Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_583117_0037	015861-19	Critical Incident System

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Centre d'Accueil Champlain
275 Perrier Street VANIER ON K1L 5C6

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

LYNE DUCHESNE (117)

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 22, 23 and 26, 2019

This inspection relates to log # 015861-19 and a critical incident report (CIS # M511-000044-19) in which a there was a medication incident / adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Associate Director of Care (ADOC), a MediSystem Pharmacy Pharcamcist, to several Registered Nurses (RNs), to several Registered Practical Nurses (RPNs), to the home's Education and Quality Assurance Coordinator, as well as to several residents and family members.

During the course of the inspector, the inspector reviewed several residents health care records, observed the provision of care and services, reviewed an internal investigation report, reviewed Medical Directives, a MediSystem Policy # MEDI-CL-ONT-038 "Medication Reconciliation Policy", dated October 1, 2018 and reviewed registered nursing staff education related medication management systems.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Medication
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 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 where this Act or this Regulation requires, the licensee of a long-term care home to have put in place any policy and procedure and that the licensee is required to ensure that the policy and procedure put in place: (b) is complied with.

As per O.Reg. 114 Medication Management Systems, the licensee is to have developed an interdisciplinary medication management system that provides safe medication management, that the licensee ensures 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 and that the written policies and protocols be implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The license has a policy MediSystems Pharmacy # MEDI-CL-ONT-038, "Medication Reconciliation Policy" in place since October 1, 2018.

The policy indicates that for any new resident admission, once the medication orders are received and processed to pharmacy, the following is to be completed:
• 8.Once processed and the digital pen is docked, a temporary MAR (for non eMar homes) and drug record book page will automatically print within 15 minutes. These forms will only print after the approval section has been filled out and the pen has been docked.
• 9. A registered staff is to review the temporary MAR print out and ensure it is accurate. The Temporary MAR can be used to record doses administered until a Digital MAR is sent from pharmacy. For eMAR homes, documentation of any doses administered is to be documented on the eMAR.

• 10. Once completed, the orders are to be verified and checked against the BPMH (Best Possible Medical History) and processed onto the MAR or checked against the eMAR entries. A second nurse is to check and verify the processed orders for accuracy and correctness.
• 11. Use the Drug Record Book page to document order and receipt of medications. File in the Drug Record Book in chronological order in the "waiting" section. This will quickly identify medication orders that have not been received.

Resident #001 was admitted to the home on specified day in 2019. The resident's admission medical orders included a prescription for an identified medication, with a specific dose, to be administered in the morning. The resident's medication order was written with medical abbreviations and processed by RN #104. RN #104 contacted the pharmacy provider MediSystems to advise them of the new resident admission and medication orders.

The medication orders were processed that same day by MediSystems with no calls for clarification or verification for any of resident #001's medication orders.

The medication arrived at the home in early evening. Evening RN #107 assumed responsibility of resident #001's medical chart and admission process. Evening RPN #106 aided by verifying received medication from MediSystems Pharmacy with the electronic Medication Administration Record and administering the resident's prescribed evening medication. RPN #106 did communicate with RN #107 that part of resident #001's medication reconciliation had been completed. However, the reconciliation process between the written orders and the eMAR was not completed by either RN #017 or RPN #106. Nor was the non-completed medication reconciliation communicated to night RN # 110 for follow-up.

The next morning, the resident was administered the identified medication, by RPN # 111, as indicated in the resident's eMAR. The resident's health status was monitored three times daily and assessed values were noted to be within therapeutic range.

The second day post admission, the resident's health status was assessed, and one assessment value was noted to be below therapeutic levels at a specified time in the morning. The resident was alert with no change in health status noted. RPN #103 reported the assessment value to RN #105 who gave directions related to the administration of the resident's prescribed medication to RPN #103. Approximately two

hours later, RPN #103 administered the identified medication as indicated in the resident's eMAR. The resident's health status was monitored a few hours later and the identified assessment value was noted to have stabilized. In the evening, the resident's health status was assessed, as per orders, by RPN # 106. The one assessment value was noted to be at the low end of therapeutic range level. The resident did not present with any health changes. Later in the evening, resident #001 was observed by RPN #106 to be presenting with changes to their health status. RN #107 was advised of the resident's change in condition, the resident was reassessed, and one assessment value was noted to be below therapeutic range levels.

RN #107 reviewed of the resident's original medical order and the eMAR. RN #107 noted that the order for the identified medication was not transcribed correctly from the medication order form to the eMAR and the medication reconciliation process had not been completed when the resident's medications were received from pharmacy. Further review of the health care record indicated that resident #001 had received the identified medication but at a 10 times higher dose, as indicated in the eMAR, than the originally prescribed dose, on both specified days. The resident's attending physician was notified of the medication error and of the changes to the resident's health status. Orders were received for the administration of specific medication to be immediately administered and for ongoing monitoring which were actioned by RN #107 and RPN #106.

On the morning of the third day post admission, resident #001 was reassessed and one assessment value was noted to be below therapeutic range level. The resident presented with signs and symptoms of an adverse medication reaction. A specified medication was administered as per medical orders. The physician was notified, and the resident transferred to hospital for further assessment. Resident #001 returned later to the home with new medication orders.

As per the home's Administrator, Director of Care, RPN # 103 and #106, as well as RN # 105 and the home's pharmacist from MediSystem, the registered nursing staff who worked on day of the resident's admission did not implement the home's policy for medication reconciliation for a new resident and the pharmacy did not question the medical order that was written without following the home's guidelines related to the writing in full script of the identified medication's dosage. This led to resident #001 receiving the identified medication at a 10 times higher dose, as indicated in the eMAR, than the originally prescribed dose, on both specified days and resident #001 having an adverse medication reaction, requiring nursing and medical interventions. [s. 8. (1) (b)]

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. 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was admitted to the home on specified day in 2019. The resident's admission medical orders included a prescription for an identified medication, with a specific dose, to be administered in the morning. The resident's medication order was processed.

The next two days post admission, the resident was administered the identified medication as indicated on the eMAR. During the evening of second day post admission, the resident became unwell and presented signs and symptoms of an adverse medication reaction which required nursing and medical interventions.

A review of the resident's electronic medication administration (eMAR) identified an error whereby the eMAR indicated an identified medication dose was 10 times greater than the originally prescribed dose. Further review of the resident's eMAR form indicated that the order for the identified medication was not transcribed correctly from the medication order form to the eMAR and the medication reconciliation process was not done when the resident's medications were received from pharmacy. (see WN# 1).

As such, resident #001's identified medication was not administered in accordance with the directions specified by the prescriber on two (2) specified days in 2019 when the resident was administered the wrong medication dose for an identified medication. [s. 131. (2)]

Additional Required Actions:

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

Issued on this 11th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2019_583117_0037
Log No. / No de registre :	015861-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 9, 2019
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Centre d'Accueil Champlain 275 Perrier Street, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Roy

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 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 O. Reg 79/10, s.8 (1) b.

Specifically, the licensee shall ensure that the MediSystems Pharmacy policy # MEDI-CL-ONT-038, "Medication Reconciliation Policy", in place since October 1, 2018. related to an interdisciplinary medication management system that provides safe medication management system and optimizes effective drug therapy outcomes for residents is complied with.

In order to ensure compliance with the medication management system, medication reconciliation policy for new resident admission, the licensee shall develop and implement monitoring and remedial processes:

A) At a minimum , adherence to the policies and procedures from the time a new prescription is written by the physician, to the transcription on the Medication Administration Record (MAR) , to the receiving of the medication from pharmacy and to the administration of the medication/treatment to resident #001, and any other new resident admission, shall be measured on a weekly basis on all units for a period of 4 consecutive weeks.
B) The licensee shall ensure that corrective action is taken if deviations from established policy policy # MEDI-CL-ONT-038, "Medication Reconciliation Policy" and procedures
C) A written record must kept of everything required under (a) and (b).

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 where this Act or this Regulation requires, the licensee of a long-term care home to have put in place any policy and procedure and that the licensee is required to ensure that the policy and procedure put in place: (b) is complied with.

As per O.Reg. 114 Medication Management Systems, the licensee is to have developed an interdisciplinary medication management system that provides safe medication management, that the licensee ensures 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 and that the written policies and protocols be implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The license has a policy MediSystems Pharmacy # MEDI-CL-ONT-038, "Medication Reconciliation Policy" in place since October 1, 2018.

The policy indicates that for any new resident admission, once the medication orders are received and processed to pharmacy, the following is to be completed:

- 8.Once processed and the digital pen is docked, a temporary MAR (for non eMar homes) and drug record book page will automatically print within 15 minutes. These forms will only print after the approval section has been filled out and the pen has been docked.
- 9. A registered staff is to review the temporary MAR print out and ensure it is accurate. The Temporary MAR can be used to record doses administered until a Digital MAR is sent from pharmacy. For eMAR homes, documentation of any doses administered is to be documented on the eMAR.
- 10. Once completed, the orders are to be verified and checked against the BPMH (Best Possible Medical History) and processed onto the MAR or checked against the eMAR entries. A second nurse is to check and verify the processed orders for accuracy and correctness.
- 11. Use the Drug Record Book page to document order and receipt of medications. File in the Drug Record Book in chronological order in the "waiting" section. This will quickly identify medication orders that have not been received.

Resident #001 was admitted to the home on specified day in 2019. The resident's admission medical orders included a prescription for an identified medication, with a specific dose, to be administered in the morning. The resident's medication order was written with medical abbreviations and processed by RN #104. RN #104 contacted the pharmacy provider MediSystems to advise them of the new resident admission and medication orders.

The medication orders were processed that same day by MediSystems with no calls for clarification or verification for any of resident #001's medication orders.

The medication arrived at the home in early evening. Evening RN #107 assumed responsibility of resident #001's medical chart and admission process. Evening RPN #106 aided by verifying received medication from MediSystems Pharmacy with the electronic Medication Administration Record and administering the resident's prescribed evening medication. RPN #106 did communicate with RN #107 that part of resident #001's medication reconciliation had been completed. However, the reconciliation process between the written orders and the eMAR was not completed by either RN #017 or RPN #106. Nor was the non-completed medication reconciliation communicated to night RN # 110 for follow-up.

The next morning, the resident was administered the identified medication, by RPN # 111, as indicated in the resident's eMAR. The resident's health status was monitored three times daily and assessed values were noted to be within therapeutic range.

The second day post admission, the resident's health status was assessed, and one assessment value was noted to be below therapeutic levels at a specified time in the morning. The resident was alert with no change in health status noted. RPN #103 reported the assessment value to RN #105 who gave directions related to the administration of the resident's prescribed medication to RPN #103. Approximately two hours later, RPN #103 administered the identified medication as indicated in the resident's eMAR. The resident's health status was monitored a few hours later and the identified assessment value was noted to have stabilized. In the evening, the resident's health status was assessed, as

per orders, by RPN # 106. The one assessment value was noted to be at the low end of therapeutic range level. The resident did not present with any health changes. Later in the evening, resident #001 was observed by RPN #106 to be presenting with changes to their health status. RN #107 was advised of the resident's change in condition, the resident was reassessed, and one assessment value was noted to be below therapeutic range levels.

RN #107 reviewed of the resident's original medical order and the eMAR. RN #107 noted that the order for the identified medication was not transcribed correctly from the medication order form to the eMAR and the medication reconciliation process had not been completed when the resident's medications were received from pharmacy. Further review of the health care record indicated that resident #001 had received the identified medication but at a 10 times higher dose, as indicated in the eMAR, than the originally prescribed dose, on both specified days. The resident's attending physician was notified of the medication error and of the changes to the resident's health status. Orders were received for the administration of specific medication to be immediately administered and for ongoing monitoring which were actioned by RN #107 and RPN #106.

On the morning of the third day post admission, resident #001 was reassessed and one assessment value was noted to be below therapeutic range level. The resident presented with signs and symptoms of an adverse medication reaction. A specified medication was administered as per medical orders. The physician was notified, and the resident transferred to hospital for further assessment. Resident #001 returned later to the home with new medication orders.

As per the home's Administrator, Director of Care, RPN # 103 and #106, as well as RN # 105 and the home's pharmacist from MediSystem, the registered nursing staff who worked on day of the resident's admission did not implement the home's policy for medication reconciliation for a new resident and the pharmacy did not question the medical order that was written without following the home's guidelines related to the writing in full script of the identified medication's dosage. This led to resident #001 receiving the identified medication at a 10 times higher dose, as indicated in the eMAR, than the originally prescribed dose, on both specified days and resident #001 having an adverse medication reaction, requiring nursing and medical interventions.

The severity of this issue was determined to be a level 3 as there was actual harm.
The scope was a level 1 as this was an isolated incident. The home had a level 3 Compliance History, with on-going non-compliance with VPC and CO.

• O.Reg. s 8 (1) b): issued as a VPC on April 30, 2019 under inspection # 2019_683126_0008
• O.Reg. s. 114: issued as a Compliance Order #001 on October 19, 2018 under inspection # 2018_683126_0018. Found to be compliant on December 24, 2018 under inspection # 2018_583117_0020.
• O.Reg. s 8 (1) b): issued as a VPC on June 21, 2018 under inspection # 2018_548592_0008
• O.Reg. s 8 (1) b): issued as a VPC on September 21, 2017 under inspection # 2017_619550_0018
(117)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

Order # / Ordre no : 002

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 be compliant with O. Reg 79/10, s.131 (2).

Specifically, the licensee shall ensure that drugs are administered to resident #001, and any newly admitted resident, in accordance with directions specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was admitted to the home on specified day in 2019. The resident's admission medical orders included a prescription for an identified medication, with a specific dose, to be administered in the morning. The resident's medication order was processed.

The next two days post admission, the resident was administered the identified medication as indicated on the eMAR. During the evening of second day post admission, the resident became unwell and presented signs and symptoms of an adverse medication reaction which required nursing and medical interventions.

A review of the resident's electronic medication administration (eMAR) identified an error whereby the eMAR indicated an identified medication dose was 10 times greater than the originally prescribed dose. Further review of the resident's eMAR form indicated that the order for the identified medication was not transcribed correctly from the medication order form to the eMAR and the medication reconciliation process was not done when the resident's medications

were received from pharmacy. (see WN# 1).

As such, resident #001's identified medication was not administered in accordance with the directions specified by the prescriber on two (2) specified days in 2019 when the resident was administered the wrong medication dose for an identified medication.

The severity of this issue was determined to be a level 3 as there was actual harm. Medications are identified as a Key Risk Indicator.
The scope was a level 1 as this was an isolated incident. The home had a level 3 Compliance History, with on-going non-compliance with VPC and CO.

• O.Reg. s 131 (2): issued as a VPC on June 21, 2018 under inspection # 2018_548592_0008
• O.Reg. s 131 (2): issued as a VPC on March 19, 2018 under inspection # 2018_621547_003
• O.Reg. s 131 (2): issued as a VPC on March 19, 2018 under inspection # 2018_621547_002
• O.Reg. s 131 (2): issued as a VPC on September 22, 2017 under inspection # 2017_619550_0018
• O.Reg. s 131 (2): issued as a VPC on March 8, 2017 under inspection # 2017_620126_003
(117)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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