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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie 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 6, 2021	2020_669642_0022	017102-20, 018911-20, 020489-20, 023529-20	Critical Incident System

Licensee/Titulaire de permis

Wikwemikong Nursing Home Limited
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Wikwemikong Nursing Home
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

AMY GEAUVREAU (642), LOVIRIZA CALUZA (687)

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): November 16-20, 23-27, 2020

The following intakes were completed during this Critical Incident System (CIS) Inspection:

-One CIS report submitted to the Director, related to alleged neglect towards a resident involving continence care;

-One CIS report submitted to the Director, related to an elopement of a resident;

-One CIS report submitted to the Director, related to an environmental hazard; and

-One CIS report submitted to the Director, related to alleged abuse from staff to a resident.

A Complaint Inspection #2020_669642_0021, was conducted concurrently with this Critical Incident Service Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Cares (DOCs), Physician, Registered Dietitian (RD), Behavioural Support Ontario (BSO) Clinical Lead, Activity Manager, Maintenance Supervisor, Dietary Manager, Maintenance staff, Finance Officer, Physiotherapist, Physiotherapist Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **8 WN(s)**
- **6 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. 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 incident of alleged, suspected or witnessed incident of abuse that was reported to the licensee was immediately investigated.

The Inspector conducted a review of the home's internal investigation related to alleged neglect of a resident by a Personal Support Worker (PSW). During the review it was identified that the PSW was also involved in two other alleged abuse incidents involving residents, on different dates.

During an interview with the current Director of Care (DOC) and the Administrator, they stated that there was no internal investigations conducted by the previous DOC in relation to the abuse incidents of two residents.

Sources: Review of the Critical Incident Service (CIS) report; review of the home's internal investigation; review of the critical incident reporting system; and interviews with the DOC and the Administrator. [s. 23. (1) (a)]

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 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 :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with.

a) A review of the home's internal investigation, identified that a PSW had been involved in an incident of abuse of a resident.

During an interview with a Registered Nurse (RN), they stated that they observed an incident of resident abuse. The RN further stated that they did not speak to the PSW and had not reported this incident to the previous DOC, until a later date.

In an interview with the Administrator, they acknowledged that the allegation of abuse was substantiated.

b) A review of the home's internal investigation, identified a PSW was involved in another incident involving a resident. The internal investigation notes indicated that a Registered Practical Nurse (RPN) had observed an incident of abuse, but had not reported the incident.

In an interview with the Administrator, they acknowledged that the allegation of abuse was substantiated.

Sources: Review of the internal investigation notes; interview with the Administrator and RN; and a review of the home's policy for Abuse and Neglect Prevention Program. [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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect neglect or abuse of a resident by a PSW, should immediately report the suspicion and the information upon which it was based to the Director.

Incidents of resident neglect and abuse occurred. A review of the CIS report indicated that this alleged incident was reported to the Director by the previous DOC on a later date, after they became aware of the incident. After reviewing the internal investigation notes there were three incidents of resident abuse/neglect that occurred and two of the incidents were not reported and one was reported late.

During an interview with the Administrator, they acknowledged that the neglect and the abuse incidents were substantiated involving this PSW towards residents. However, the previous DOC had not reported two incidents immediately to the Director and one was reported late.

Sources: CIS report; the home's Critical Incident policy; review of internal investigation notes; review of the critical incident reporting system; interview with PSW and the Administrator. [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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that, each resident who is unable to toilet independently some or all the time received assistance from staff to manage and maintain continence.

A review of the home’s internal investigation, indicated that a PSW was involved in an incident towards a resident. During an interview with another PSW, the PSW stated that when this resident required continence care, the specific PSW would not provide the required care.

In an interview with the Administrator, they acknowledged that this specific PSW was found not providing continence care for this resident.

Sources: Review of the CIS report; Review of the internal investigation notes; interview with the Administrator and another PSW. (687) [s. 51. (2) (c)]

2. Every licensee of a long-term care home shall ensure that, residents who require continence care products should have sufficient changes to remain clean, dry and comfortable.

A PSW noted that a resident needed a change in their continence care product. This PSW informed the other PSW that their resident would require their continence product changed. The PSW acknowledged that their resident required continence care but did not attend to the continence care needs of the resident, until a specific time later.

In an interview with the Administrator, they stated that this PSW was found negligent of their resident's continence care needs.

Sources: Review of the CIS report; review of the internal investigation notes; an interview with the Administrator, interview with another PSW. (687) [s. 51. (2) (g)]

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 each resident who is unable to toilet independently some or all the time receives assistance from staff to manage and maintain continence; and residents who require continence care products should have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or intervals provided for in the regulations:
1. Abuse recognition and prevention. 76 (7) (1).

According to O. Reg. 79/10., section 221 (2) (1), 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.

A CIS report was submitted to the Director regarding an alleged neglect towards a resident by a specific PSW.

During a review of the home's annual Abuse Prevention training documentation for 2019, it was identified that fifty two per cent (52%) of staff had not completed their abuse training on time.

In an interview with the current DOC, they acknowledged that the majority of the staff members did not complete the training for Abuse Prevention on time.

Sources: Review of the CIS report; review of the home's policy for Abuse and Neglect Prevention Program ; and a interview with the DOC. [s. 76. (7) 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 all staff at the home have received training as required by this section; and that abuse recognition and prevention training is completed annually, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee of a long-term care home has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents.

The home submitted a Critical Incident report to the Director, which outlined allegations of alleged abuse by a specific PSW toward a resident.

The Inspector conducted a record review of the home's policy titled, Abuse and Neglect Prevention Program, which indicated the home would ensure that the monitoring and analyzing of the Abuse Prevention Program was conducted annually to determine the effectiveness of the program.

In an interview with the Administrator, they stated that the home's policy for, Abuse and Neglect Prevention Program, was reviewed and revised annually by the DOC in collaboration with the Administrator. The Administrator acknowledged that the original date of the policy was on a specific date, and that the policy should have been reviewed and revised annually as stated in the Abuse and Neglect Prevention Program policy but it was not.

Sources: Review of the CIS; Abuse and Neglect Prevention Program Policy; and interview with the DOC and the Administrator. [s. 99. (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 at least once in a calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day regarding a resident who was missing for less than three hours and who returns to the home with no injury or adverse change in condition.

A Critical Incident report was submitted to the Director, related to a resident's elopement from the home.

A review of the resident's electronic progress notes identified the resident had a previous elopement incident, and had returned to the home with no injuries.

In an interview with the Administrator, they acknowledged that this resident had eloped, and that this was not previously reported to the Ministry. The Administrator further stated that the previous DOC had not reported this incident as they did not recognize this as a reportable incident.

Sources: A review of the CIS report; this resident's electronic progress notes; review of the home’s policy titled, Critical Incidents; and a interview with the Administrator. [s. 107. (3) 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 Director is informed no later than one business day after the occurrence of the incident, regarding a resident who is missing for less than three hours, and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. Every licensee of a long-term home shall ensure that each resident of the home is bathed, at a minimum, twice a week, and more frequently as determined by the resident's hygiene requirements.

On a specific date, a resident was scheduled to receive their bath/or shower. According to a PSW, the resident did not appear to have received their bath/or shower from the PSW who was providing their care, however it was documented as completed.

During an interview with the DOC, they stated that the PSW had not provided this resident with their second bath for the week, and the staff member received disciplinary action.

Sources: Review of the CIS report; review of this resident's care plan and point of care documentation; interview with the DOC, and a PSW. (687) [s. 33. (1)]

Issued on this 18th day of January, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMY GEAUVREAU (642), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2020_669642_0022
Log No. / No de registre :	017102-20, 018911-20, 020489-20, 023529-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 6, 2021
Licensee / Titulaire de permis :	Wikwemikong Nursing Home Limited 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	Wikwemikong Nursing Home 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

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 Wikwemikong Nursing Home Limited, 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. 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 O. Reg 79/10.

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 a staff member 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.

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

Grounds / Motifs :

1. The licensee has failed to ensure that every incident of alleged, suspected or witnessed incident of abuse that was reported to the licensee was immediately investigated.

The Inspector conducted a review of the home's internal investigation related to alleged neglect of a resident by a Personal Support Worker (PSW). During the review it was identified that the PSW was also involved in two other alleged abuse incidents involving residents, on different dates.

During an interview with the current Director of Care (DOC) and the Administrator, they stated that there was no internal investigations conducted by the previous DOC in relation to the abuse incidents of two residents.

Sources: Review of the Critical Incident Service (CIS) report; review of the home's internal investigation; review of the critical incident reporting system; and interviews with the DOC and the Administrator. (687)

2. The Compliance Order was made by taking the following factors into account:

Severity: There was actual risk specifically to three residents as the licensee did not take appropriate action in investigating and responding to reported abuse and neglect of these residents.

Scope: The scope of this non-compliance was a pattern.

Compliance History: One voluntary plans of correction (VPC) and one compliance order (CO) were issued to the home. The CO have previously been complied, and all were related to the same section of the legislation in the past 36 months. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2021

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:

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

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 6th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

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