Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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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
Sep 10, 2020	2020_648741_0011	008845-20, 013017-20	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Afton Park Place Long Term Care Community
1200 Afton Drive SARNIA ON N7S 6L6

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

AYESHA SARATHY (741), CASSANDRA ALEKSIC (689)

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): August 19, 20, 24 and 25, 2020

The following Critical Incident Systems (CIS) were inspected as a part of this inspection:

2872-000008-20 related to a missing or unaccounted for controlled substance
2872-000014-20 related to staff to resident neglect

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPNs), a Registered Nurse (RN) and the Manager of Resident Care (MRC).

The Inspectors also reviewed relevant policies and procedures, the home's investigation notes, Medication Incident Forms and clinical records for an identified resident.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff failed to comply with the home's “Medication Disposal of Controlled Substances in Long Term Care Homes” policy #9.2, last revised March 2020 and the home's “Medication – Destruction and Disposal” policy #RCM 17-26, last revised April 2020, which were part of the licensee's medication management system.

A. A Critical Incident System (CIS) was submitted to the Ministry of Long-Term Care (MOLTC), related to a controlled substance being missing for a resident on a day in May 2020. During the inspection, the Manager of Resident Care (MRC) said that the medication that was missing for the resident was found a month later. They said that they, along with a Registered Nurse (RN), discarded the medication in the drug destruction bin on a day in June 2020 and found the resident's missing medication. The MRC said the date of disposal was written on the medication but could not recall any other details about it, such as the resident's name or whether there were any staff signatures on it. They said they knew which resident the medication belonged to as they were the only resident who took that medication in the home. They also said that they did not know who found and disposed of the medication as it was not reported to

management or documented on the appropriate form.

In an interview, the MRC said that staff did not follow the home’s "Medication Disposal of Controlled Substances in Long Term Care Homes" policy when they did not document the disposal of the resident’s missing medication when it was found.

B. During review of a form that staff used to document the disposal of controlled substances, it was noted that there was missing documentation for the disposal of a controlled substance for a resident on a day in June 2020.

A Medication Incident Form that was completed related to the medication incident was reviewed and indicated that the MRC initiated an investigation into the incident seven weeks after the occurrence of the missing controlled substance. The Medication Incident Form documented that upon emptying the drug destruction bin on a day in August 2020, a controlled substance that was disposed of for a resident in June 2020 was found to be missing. The investigation notes included an interview between the MRC and the RPN who was responsible for disposing of the resident’s medication and stated that the RPN disposed of the controlled substance in the garbage instead of the drug destruction bin as they were not aware that the medication was a controlled substance. The form documented that a factor that contributed to the incident was a lack of education.

During a phone interview with the RPN who was involved in the incident, they said they no longer worked at the home. They said the incident occurred on their first shift after they began their position at the home, and that they probably disposed of the resident’s medication in the garbage as they had not been trained on the process for disposal of controlled substances and thought the medication could be disposed of in the garbage. The RPN explained that during their orientation to the home, they were not provided training on the home’s “Medication – Destruction and Disposal” policy #RCM 17-26, last revised April 2020 or the process for disposing narcotics. They said they requested to have a nursing orientation and were provided with two hours on the floor with an RPN, who did not show them the process for disposal and destruction of narcotics. They said that neither the home nor the staffing agency they worked for provided them with home specific education or training related to the home’s medication destruction and disposal policy and procedures. They said when they started their role at the home, they had to figure out how to dispose of narcotics on their own.

The RPN’s completed Orientation Checklist from the staffing agency they worked for was reviewed and indicated that the home’s medication disposal and destruction policy or

procedures was not included as a component on the checklist and not covered as a part of their orientation.

In an interview with the MRC, they were asked how they became aware that the resident had a missing controlled substance on a day in June 2020 and they said that they learned about it when they discarded the medications from the drug destruction box on a day in August 2020. They were asked how often the forms that staff documented the disposal of controlled substances on were reviewed, and they said that the forms were not reviewed on a regular basis and that their current practice was to review them when the drug destruction bin was full and emptied into the pharmacy provided Daniels's bin. The MRC said that the RPN who disposed of the resident's medication was hired pursuant to a contract or agreement between the home and a staffing agency and was provided with one day of orientation before starting their role, which comprised of an eight hour shift with an RPN on the floor. They said that the RPN completed an orientation checklist that was provided by the staffing agency but that the checklist did not cover medication destruction and disposal. They said that the home's medication destruction and disposal policy and procedures were relevant to the RPN's responsibilities and that there was a definite gap with the home's orientation for agency staff as they were not being trained on medication destruction and disposal prior to starting their responsibilities.

They said that the RPN did not follow the home's "Medication – Destruction and Disposal" policy when they disposed of the resident's controlled substance in the garbage instead of the drug destruction bin as per the home's policy.

C. The form that staff used to document the disposal of controlled substances was reviewed for August 2020 as a part of an expanded sample size for this inspection. The review of the form indicated that there was missing documentation for the disposal of a controlled substance for a resident on a day in August 2020.

A Medication Incident Form that was completed related to the medication incident was reviewed and indicated that the MRC initiated an investigation into the incident ten days after the occurrence of the missing controlled substance. The Medication Incident Form documented that the MRC discovered that the resident's medication was missing after emptying the drug destruction bin on a day in August 2020. The investigation notes included an interview between the MRC and the RPN who was responsible for disposing of the resident's medication, and stated that the RPN disposed of the controlled substance in the garbage instead of the drug destruction bin as they were not aware that

the medication was a controlled substance.

During an interview with the RPN who was involved in the incident, they said that they recalled the incident and on the day of the incident, they disposed of the resident’s controlled substance in the garbage instead of the drug destruction bin. They said that they were trained on the process for disposing controlled substances but were not aware that the resident’s medication was a controlled substance.

In an interview with the MRC, they were asked how they became aware that the resident had a missing controlled substance in August 2020 and they said that they learned about it when they discarded the medications from the drug destruction box on a day in August 2020. They said that medication disposal and destruction would have been covered during the RPN’s orientation and that the RPN did not follow the home’s "Medication – Destruction and Disposal" policy when they disposed of the resident’s controlled substance in the garbage instead of the drug destruction bin.

D. An RPN was interviewed as a part of an expanded sample size for a different non-compliance identified during the inspection. During the interview, the RPN was asked about the process for disposing wasted controlled substances in the home. They said that to dispose of narcotics they either put them in the blue and white Daniels bin or dissolved them in a small cup of warm water with another registered staff member present. They said they would dissolve a narcotic if they had already popped the pill out from the blister pack and the resident refused it or was unable to take their narcotic for some reason. They said that if a narcotic did not dissolve then they would throw it in the blue and white Daniels bin. When asked how they determined which method to use to dispose of a narcotic, they said it was whatever a staff member preferred at the time and that it made them feel better to watch a strong narcotic dissolve in water to prevent it from getting in the wrong hands. They said that they learned the practice of dissolving narcotics at another place of work and utilized it at this home as well, despite being trained to dispose of narcotics in the blue and white Daniels bin.

In an interview with the MRC, they said that staff were expected to dispose of a narcotic that was refused or missed by a resident by putting it into the blue and white Daniels bin and completing the appropriate documentation. They said that it was not standard practice at the home for staff to dissolve and denature narcotics and that it was not right for the RPN to implement this practice at the home.

The licensee failed to ensure that an RPN complied with the home’s policy to dispose of

refused or wasted narcotics in the home's blue and white Daniels bin.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance no later than one business day after the occurrence of the incident.

A. During review of a form that staff documented the disposal of controlled substances on for June 2020, it was noted that there was missing documentation for the disposal of a controlled substance for a resident. A Medication Incident Form was completed seven weeks later related to the medication incident and indicated that the Manager of Resident Care (MRC) initiated an investigation into the incident after emptying patches from the drug destruction box in the Registered Nurse (RN) supply room and noting that a controlled substance was missing for the resident. The incident was not reported by the home to the Ministry of Long-Term Care (MOLTC).

Included in the home's investigation notes for the incident was a telephone interview conducted by the MRC with a Registered Practical Nurse (RPN), in which the RPN said they would have thrown the medication into the garbage as they did not realize it was a controlled substance.

During an interview with the RPN, they said that the incident occurred on their first shift after they began their position at the home, and that they probably put the resident's

medication in the garbage as they were not aware that it was a controlled substance.

In an interview with the MRC, they said they learned about the missing controlled substance when they emptied the drug destruction box on a day in August 2020. They said the controlled substance for the resident was not found or accounted for. They acknowledged that the incident should have been reported to the MOLTC within one business day.

B. The form that staff used to document the disposal of controlled substances was reviewed for August 2020 as a part of an expanded sample size for this inspection. During the review, it was noted that there was missing documentation for a resident's medication that was a controlled substance. A Medication Incident Form was completed ten days later related to the medication incident and indicated that the MRC initiated an investigation into the incident after emptying medication from the drug destruction box in the RN supply room and noting that a controlled substance was missing for the resident. The incident was not reported by the home to the Ministry of Long-Term Care (MOLTC).

Included in the home's investigation notes for the incident was a telephone interview conducted by the MRC with a Registered Practical Nurse (RPN), in which the RPN said they would have thrown the medication into the garbage as they did not realize it was a controlled substance.

During an interview with the RPN, they said that they recalled the incident and that they had disposed of the resident's medication in the garbage instead of the drug destruction bin as they were not familiar with the medication and did not know it was a narcotic.

In an interview with the MRC, they said they learned about the missing controlled substance when they emptied the drug destruction box on a day in August 2020. They said the controlled substance for the resident was not found or accounted for. They acknowledged that the incident should have been reported to the MOLTC within one business day.

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 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: A missing or unaccounted for controlled substance, to be implemented voluntarily.

Issued on this 10th day of September, 2020

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	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8	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) :	AYESHA SARATHY (741), CASSANDRA ALEKSIC (689)
Inspection No. / No de l'inspection :	2020_648741_0011
Log No. / No de registre :	008845-20, 013017-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 10, 2020
Licensee / Titulaire de permis :	S & R Nursing Homes Ltd. 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	Afton Park Place Long Term Care Community 1200 Afton Drive, SARNIA, ON, N7S-6L6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeff Harvey

To S & R Nursing Homes Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (1) of the Ontario Regulation 79/10.

Specifically;

A) The licensee must ensure that the home's medication disposal and destruction policies are complied with for resident #001 and any other resident who receives the same narcotic.

B) The licensee must ensure that the home's narcotic disposal sheets are reviewed weekly, at a minimum, for inconsistencies, and that documentation of each review is kept at the home, and includes the date of review and name of the reviewer.

C) The licensee must ensure that all Registered Practical Nurses and Registered Nurses receive re-training related to the home's medication disposal and destruction policies and processes, specifically the process that pertains to the disposal and destruction of controlled substances.

D) The licensee must keep written records in the home all the re-training and education that is reviewed with registered staff related to the disposal and destruction of controlled substances, and must include:
- A copy of the content that was reviewed with registered staff during re-training
- The name of the staff member(s) that provided the re-training
- The method by which the training was provided to registered staff
- A list of attendance and completion of training that includes the staff member's printed name, signature, designation and date of attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff failed to comply with the home's "Medication Disposal of Controlled Substances in Long Term Care Homes" policy #9.2, last revised March 2020 and the home's "Medication – Destruction and Disposal" policy #RCM 17-26, last revised April 2020, which were part of the licensee's medication management system.

A. A Critical Incident System (CIS) was submitted to the Ministry of Long-Term Care (MOLTC), related to a controlled substance being missing for a resident on a day in May 2020. During the inspection, the Manager of Resident Care (MRC) said that the medication that was missing for the resident was found a month later. They said that they, along with a Registered Nurse (RN), discarded the medication in the drug destruction bin on a day in June 2020 and found the resident's missing medication. The MRC said the date of disposal was written on the medication but could not recall any other details about it, such as the resident's name or whether there were any staff signatures on it. They said they knew which resident the medication belonged to as they were the only resident who took that medication in the home. They also said that they did not know who found and disposed of the medication as it was not reported to management or documented on the appropriate form.

In an interview, the MRC said that staff did not follow the home's "Medication Disposal of Controlled Substances in Long Term Care Homes" policy when they did not document the disposal of the resident's missing medication when it was found.

B. During review of a form that staff used to document the disposal of controlled substances, it was noted that there was missing documentation for the disposal of a controlled substance for a resident on a day in June 2020.

A Medication Incident Form that was completed related to the medication incident was reviewed and indicated that the MRC initiated an investigation into the incident seven weeks after the occurrence of the missing controlled substance. The Medication Incident Form documented that upon emptying the drug destruction bin on a day in August 2020, a controlled substance that was disposed of for a resident in June 2020 was found to be missing. The investigation notes included an interview between the MRC and the RPN who

was responsible for disposing of the resident's medication and stated that the RPN disposed of the controlled substance in the garbage instead of the drug destruction bin as they were not aware that the medication was a controlled substance. The form documented that a factor that contributed to the incident was a lack of education.

During a phone interview with the RPN who was involved in the incident, they said they no longer worked at the home. They said the incident occurred on their first shift after they began their position at the home, and that they probably disposed of the resident's medication in the garbage as they had not been trained on the process for disposal of controlled substances and thought the medication could be disposed of in the garbage. The RPN explained that during their orientation to the home, they were not provided training on the home's "Medication – Destruction and Disposal" policy #RCM 17-26, last revised April 2020 or the process for disposing narcotics. They said they requested to have a nursing orientation and were provided with two hours on the floor with an RPN, who did not show them the process for disposal and destruction of narcotics. They said that neither the home nor the staffing agency they worked for provided them with home specific education or training related to the home's medication destruction and disposal policy and procedures. They said when they started their role at the home, they had to figure out how to dispose of narcotics on their own.

The RPN's completed Orientation Checklist from the staffing agency they worked for was reviewed and indicated that the home's medication disposal and destruction policy or procedures was not included as a component on the checklist and not covered as a part of their orientation.

In an interview with the MRC, they were asked how they became aware that the resident had a missing controlled substance on a day in June 2020 and they said that they learned about it when they discarded the medications from the drug destruction box on a day in August 2020. They were asked how often the forms that staff documented the disposal of controlled substances on were reviewed, and they said that the forms were not reviewed on a regular basis and that their current practice was to review them when the drug destruction bin was full and emptied into the pharmacy provided Daniels's bin. The MRC said that the RPN who disposed of the resident's medication was hired pursuant to a

contract or agreement between the home and a staffing agency and was provided with one day of orientation before starting their role, which comprised of an eight hour shift with an RPN on the floor. They said that the RPN completed an orientation checklist that was provided by the staffing agency but that the checklist did not cover medication destruction and disposal. They said that the home's medication destruction and disposal policy and procedures were relevant to the RPN's responsibilities and that there was a definite gap with the home's orientation for agency staff as they were not being trained on medication destruction and disposal prior to starting their responsibilities.

They said that the RPN did not follow the home's "Medication – Destruction and Disposal" policy when they disposed of the resident's controlled substance in the garbage instead of the drug destruction bin as per the home's policy.

C. The form that staff used to document the disposal of controlled substances was reviewed for August 2020 as a part of an expanded sample size for this inspection. The review of the form indicated that there was missing documentation for the disposal of a controlled substance for a resident on a day in August 2020.

A Medication Incident Form that was completed related to the medication incident was reviewed and indicated that the MRC initiated an investigation into the incident ten days after the occurrence of the missing controlled substance. The Medication Incident Form documented that the MRC discovered that the resident's medication was missing after emptying the drug destruction bin on a day in August 2020. The investigation notes included an interview between the MRC and the RPN who was responsible for disposing of the resident's medication, and stated that the RPN disposed of the controlled substance in the garbage instead of the drug destruction bin as they were not aware that the medication was a controlled substance.

During an interview with the RPN who was involved in the incident, they said that they recalled the incident and on the day of the incident, they disposed of the resident's controlled substance in the garbage instead of the drug destruction bin. They said that they were trained on the process for disposing controlled substances but were not aware that the resident's medication was a controlled substance.

In an interview with the MRC, they were asked how they became aware that the resident had a missing controlled substance in August 2020 and they said that they learned about it when they discarded the medications from the drug destruction box on a day in August 2020. They said that medication disposal and destruction would have been covered during the RPN's orientation and that the RPN did not follow the home's "Medication – Destruction and Disposal" policy when they disposed of the resident's controlled substance in the garbage instead of the drug destruction bin.

D. An RPN was interviewed as a part of an expanded sample size for a different non-compliance identified during the inspection. During the interview, the RPN was asked about the process for disposing wasted controlled substances in the home. They said that to dispose of narcotics they either put them in the blue and white Daniels bin or dissolved them in a small cup of warm water with another registered staff member present. They said they would dissolve a narcotic if they had already popped the pill out from the blister pack and the resident refused it or was unable to take their narcotic for some reason. They said that if a narcotic did not dissolve then they would throw it in the blue and white Daniels bin. When asked how they determined which method to use to dispose of a narcotic, they said it was whatever a staff member preferred at the time and that it made them feel better to watch a strong narcotic dissolve in water to prevent it from getting in the wrong hands. They said that they learned the practice of dissolving narcotics at another place of work and utilized it at this home as well, despite being trained to dispose of narcotics in the blue and white Daniels bin.

In an interview with the MRC, they said that staff were expected to dispose of a narcotic that was refused or missed by a resident by putting it into the blue and white Daniels bin and completing the appropriate documentation. They said that it was not standard practice at the home for staff to dissolve and denature narcotics and that it was not right for the RPN to implement this practice at the home.

The licensee failed to ensure that an RPN complied with the home's policy to dispose of refused or wasted narcotics in the home's blue and white Daniels bin.

The severity of this issue was determined to be a level two as there was minimal

risk of harm as a result of this non-compliance. The scope of the issue was a level three as it was widespread in the home. The home had a level two compliance history as the home had previous non-compliance but to a different subsection of the Long-Term Care Homes Act. (741)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Nov 01, 2020

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 10th day of September, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Ayesha Sarathy

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