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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Jul 6, 2021	2021_650565_0006	014788-20, 018284-20, 019387-20, 020670-20, 025491-20, 000981-21, 001547-21, 002868-21, 005498-21, 005752-21	Critical Incident System

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street Toronto ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street North York ON M6A 2E1

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

MATTHEW CHIU (565), BABITHA SHANMUGANANDAPALA (673)

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): On-site on March 17-19, 22 -26, 29-31, April 1, 6-9, 12-15, and 19-22, 2021; Off-site on April 27, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #001547-21 was related to infection prevention and control;
Log #002868-21 was related to unexpected death of a resident;
Log #025491-20; Log #000981-21; Log #014788-20 were related to prevention of abuse and neglect;
Log #020670-20; Log #019387-20; Log #18284-20; Log #005752-21 were related to medication administration and management system; and
Log #005498-21 was related to follow-up to Compliance Order (CO) #001.

Voluntary Plans of Correction related to LTCHA, s. 6 (10) (c) and s. 19 (1) were identified in this inspection and have been issued in a concurrent inspection #2021_650565_0008.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Long-Term Care Managers (LTCMs), Director of Infection Prevention and Control (DOIPAC), Occupational Health and Safety Manager (OHSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitians (RDs), Food and Nutrition Services Manager (FNSM), Point Click Care (PCC) Coordinator, Clinical Educator (CE), Pharmacy Consultant (PC), Assistant to Executive Director, Residents, and Family Members.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_833763_0021	673

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

A RPN administered a medication to resident #015 with a dosage that was not specified by the physician. The RPN documented and told the inspector the administrated dosage, which differed from the physician's order. On the same day, the resident had a significant change in their health status.

The DOC acknowledged that the RPN did not administer the medication to resident #015 in accordance with the directions for use specified by the prescriber.

Sources: The inspector's observations; resident's clinical records; the home's investigation notes; and interviews with the RPN and the DOC. [s. 131. (2)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

RPN #116 could not conveniently and immediately access the contents of resident #004's plan of care, and they were not aware of the resident's specified care needs. They were not aware of resident #004's plan of care since admission, nor when the resident had a significant change in condition.

PSW #118 was also not able to conveniently and immediately access resident #004's specified plan of care.

RPN #123 could not conveniently and immediately access the contents of resident #013's specified plan of care. RPN #123 was unable to clearly identify which residents on the unit were assessed to be at high risk for the specified care needs.

The FNSM acknowledged that staff were not easily able to access the contents and remain aware of the specified plan of care for residents.

Sources: The residents' clinical records; and interviews with the PSW, the RPNs, and the FNSM. [s. 6. (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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O. Reg. 79/10, s. 114 (2) requires that written policies and protocols are 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.

a) Staff did not comply with the home's policy and procedure "Medisystem Policies and Procedures: F. Specialty Drugs; Section 22.1; Narcotics, controlled and targeted substances", which states that:
- it is recommended two nurses count and document all narcotics on every shift change.

During a shift, the narcotics shift counts were noted to have one signature, and they were not signed off by registered staff on the previous shift change.

The RPN stated that they had completed the count but failed to sign off on it. They acknowledged it should have been completed at shift change when the count was completed.

The DOC acknowledged that narcotic shift counts should be documented by two nurses and signed for at the time of the shift count as per the home's process.

b) There was a change in the physician order for a medication for a resident. During the day when the change occurred, review of the narcotics binder indicated that only one administration recorded for the medication before the order changed.

i) Staff did not comply with the home's policy and procedure "Medisystem Policies and Procedures: F. Specialty Drugs; Section 22.1; Narcotics, controlled and targeted substances", which states that:
- all entries must be made at the time the drug is removed from the container.

The last documentation in the record was from the previous shift change. The RPN had administered this medication four times after the shift change and did not sign off on the Narcotic and Controlled Substance Administration Record at the time when the drug was removed from the container, as per the home's policy and process.

ii) Staff did not comply with the home's policy and procedure "Medisystem Policies and Procedures: D. Medication; Section 17.1.2; Change of Direction" which states that staff responsible for transcribing/processing orders will locate the drug product and apply a change of direction auxiliary label to the affected pouch or product. If new product is required to be sent from pharmacy, notify pharmacy to send more product.

The Narcotic and Controlled Substance Administration Record for a resident did not have a change of direction auxiliary label applied after a physician order was discontinued and changed.

The DOC indicated that the RPN should have applied a change in direction auxiliary label to the existing Narcotic and Controlled Substance Administration Record for the previous order when the physician discontinued it, and they should have created a new order by revising the document to indicate the new order.

iii) Staff did not comply with the home's policy and procedure "Medisystem Policies and Procedures: E. Medication Handling; Section 19; Emergency Box Policy" which states that:
- a medication from the Emergency Drug Box is used when a new medication order is received by the prescriber which requires initiation of therapy prior to the next scheduled pharmacy delivery.
- document removal in the emergency box long sheet(s).

There was a change in a resident's medication order, and the RPN administered the new order to the resident by obtaining the medication from the medication container of the previous order.

The Pharmacist stated as it was before the pharmacy delivery time, the RPN should have obtained a new medication container from the emergency drug box, documented in the emergency drug box count sheet of its removal, and initiated a new medication administration record for this order.

There was no new medication administration record initiated for the new order.

The DOC acknowledged that the emergency box policy was not followed by the RPN.

iv) Staff did not comply with the home's policy and procedure "Medisystem Policies and Procedures: F. Specialty Drugs; Section 22.1; Narcotics, controlled and targeted substances", which states that:
- entries for wasted/damaged doses must be filled in completely with an explanation and the signature of a witness on the Narcotic and Controlled Substances Administration Record. The wastage must be denatured to the extent that consumption is impossible or improbable and immediately placed in the destruction pail.

During an observation, the inspector observed a specified number of open medication vials in the medication cart.

The RPN stated they had administered the medication to a resident the specified number of times during the shift and some of the medication had accidentally spilled.

The DOC indicated that the RPN should have, as per the home's policy and process, wasted the medications as soon as feasibly possible and that with the number of ampoules and the time of day, there had been opportunity to waste with another nurse sooner.

The DOC acknowledged that the RPN had not complied with home's policies related to medication changes and discontinuation, medication handling, and appropriate wastage and documentation as required.

Sources: The inspector's observations; the residents' clinical records; the home's records, relevant policies and procedures; and interviews with the RPNs, the Pharmacist, and the DOC. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the organized program of nutrition care and dietary services, and the organized program of hydration for the home, there was a written description of the program that includes relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

a) Review of the policy for the hydration program in the home titled ‘Hydration Program’ revised November 2020, stated that the registered dietitians should asses upon referral residents who consistently fall below the recommended intake and/or are at risk for dehydration and plan additional interventions as appropriate. The policy did not include protocols such as when and who makes these referrals to the registered dietitian.

RD #109 stated that they were unsure of when staff were to make a referral to them as it related to resident hydration status.

The FNSM acknowledged that the policy did not meet the general requirements of the Regulation as it did not include the protocols for referral of residents to the RD.

b) Review of the policy for the nutrition program in the home titled ‘Nutrition Program’, revised November 2020, stated that the registered dietitians should respond to all nutrition referrals. The policy stated that nurses should refer to the RD if there are “unexpected changes”. The policy did not indicate the definition of unexpected changes or other protocols for making a referral the RD in relation to the nutrition program.

The FNSM acknowledged that the policy did not meet the general requirements of the Regulation as it did not specify protocols for referral of residents to the RD.

Sources: The home's Nutrition Program Policy (revised Nov 2020), Hydration Program policy (revised Nov 2020); and interviews with the RD and the FNSM. [s. 30. (1) 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 for the organized program of nutrition care and dietary services, and the organized program of hydration for the home, there is a written description of the program that includes relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #5: 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 controlled substances were stored in a separate locked area within the locked medication cart.

a) During an observation, the inspector observed a number of open controlled substances in the first drawer of the medication cart. They were not stored in a separate locked area within the locked medication cart.

The RN indicated their practice was to keep narcotics locked in the top drawer and wait until end of shift to waste with the oncoming nurse.

The DOC stated that narcotics should always be kept double locked and acknowledged that in this case they had not been double locked.

b) When a RPN was administering a narcotic medication to a resident, they unlocked the narcotic bin and removed the narcotic from the bin within the medication cart. When the RPN closed the bin, it did not lock. The RPN locked the medication cart and administered the medication to the resident. Upon returning to the medication cart, the RPN acknowledged the narcotic bin did not lock and should lock when pressed down upon.

Sources: The inspector’s observations; the home's investigation notes; and interviews with the RPNs and the DOC. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review were implemented, and a written record was kept of everything in (a) and (b).

A review of minutes from the Medication Management Committee for quarters two, three, and four from the year 2020 indicated that medication incidents and adverse drug reactions were reviewed, and specified issues and incidents were identified.

In an interview, the DOC stated that actions had been taken to address and reduce medication incidents.

There was no documentation in the meeting minutes of actions taken in order to reduce and prevent medication incidents and adverse drug reactions.

Sources: The home's Medication Management Committee meeting minutes; and interview with the DOC. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and a written record is kept of everything in (a) and (b), to be implemented voluntarily.

Issued on this 28th day of July, 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) :	MATTHEW CHIU (565), BABITHA SHANMUGANANDAPALA (673)
Inspection No. / No de l'inspection :	2021_650565_0006
Log No. / No de registre :	014788-20, 018284-20, 019387-20, 020670-20, 025491-20, 000981-21, 001547-21, 002868-21, 005498-21, 005752-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 6, 2021
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, Toronto, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, North York, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Simon Akinsulie

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

To The Jewish Home for the Aged, 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 :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 131 (2).

Specifically, the licensee shall:
1. Ensure administration of narcotics and controlled substances are administered to residents in accordance with the directions for use by the prescriber;
2. Conduct weekly audits, for two months following service of this order, of administration of narcotics and controlled substances administered by Registered Practical Nurses for accurate administration;
3. Document audits completed, to include at minimum: resident name, staff member audited, medication administered, dose administered, prescriber's order, result of audit and any corrective action taken in response to the audit; and
4. Maintain a record of audits conducted to be provided upon request.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

1. The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

A RPN administered a medication to resident #015 with a dosage that was not specified by the physician. The RPN documented and told the inspector the administrated dosage, which differed from the physician's order. On the same day, the resident had a significant change in their health status.

The DOC acknowledged that the RPN did not administer the medication to resident #015 in accordance with the directions for use specified by the prescriber.

Sources: The inspector’s observations; resident's clinical records; the home's investigation notes; and interviews with the RPN and the DOC.

An order was made by taken the following factors into account:
Severity: A medication was not administered to a resident in accordance with the directions for use specified by the prescriber causing actual risk to the resident.
Scope: This was an isolated case as medication, for one out of the three residents reviewed, was not administered to one resident in accordance with the directions for use specified by the prescriber.
Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10, s. 131 (2). One written notification (WN) and one voluntary plan of correction (VPC) were issued to the home. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 08, 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 July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Matthew Chiu

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