | 2019_659189_0006 (A1) | 011164-18, 016608-18, 007355-19 | Critical Incident System |

### Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

Amended by NICOLE RANGER (189) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

**Extension of compliance order due date to September 27, 2019**

**Issued on this 13th day of August, 2019 (A1)**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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


**Long-Term Care Homes Division**
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2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

Amended by NICOLE RANGER (189) - (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): June 10, 11, 12, 13, 14, 17, 18, 19, 20, 25, 26, 2019.**

**The following intakes were inspected:**

**Log #007355-19, Log #011164-18 and Log # 016608-18 related to prevention of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Director of Recreation, Behavioual Support Ontario (BSO) Lead, Neighbourhood Coordinator, registered staff, personal support workers and residents.**

**During the course of the inspection the inspector observed staff to resident interactions, conducted observations of the residents, reviewed residents' health records, the home's investigation notes, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**

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

**4 WN(s)**
**2 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 | Légende<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. 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 :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

The home contacted the Ministry of Health and Long Term Care (MOHLTC) after hours pager to notify of an alleged resident to resident physical abuse, and the Critical Incident System (CIS) report was submitted on an identified date.

Interview with RN #113 who worked the day of the incident, revealed that resident #003 approached in a tearful manner and reported that they were hit by resident #004. RN #113 reported that they assessed the resident who had no bruising or injury. RN #113 reported that the Director of Recreation #119 then came to the unit to speak to the resident about the incident. RN #113 reported because they had not witnessed the incident, and that the incident occurred in the main street auditorium while the Director of Recreation was present, it was expected that the Director of Recreation would start the investigation and so they did not report the incident to the management.

Interview with the Director of Recreation #119 revealed that they were present during the memorial services, however they did not witness the incident between the residents. The Director of Recreation reported that they witnessed resident

#003 exiting the service, and went to check on the resident as there were more festivities to take place that day. The Director of Recreation reported that when they saw resident #003 with RN #113, the resident reported what had occurred in the memorial service. The Director of Recreation reported that because the resident informed RN #113 about the incident, they believed that RN #113 would report the incident to management to start the investigation.

Interview with the Neighbourhood Coordinator #102 revealed that the management was notified of the incident five days after, during a conversation with resident #003 on other concerns made. The Neighbourhood coordinator stated that an investigation was started that day. Interviews with RN #113, Director of Recreation #119, and Neighbourhood Coordinator #102 confirmed that the allegation of abuse that was reported on the identified date was not was immediately investigated. [s. 23. (1) (a)]

2. The MOHLTC received a CIS report from the home related to an allegation of resident to resident abuse.

Interview with PSW #110 who worked the evening shift on the identified date, revealed that after the dining services, resident #003 required assistance. As the PSW was assisting the resident, they passed resident #005 in the dining room, who made a gesture to resident #003. PSW #110 reported that they told resident #005 to stop, and that the behaviour was inappropriate. PSW #110 reported that they followed resident #003 to their room and informed the resident that what resident #005 did was inappropriate. PSW #110 reported after the discussion with the resident, they did not inform the charge nurse nor the management of the incident.

Interview with the Neighbourhood Coordinator #120 revealed that they received an email from resident #003 on an identified date at 2345 hours but did not read the email until the next day at 1500 hours when they returned to the home. The Neighbourhood Coordinator stated that an investigation was started the same day after receipt of email from the resident. Interview with the Neighbourhood coordinator and the Assistant General Manager confirmed that the allegation of abuse that was reported on the identified date was not was immediately investigated. [s. 23. (1) (a)]

3. During a review of resident #005 progress notes, the inspector noted that on an identified date, resident #006 reported that resident #005 asked if they can come

into their room and that the incident made resident #006 uncomfortable.

Interview with PSW #112 revealed that on the identified date, resident #006 reported that resident #005 asked to come into their room and the incident made the resident feel uncomfortable. PSW #112 told the resident that it was inappropriate and reported this to RN #111. Interview with RN #111 revealed that they were informed by PSW #112 about the incident, and they completed an incident report and informed the Neighbourhood Coordinator #120 about the incident.

Interview with Neighbourhood Coordinator #120 revealed that they were unaware of an incident that occurred on the identified date. The Neighbourhood Coordinator acknowledged that an investigation into the incident should have completed, and that it was not done. [s. 23. (1) (a)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met;  2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or  2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective.  2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change.

The MOHLTC received a CIS report from the home related to an allegation of resident to resident abuse. According to the CIS report, resident #003 sent an email to the Neighbourhood Coordinator on an identified date, informing of an incident that occurred earlier that day. Resident #003 reported that resident #005 made an unwelcome gesture, and that an incident like this had occurred prior in the past.

A review of the progress notes also identified that on an identified date, resident #006 reported that resident #005 asked if they can come into their room and that the incident made resident #006 uncomfortable.

Interviews with PSW #121, PSW #112 and PSW #110 revealed that resident #005 would often ask the staff on multiple occasions to come into their room. A review of the plan of care identified the interventions as related to staff, but does not identify the interventions as related to behaviours with co residents.

Interviews with Neighbourhood Coordinator #102 acknowledge that the plan of care was not reviewed and revised. [s. 6. (10) (b)]

2. The MOHLTC received a CIS report related to an incident of resident to resident abuse. According to the CIS, resident #007 went into resident #008's bedroom and an altercation took place and resident #008 sustained an injury.

A review of the progress notes identified multiple dates of altercations between resident #007 and resident #008. A review of resident #007's plan of care did not identify that resident #008 is a trigger for resident #007.

Interviews with RPN #116, RPN #117, PSW #115, Neighbourhood Coordinator #118 and BSO Lead #102 revealed that the staff identified that resident # 008 is a trigger for resident #007's behaviour.

Interviews with RPN#116, RPN#117, Neighbourhood Coordinator #118 acknowledge that the plan of care was not updated to identified resident #007's triggers. [s. 6. (10) (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 is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

The MOHLTC received a CIS report from the home related to an incident of resident to resident abuse .  According to the CIS, resident #007 went into resident #008's bedroom and an altercation took place and resident #008 sustained an injury.

Record review of resident #007's progress notes revealed four incidents of resident to resident altercations prior to the incident that took place where resident #008 sustained an injury.

Interviews with RPN #116, RPN #117, PSW #115, Neighbourhood Coordinator #118 and BSO Lead #102 revealed that the staff identified that resident #008 was a trigger for resident #007's behaviour.

Review of progress notes and interviews with staff did not identify any steps that were taken to minimize the risk of altercations and potentially harmful interactions between resident #007 and resident #008. Interviews with staff identified that the residents were separated, however no referral to BSO, assessments or identifying interventions were conducted.

Interviews with RPN#116, RPN#117, Neighbourhood Coordinator #118 and BSO Lead #102 confirmed that no interventions were in place to minimize the risk of altercations and potentially harmful interactions between the residents prior to the incident. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

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

**s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:**
**1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).**
**2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all direct care staff receive the required training annually.

The MOHLTC received a CIS report from the home related to an incident of resident to resident abuse . According to the CIS, resident #007 went into resident #008's bedroom and an altercation took place and resident #008 sustained an injury.

Interview with RPN #116 who provides care to resident #007, reveals that they did not receive training on responsive behaviour in 2018. A review of the Responsive Behaviours (Personal Expressions) training records for 2018 revealed that 225 out of 240 direct care staff received the training in 2018. Interview with the Assistant General Manager confirmed that only 91% of staff received the annual training. [s. 221. (2)]

**Issued on this 13th day of August, 2019 (A1)**

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

**Original report signed by the inspector.**

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by NICOLE RANGER (189) - (A1) |
| **Inspection No. / No de l'inspection :** | 2019_659189_0006 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 011164-18, 016608-18, 007355-19 (A1) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Aug 13, 2019(A1) |
| **Licensee / Titulaire de permis :** | Schlegel Villages Inc.<br>325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5 |
| **LTC Home / Foyer de SLD :** | The Village of Erin Meadows<br>2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Anneliese Krueger |

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 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;

(b) appropriate action is taken in response to every such incident; and

(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).

**Order / Ordre :**

The licensee must be compliant with s. 23 (1) of the LTCHA, 2007. Specifically, the licensee must :

1) Ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2) Ensure that appropriate action is taken in response to every such incident including any requirements that are provided for in the regulations for investigating and responding.

3) Retrain all staff responsible for investigating abuse and/or neglect of a resident.

4) Maintain records of re-training, including who received the training, when it occurred, and what the content of the training included.

**Grounds / Motifs :**

## 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

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

The home contacted the Ministry of Health and Long Term Care (MOHLTC) after hours pager to notify of an alleged resident to resident physical abuse, and the Critical Incident System (CIS) report was submitted on an identified date.

Interview with RN #113 who worked the day of the incident, revealed that resident #003 approached in a tearful manner and reported that they were hit by resident #004. RN #113 reported that they assessed the resident who had no bruising or injury. RN #113 reported that the Director of Recreation #119 then came to the unit to speak to the resident about the incident. RN #113 reported because they had not witnessed the incident, and that the incident occurred in the main street auditorium while the Director of Recreation was present, it was expected that the Director of Recreation would start the investigation and so they did not report the incident to the management.

Interview with the Director of Recreation #119 revealed that they were present during the memorial services, however they did not witness the incident between the residents. The Director of Recreation reported that they witnessed resident #003 exiting the service, and went to check on the resident as there were more festivities to take place that day. The Director of Recreation reported that when they saw resident #003 with RN #113, the resident reported what had occurred in the memorial service. The Director of Recreation reported that because the resident informed RN #113 about the incident, they believed that RN #113 would report the incident to management to start the investigation.

Interview with the Neighbourhood Coordinator #102 revealed that the management was notified of the incident five days after, during a conversation with resident #003 on other concerns made. The Neighbourhood coordinator stated that an investigation was started that day. Interviews with RN #113, Director of Recreation #119, and Neighbourhood Coordinator #102 confirmed that the allegation of abuse that was reported on the identified date was not was immediately investigated. (189)

2. The MOHLTC received a CIS report from the home related to an allegation of resident to resident abuse.

Interview with PSW #110 who worked the evening shift on the identified date, revealed that after the dining services, resident #003 required assistance. As the PSW was assisting the resident, they passed resident #005 in the dining room, who made a gesture to resident #003. PSW #110 reported that they told resident #005 to stop, and that the behaviour was inappropriate. PSW #110 reported that they followed resident #003 to their room and informed the resident that what resident #005 did was inappropriate. PSW #110 reported after the discussion with the resident, they did not inform the charge nurse nor the management of the incident.

Interview with the Neighbourhood Coordinator #120 revealed that they received an email from resident #003 on an identified date at 2345 hours but did not read the email until the next day at 1500 hours when they returned to the home. The Neighbourhood Coordinator stated that an investigation was started the same day after receipt of email from the resident. Interview with the Neighbourhood coordinator and the Assistant General Manager confirmed that the allegation of abuse that was reported on the identified date was not was immediately investigated. (189)

3. During a review of resident #005 progress notes, the inspector noted that on an identified date, resident #006 reported that resident #005 asked if they can come into their room and that the incident made resident #006 uncomfortable.

Interview with PSW #112 revealed that on the identified date, resident #006 reported that resident #005 asked to come into their room and the incident made the resident feel uncomfortable. PSW #112 told the resident that it was inappropriate and reported this to RN #111. Interview with RN #111 revealed that they were informed by PSW #112 about the incident, and they completed an incident report and informed the Neighbourhood Coordinator #120 about the incident.

Interview with Neighbourhood Coordinator #120 revealed that they were unaware of an incident that occurred on the identified date. The Neighbourhood Coordinator acknowledged that an investigation into the incident should have completed, and that it was not done.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as level 2 pattern as it related to 2 out of 3 residents reviewed. Review of the home's compliance history revealed unrelated non compliances. Due to the scope being pattern and severity as potential for actual harm, a compliance order is warranted. (189)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 27, 2019(A1)

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

## 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 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  13th  day of August, 2019 (A1)**

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

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

Amended by NICOLE RANGER (189) - (A1)

Ontario

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

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

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