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
Aug 6, 2019	2019_780699_0017	011945-19	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Cummer Lodge
205 Cummer Avenue NORTH YORK ON M2M 2E8

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

PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 17-19, 22-24, 2019 and off site July 25, 2019.

During this inspection, the following intake was inspected:
-Log #011945-19 related to altered skin integrity issues.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nurse Managers (NMs), Registered Nurses (RN), Registered Practical Nurses (RPN), Medical Director (MD), physician, and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident's health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from neglect.

Neglect as outlined in Section 5 of the Regulation (O.Reg.79/10) means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The Ministry of Long-term Care (MOLTC) was forwarded a letter of complaint written by a family member of resident #001 by the long-term care home. Review of the complaint letter indicated that they wanted clarification regarding resident #001’s altered skin integrity issues.

Record review of the resident's past medical history included multiple diagnoses. Review of the resident's clinical health record showed that the resident passed away on a specific date related to their multiple diagnoses.

Record review of resident #001’s progress notes indicated that the resident was sent to hospital on a specified day for an identified condition. Resident #001 was subsequently admitted to hospital. Resident #001 was discharged back to the home on a specified date with the following medication orders:
-hold an identified medication for an identified time period; and
-new medication once daily for an identified diagnosis.

Review of resident #001's best possible medication history form, showed that the new medication was ordered to be given once daily and an identified medication to be held for identified time period. Further review of the form does not indicate that the form was faxed to the pharmacy on specified date as the box beside "Fax to pharmacy" was not ticked.

Review of resident #001’s patient medical history report for a specified date, from a specific pharmacy, did not indicate that an identified medication was held or that the new medication was dispensed by the pharmacy.

Review of the written medication administration record (MAR) indicated that on the following days, the new medication was marked as not administered (N/A) on the MAR and that an identified medication was held for three days.

Record review of the progress notes did not indicate that the physician was notified that resident #001 had not received their new medication for three days. Further review of the

progress notes did not indicate that the pharmacy was notified of the missing medication.

Further review of the progress notes did not show any documentation indicating that resident #001 was not given their new medication or that the resident was monitored for any adverse reactions related to not receiving their prescribed medication. There was no documentation to indicate that incoming shifts were notified or aware that resident #001 did not receive their medication, nor was there any request to follow up with the pharmacy to get the medication for the resident.

In separate interviews with RN #103 and RPN #102, they indicated that when a resident returns from hospital, the registered staff would review the hospital notes, complete the medication reconciliation process with the attending or on-call physician and fax the form to pharmacy. RN #103 stated that they would call pharmacy to ensure that the forms were received and wait for the medications with the new printed MAR sheet. RN #103 further indicated that once they received the new printed MAR, they would inform the RPN of the new medications and if there was any medication missing, they would follow up with the pharmacy. RPN #102 stated a resident who did not receive their ordered medications would be a form of neglect.

In an interview with RN #101, they stated that when a resident returns from the hospital, the best possible medication history form would be faxed to the pharmacy. They further indicated that if a medication was not available, staff would have to follow up with the pharmacy to send the medication and document in the progress notes. RN #101 stated that if N/A was written on the MAR beside the medication, it indicated that the medication was not available to administer. They further indicated that staff should have followed up with the pharmacy and request for the medication urgently. RN #101 stated that it was not brought to their attention that the medication was not administered for three days and was unsure that resident #001 was appropriately monitored for any adverse reaction related to the resident not receiving their medication. RN #101 indicated that this incident was neglectful as the resident did not receive their medication for three days.

In an interview with the medication program lead RN #104, they stated that if a medication was unavailable, the staff should find out why the medication is not available, use the emergency stock box or contact the emergency pharmacy if it is after hours to have the medication delivered. They further stated that for resident #001, the staff should have documented why the medication was not available and what they did about it as this medication was important for resident #001's health.

In an interview with the Medical Director (MD) #108, they stated that staff should have informed the physician that the medication was not given to the resident and follow the direction given by the physician. They further stated that they would expect staff to follow up with the pharmacy to get the medication for the resident. MD #108 further indicated that it was not the best nursing practice as the physician was not informed that resident #001 was not given the medication, and that vital signs were not appropriately assessed.

In an interview with the attending physician #107, they stated that they were not informed that resident #001 did not receive their new medication for three days.

In an interview with the DOC #100, they stated for resident #001, they would have expected staff to call the physician to inform them that the medication was not given and ask for further direction. They further stated that the staff should have followed up and ensured that the medication was given and DOC #101 stated that the process for medication reconciliation was not followed for resident #001.

The licensee failed to ensure that resident #001 was administered their ordered medication for an identified diagnosis for three days. Staff were aware that the resident required this medication daily and it was signed off as N/A on the written MAR. There was no follow up with the pharmacy or the incoming shift to ensure that resident received their medication, nor was the physician informed that the resident did not receive their medication for three days. Resident #001 was not assessed for any negative impact related to not receiving the medication as ordered. Resident #001 passed away on a specified date related their multiple co-morbidities. The staff failed to provide resident #001 with treatment that was required for their health. [s. 19. (1)]

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001’s plan of care for transfers was updated.

The MOLTC was forwarded a letter of complaint written by a family member of resident #001 by the long-term care home. Review of the complaint letter indicated that they wanted clarification regarding resident #001’s altered skin integrity issues.

Record review of resident’s care plan, indicated the following for transfers:
-identified level of assistance with specific number of staff assistance, using a specified transfer device.

Review of the progress notes by the occupational therapist (OT), indicated that resident #001 was changed to an alternate transfer device as there was a concern related to increased risk of skin injury. Further review of the progress notes and nursing & personal care record (NPCR), indicated that after resident #001 returned from hospital, the resident was transferred via the alternate transfer device.

In an interview with RN #103 and DOC #100 they indicated that resident #001’s plan of care should be updated to reflect that the resident was only to be transferred by the alternate transfer device.
. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary, 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 failed to ensure that for resident #001, the hospital readmission policy was followed.

The MOLTC was forwarded a letter of complaint written by a family member of resident #001 by the long-term care home. Review of the complaint letter indicated that they wanted clarification regarding resident #001’s altered skin integrity issues.

Resident was discharged back to the home with a new medication to be given daily and another medication to be held for a specified amount of time.

Review of resident #001's best possible medication history showed that the medication was to be given once daily and another medication to be held for a specified amount of time. Further review of the form does not indicate that the form was faxed to the pharmacy on a specified date, as the box beside “Fax to pharmacy” was not ticked.

Review of resident #001’s patient medical history report for a specified month, from an identified pharmacy did not indicate that an identified medication was held or that the ordered new medication was dispensed by the pharmacy.

Review of the home’s policy titled “Physician Admission/Readmission Orders and Medication Reconciliation”, last revised April 7, 2017, indicated the following:
-fax the physician admission/readmission order form and page 1 of the best possible medication history; and
-nurses will check new printed MAR from pharmacy for any discrepancies, nurse will place the new MAR/Treatment Administration Record (TAR) in the binder and file the temporary MAR/TAR in the Nursing Data section of the resident’s chart.

Review of resident #001’s clinical health record did not show that a new MAR/TAR was printed after a specified date.

In an interview with the medication lead RN #104, they stated that the registered staff would complete the best possible medication history form and fax it the pharmacy. They further stated if a medication was missing, the staff were expected to follow up and ensure the medication was delivered and administered.

In an interview with DOC #100, they acknowledged that the readmission medication process was not followed for resident #001. [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 the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a clinically appropriate tool was used to assess resident #001 when they exhibited altered skin integrity.

The MOLTC was forwarded a letter of complaint written by a family member of resident #001 by the long-term care home. Review of the complaint letter indicated that they wanted clarification regarding resident #001’s altered skin integrity issues.

Review of resident #001’s progress indicated that on a specified date the resident was noted to have altered skin integrity. Further review of the notes indicated that the altered skin integrity was monitored for three consecutive shifts. Further review of the progress notes did not indicate that the altered skin integrity was resolved or worsened.

Review of the clinical health record did not show any documentation that a head to toe assessment was completed for the altered skin integrity noted on a specified date. No other assessment tool was found to be completed for the resident's altered skin integrity upon further of the clinical health record.

In an interview with RN #103, they stated that if a resident exhibits altered skin integrity such as redness, bruising, skin tear or pressure ulcers, a skin assessment using the head to toe assessment form will be completed.

In an interview with the skin and wound lead RN #105, they stated that any resident exhibiting altered skin integrity would have a head to toe assessment completed. They further stated that for resident #001, the altered skin integrity should have been monitored until it was healed, or have documentation indicating whether the altered skin integrity improved or worsened. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that five staff members received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Record review of the home's "Abuse and Neglect Prevention and Response Protocol" for 2018, indicated that the status of completion for five staff members who provided resident care were coded as "registered/overdue".

In an interview with DOC #100, they confirmed that the five staff members were present and provided care to residents in 2018. DOC #100 acknowledged that the five staff members did not complete the required training. [s. 76. (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 all staff at the home have received training as required by this section, to be implemented voluntarily.

Issued on this 7th day of August, 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

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

Ministère de la Santé et des Soins de longue durée

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) :	PRAVEENA SITTAMPALAM (699)
Inspection No. / No de l'inspection :	2019_780699_0017
Log No. / No de registre :	011945-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 6, 2019
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Cummer Lodge 205 Cummer Avenue, NORTH YORK, ON, M2M-2E8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tim Burns

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA.
Specifically, the licensee must:

A) Train all registered staff regarding the home's physician admission/readmission orders and medication reconciliation policy. Attendance records are to be maintained related to this training.

B) Develop an admission/readmission process checklist tool to be completed for all residents that are admitted or readmitted to the home. The checklist must include when the resident's medication reconciliation was completed, when the form was faxed to pharmacy, when the new medication administration record (MAR) sheet was printed by pharmacy and received by the home, when the registered staff checked the MAR for any discrepancies, and when resident has received all ordered medications from pharmacy. Written record of this checklist must be maintained.

C) Develop an internal auditing system that is conducted monthly for the next three months as of the receipt of this order to ensure that any medications that have been ordered by the physician that are not available in the home upon any resident's admission/readmission to the home are ordered immediately, and administered as ordered by the physician.

D) Maintain a written record of the above-mentioned audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit, the outcome of the audit and any action taken as a result of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from neglect.

Neglect as outlined in Section 5 of the Regulation (O.Reg.79/10) means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The Ministry of Long-term Care (MOLTC) was forwarded a letter of complaint written by a family member of resident #001 by the long-term care home. Review of the complaint letter indicated that they wanted clarification regarding resident #001's altered skin integrity issues.

Record review of the resident's past medical history included multiple diagnoses. Review of the resident's clinical health record showed that the resident passed away on a specific date related to their multiple diagnoses.

Record review of resident #001's progress notes indicated that the resident was sent to hospital on a specified day for an identified condition. Resident #001 was subsequently admitted to hospital. Resident #001 was discharged back to the home on a specified date with the following medication orders:
-hold an identified medication for an identified time period; and
-new medication once daily for an identified diagnosis.

Review of resident #001's best possible medication history form, showed that the new medication was ordered to be given once daily and an identified medication to be held for identified time period. Further review of the form does not indicate that the form was faxed to the pharmacy on specified date as the box beside "Fax to pharmacy" was not ticked.

Review of resident #001's patient medical history report for a specified date, from a specific pharmacy, did not indicate that an identified medication was held or that the new medication was dispensed by the pharmacy.

Review of the written medication administration record (MAR) indicated that on the following days, the new medication was marked as not administered (N/A)

on the MAR and that an identified medication was held for three days.

Record review of the progress notes did not indicate that the physician was notified that resident #001 had not received their new medication for three days. Further review of the progress notes did not indicate that the pharmacy was notified of the missing medication.

Further review of the progress notes did not show any documentation indicating that resident #001 was not given their new medication or that the resident was monitored for any adverse reactions related to not receiving their prescribed medication. There was no documentation to indicate that incoming shifts were notified or aware that resident #001 did not receive their medication, nor was there any request to follow up with the pharmacy to get the medication for the resident.

In separate interviews with RN #103 and RPN #102, they indicated that when a resident returns from hospital, the registered staff would review the hospital notes, complete the medication reconciliation process with the attending or on-call physician and fax the form to pharmacy. RN #103 stated that they would call pharmacy to ensure that the forms were received and wait for the medications with the new printed MAR sheet. RN #103 further indicated that once they received the new printed MAR, they would inform the RPN of the new medications and if there was any medication missing, they would follow up with the pharmacy. RPN #102 stated a resident who did not receive their ordered medications would be a form of neglect.

In an interview with RN #101, they stated that when a resident returns from the hospital, the best possible medication history form would be faxed to the pharmacy. They further indicated that if a medication was not available, staff would have to follow up with the pharmacy to send the medication and document in the progress notes. RN #101 stated that if N/A was written on the MAR beside the medication, it indicated that the medication was not available to administer. They further indicated that staff should have followed up with the pharmacy and request for the medication urgently. RN #101 stated that it was not brought to their attention that the medication was not administered for three days and was unsure that resident #001 was appropriately monitored for any adverse reaction related to the resident not receiving their medication. RN #101

indicated that this incident was neglectful as the resident did not receive their medication for three days.

In an interview with the medication program lead RN #104, they stated that if a medication was unavailable, the staff should find out why the medication is not available, use the emergency stock box or contact the emergency pharmacy if it is after hours to have the medication delivered. They further stated that for resident #001, the staff should have documented why the medication was not available and what they did about it as this medication was important for resident #001's health.

In an interview with the Medical Director (MD) #108, they stated that staff should have informed the physician that the medication was not given to the resident and follow the direction given by the physician. They further stated that they would expect staff to follow up with the pharmacy to get the medication for the resident. MD #108 further indicated that it was not the best nursing practice as the physician was not informed that resident #001 was not given the medication, and that vital signs were not appropriately assessed.

In an interview with the attending physician #107, they stated that they were not informed that resident #001 did not receive their new medication for three days.

In an interview with the DOC #100, they stated for resident #001, they would have expected staff to call the physician to inform them that the medication was not given and ask for further direction. They further stated that the staff should have followed up and ensured that the medication was given and DOC #101 stated that the process for medication reconciliation was not followed for resident #001.

The licensee failed to ensure that resident #001 was administered their ordered medication for an identified diagnosis for three days. Staff were aware that the resident required this medication daily and it was signed off as N/A on the written MAR. There was no follow up with the pharmacy or the incoming shift to ensure that resident received their medication, nor was the physician informed that the resident did not receive their medication for three days. Resident #001 was not assessed for any negative impact related to not receiving the medication as ordered. Resident #001 passed away on a specified date related their multiple

co-morbidities. The staff failed to provide resident #001 with treatment that was required for their health.

The severity of this issue was determined to be a level 3 as there was actual risk to resident #001. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:
-CO issued November 25, 2016 (2016_413500_0011);
-VPC issued November 23, 2016 (2016_168202_0020);
-Written Notification (WN) issued January 13, 2017 (2016_432654_0010);
-Compliance Order (CO) issued June 15, 2017 (2017_493652_0004); and
-Voluntary Plan of Correction (VPC) issued January 17, 2019 (2018_644507_0027). (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 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 6th day of August, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Praveena Sittampalam

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