Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 23, 2021	2021_715672_0017 (A1)	003211-21, 003805-21	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street Aurora ON L4G 3G8

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An amendment was made to the report as the licensee requested an extension of the compliance order due date for Compliance Order #001 until July 8, 2021.

Issued on this 23rd day of June, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Long-Term Care Inspections Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 23, 2021	2021_715672_0017 (A1)	003211-21, 003805-21	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
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The Willows Estate Nursing Home
13837 Yonge Street Aurora ON L4G 3G8

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 26, 27, 28, 29 and 30, 2021

The following intakes were completed during this inspection:

One intake related to allegations of staff to resident abuse and medication administration practices occurring in the home.

One intake related to allegations of staff to resident abuse.

During the course of the inspection, Complaint and Follow Up inspections were conducted concurrently.

During the Complaint inspection, the following intake(s) were completed:

One intake related to a complaint received regarding allegations of resident neglect, staff to resident abuse, restraining of residents and IPAC practices in the home.

During the Follow Up inspection, the following intake(s) were completed:

One intake conducted as a follow up to a previous Compliance Order issued to the home in inspection report #2021_715672_0002, related to the internal infection prevention and control program.

Within this inspection, a finding of non-compliance under s. 24 (1) was noted and will be issued within the Complaint Inspection (#2021_715672_0018) report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Acting Director of Care (ADOC), Nutrition Services Manager (NSM), Registered Dietitian (RD), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Care Aides (CAs), administration assistants, nursing assistant services manager (NASM), housekeepers, recreation aides, health screeners, maintenance workers, unit clerks, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Nutritional Care and Prevention of Resident Abuse and Neglect. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control and medication administration practices in the home.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

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

- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

Inspector noted daily that medicated treatment creams were stored in resident rooms, in the common bath/shower rooms and on care trolleys parked in the resident home area (RHA) hallways. During separate interviews, PSW and Registered staff indicated it was a common practice in the home for the medicated treatment creams to be stored in those areas, so that they were easily available for PSW staff to apply. The DOC indicated they were unsure where the medicated treatment creams were supposed to be stored and left them on the RHAs.

The Acting DOC indicated the expectation in the home was for medicated treatment creams to be stored in the locked medication room when not being used.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, the Acting DOC and DOC. [s. 129. (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 / 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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training in the required areas, according to the legislation, before performing their responsibilities.

Two Critical Incident Reports were submitted to the Director related to allegations of staff to resident abuse. Inspector was informed by multiple staff members who indicated they had worked in the home ranging from one day to several months, that they had not received any education/training related to the Residents' Bill of Rights, the home's mission statement or policy to minimize the restraining of residents, fire prevention and safety or the emergency and evacuation procedures, nor the internal prevention of resident abuse and neglect policies prior to working in the home. Some staff members indicated they had received the education several months after beginning work and others indicated they were still waiting to receive the education.

During an interview, the Administrator indicated they were new to working in the home but was aware there had been increased staffing needs during the pandemic, which led to a lot of new staff being hired recently. Due to the high volume of new staff members, they had not had an opportunity to ensure that each received the required orientation, education and training required according to the legislation prior to working in the home. The Administrator further indicated they were aware of the legislative requirements and had already begun working to implement educational sessions to ensure the new staff members received the orientation and education required and were implementing new procedures to ensure that all new staff hired would receive the required orientation and education prior to physically working in the home. By failing to ensure that every staff member received training related to the areas required under the legislative reference, residents were placed at risk of staff not knowing how to react in an emergency or possibly be subjected to an incident of being restrained or abused.

Sources: Interviews with CAs #119 and #121, Activity Aides #120 and #125 and the Administrator. [s. 76. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #018 was afforded privacy in treatment and in caring for their personal needs.

Inspector noted resident #018 being assisted and supervised in the common bathroom by PSW #126. The bathroom door to the main hallway was left wide open, while staff members and residents were in the area returning from the dining room.

During separate interviews, PSW #126, RPN #123, the Acting DOC and DOC indicated the expectation in the home was for staff to ensure resident's privacy was maintained at all times.

By not ensuring resident's privacy was always maintained, residents were put at risk of having their personal dignity damaged.

Sources: Observation conducted; interviews with PSW #126, RPN #123, the Acting DOC and DOC. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all drugs administered to resident #019 were prescribed for the resident.

Inspector noted a medicated treatment cream in resident #019's bedroom, which was prescribed to resident #022. During an interview, PSW #103 indicated they had applied the medicated treatment cream to resident #019 during care that morning as they had not read the prescription label on the bottle. PSW #103 further indicated they could not indicate how long the treatment cream had been in resident #019's bedroom or how often it had been applied to the resident. Upon inspection, the bottle of medicated treatment cream appeared to be 3/4 empty. PSW #103 indicated the expectation in the home was for staff to always read and follow the label for directions related to who the medicated treatment creams were prescribed for and the required application.

During separate interviews, RPN #104 indicated medicated treatment creams were supplied to the PSW staff as soon as they were received from the pharmacy and it was the responsibility of the PSW providing care to ensure the treatment cream was applied to the correct resident in the prescribed way. The DOC indicated the expectation in the home was for staff to ensure the medicated treatment cream was prescribed for the resident it was applied to and the directions for application were always followed.

Sources: Observation conducted; interviews with PSW #103, RPN #104 and the DOC. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 23rd day of June, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2021_715672_0017 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003211-21, 003805-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 23, 2021(A1)
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, Peterborough, ON, K9J-6X6
LTC Home / Foyer de SLD :	The Willows Estate Nursing Home 13837 Yonge Street, Aurora, ON, L4G-3G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matthew Riel

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 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

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

The licensee must be compliant with section s. 129. (1) (a) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that drugs and medicated treatment creams are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, which is kept secured and locked when not in use.

2. Conduct bi-weekly audits of the resident home areas, including Spa/shower rooms, to ensure medicated treatment creams are not being stored there. Keep a documented record of the audits completed.

3. Reeducate nursing staff (both Registered and PSWs) to remind them of the requirement for drugs and medicated treatment creams to be stored in an area or medication cart that is used exclusively for drugs and drug-related supplies. Keep a documented record of the education provided and staff signatures that education was received and understood.

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 drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

Inspector noted daily that medicated treatment creams were stored in resident rooms, in the common bath/shower rooms and on care trolleys parked in the resident home area (RHA) hallways. During separate interviews, PSW and Registered staff indicated it was a common practice in the home for the medicated treatment creams to be stored in those areas, so that they were easily available for PSW staff to apply. The DOC indicated they were unsure where the medicated treatment creams were supposed to be stored and left them on the RHAs.

The Acting DOC indicated the expectation in the home was for medicated treatment creams to be stored in the locked medication room when not being used.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, the Acting DOC and DOC.

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

Severity: There was actual risk of harm to the residents as residents had access to medicated treatment creams not prescribed to them.

Scope: The scope of this non-compliance was widespread, as all resident home areas were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 08, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with section s. 76 (2) of O. Reg. 79/10.

Specifically, the licensee must:

1. All staff must receive training in the areas required by s. 76 (2) of O. Reg 79/10 prior to performing their responsibilities.

Grounds / Motifs :

1. The licensee has failed to ensure that staff received training in the required areas, according to the legislation, before performing their responsibilities.

Two Critical Incident Reports were submitted to the Director related to allegations of staff to resident abuse. Inspector was informed by multiple staff members who indicated they had worked in the home ranging from one day to several months, that they had not received any education/training related to the Residents' Bill of Rights, the home's mission statement or policy to minimize the restraining of residents, fire prevention and safety or the emergency and evacuation procedures, nor the internal prevention of resident abuse and neglect policies prior to working in the home. Some staff members indicated they had received the education several months after beginning work and others indicated they were still waiting to receive the education.

During an interview, the Administrator indicated they were new to working in the home but was aware there had been increased staffing needs during the pandemic, which led to a lot of new staff being hired recently. Due to the high volume of new staff members, they had not had an opportunity to ensure that each received the required orientation, education and training required according to the legislation prior to working in the home. The Administrator further indicated they were aware of the legislative requirements and had already begun working to implement educational sessions to ensure the new staff members received the orientation and education required and were implementing new procedures to ensure that all new staff hired would receive the required orientation and education prior to physically working in the home. By failing to ensure that every staff member received training related to the areas required under the legislative reference, residents were placed at risk of staff not knowing how to react in an emergency or possibly be subjected to an incident of being restrained or abused.

Sources: Interviews with CAs #119 and #121, Activity Aides #120 and #125 and the Administrator.

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

Severity: There was minimal risk of harm to the residents as residents could possibly be placed in situations where new staff members did not know how to safely react.

Scope: The scope of this non-compliance was widespread, as most staff members newly hired to the home had not received the required training prior to performing their responsibilities.

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

Compliance History: Two previous Voluntary Plans of Correction were issued to the home under the same subsection of the legislation, during Critical Incident System Inspection #2021_715672_0002 on January 19, 2021, and during Resident Quality Inspection #2018_594624_0010 on August 9, 2018. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 24, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

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

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.

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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
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 23rd day of June, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JENNIFER BATTEN (672) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

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