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

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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
Sep 24, 2020	2020_816722_0017	012869-20, 016850-20, 017722-20	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Erin Mills Lodge Nursing Home
2132 Dundas Street West MISSISSAUGA ON L5K 2K7

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

COREY GREEN (722)

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): August 25-28, 2020; and September 1-4, and 9-11, 2020.

The following intakes were inspected during this inspection:

Log #012869-20 related to responsive behaviours;
Log #017722-20 related to allegation of abuse; and
Log #016850-20 related to an allegation of neglect, and skin and wound issues.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physicians, Registered Dietitian (RD), Physiotherapist (PT), the Behavioural Support Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a substitute decision maker (SDM), and a resident.

During the inspection, the inspector reviewed resident health records (electronic and paper copy), as well as administrative records in the home, including relevant policies and procedures. The inspector also made observations of residents and resident care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Medication Reconciliation policy was complied with for residents #001, #007, and #008 when they moved into the home.

Under s. 114. (1) of O. Reg. 79/10, the licensee was required to have an interdisciplinary medication management system that provided safe medication management for residents. Under s. 114. (2) of O. Reg. 79/10, the licensee was required to ensure that policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, and administration of all drugs used in the home.

The home's Medication Reconciliation policy (Tab 05-28) indicated the following:
- For residents being admitted from hospital, registered staff were expected to use at least two sources of information to complete the New Admission Order Form on admission, including any two of the following: discharge list from the hospital, consultation with the resident or their family member, medication vials/containers brought by resident or family member, and the family physician.
- Registered staff were expected to compare the two lists, along with speaking to the resident or their substitute decision-maker (SDM), and note any discrepancies; these discrepancies were to be discussed with the physician to determine which medication orders to continue.
- The status of each medication entered on the New Admission Order Form was to be checked off as 'Continue', 'Discontinue' or 'Hold', upon verification of the orders with the physician.

(A) RPN #115 completed the New Admission Order Form for resident #001 when they were admitted to the home. The RPN used one source of information to identify the

resident's medications when they were completing the form, which showed that a drug was to be held/stopped. They did not enter the drug onto the New Admission Order Form, and did not notify the physician that the resident had been receiving the drug, so the resident never received the drug when they were admitted. There were several other medication lists and assessments among the admission documents that indicated the resident had received the drug up until the day prior to admission to the home. The Physician said that they would have continued any medications that the resident had received up until admission to the home, and then discussed stopping any medications with the family member. The DOC said that the home's Medication Reconciliation policy required registered staff to use two sources of information when identifying resident's medications on admission, and that all medications should be written on the New Admission Order Form and reviewed with the physician by telephone. There was minimal risk of harm to the resident because, although they did not receive the medication, they were being routinely monitored and assessed by registered staff, the physician, and other allied health professions when they moved into the home.

Sources: Resident's New Admission Order Form, medication lists, and other health records received on admission to the home; the home's Medication Reconciliation policy (Tab 05-20); and interviews with the resident's SDM, the RPN, the Physician, and the DOC.

(B) RPN #118 completed the New Admission Order Form for resident #007 when they were admitted to the home. The RPN did not not enter a check mark on the form to show if four drugs on the form should be 'Held', 'Continued' or 'Discontinued'; the form was blank where the RPN should have entered the date/time they discussed the medication orders with the physician; and the RPN did not use two sources of information to identify the resident's medications when they completed the form. The DOC indicated that according to the home's Medication Reconciliation policy, the RPN should have specified the appropriate action for all drugs entered on the form, the date/time that the admission orders were reviewed with the physician should have been entered, and at least two sources of information should have been used to identify the resident's medications on admission.

Sources: Resident's New Admission Order Form, medication lists, and other health records received on admission to the home; the home's Medication Reconciliation policy (Tab 05-20); and interviews with the RPN, Physician, and the DOC.

(C) RPN #118 completed the New Admission Order Form for resident #008 when they

were admitted to the home. The RPN did not enter a check mark to show if three drugs on the form should be 'Held', 'Continued' or 'Discontinued'. There was a slash mark through these medications on the form, and the RPN said that the actions for these drugs were not checked off because they were part of the home's medical directives. The DOC said the registered staff should always fill in the boxes for each medication entered on the form after talking to the physician. The RPN missed three medications, including a cardiac medication, because they used one source of information to identify the resident's medications on admission. The DOC said that registered staff should always use at least two sources of information when identifying resident drugs on admission and completing the New Admission Order Form.

Sources: Resident's New Admission Order Form, medication lists, and other health records received on admission to the home; the home's Medication Reconciliation policy (Tab 05-20); and interviews with the RPN, the Physician, and the DOC. [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 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 a resident's plan of care was reviewed and revised when they had a significant change in their health status.

The resident had a significant change in their health condition resulting in several deficits that required additional care and support. These deficits were documented when the registered staff assessed the resident. However, the change in condition and additional care required were not identified in the resident's plan of care until a week after the change occurred. As a result, one PSW said that they decided themselves what additional support was needed for the resident for one aspect of care. Another staff person was not aware of the resident's change in condition, and tried to provide care that was not possible for the resident due to their change in condition. The DOC said that the resident's care plan should have been revised by registered staff to identify the change in condition and the additional support required. There was minimal risk of harm to the resident as staff reported that they provided additional support to the resident as needed related to their deficits, the resident's deficits improved, and the resident's needs were communicated among the staff.

Sources: Resident's progress notes, care plan, and assessments in the electronic health record. Interviews with a PSW, RPN, Physician, PT, and the DOC. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident’s health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian (RD) completed a nutritional assessment of a resident when there was a significant change in the resident's health condition.

A resident had a significant change in their condition with a risk of harm related to food and fluid intake. An RPN and PSW were aware of the deficits that resulted from the resident's change in condition and took actions to protect the resident from potential harm when eating and drinking. The RPN did not send a referral to the home's RD. The RD said that they were not notified of the resident's change in condition and they did not assess the resident. They said that if they had been notified, they would have changed the resident's nutritional risk level, and made changes to their care plan. The DOC confirmed that the resident had a significant change in status, and that registered staff should have made a referral to the RD so they could re-assess the resident. There was minimal risk of harm to the resident, as staff provided care that protected the resident and the resident's condition improved.

Sources: Resident's care plan, progress notes, and nutritional assessments; interviews with an RPN, PSW, the RD, and the home's DOC. [s. 26. (4) (a),s. 26. (4) (b)]

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 resident was assessed by the registered dietitian (RD) when they developed a wound.

A resident developed a wound that was assessed and treated as required. However, there were no referrals to or assessments by the RD identified in the health record related to the wound. The RPN who first identified the wound confirmed that a referral had not been sent to the home's RD. The RD was not aware that the resident had a wound and did not assess the resident. After reviewing the resident's health record, and assessments of the wound, the RD said they would have changed the resident's nutrition risk, and ordered a protein supplement for the resident. The DOC, who was the skin and wound care lead in the home at the time, said that the expectation was that the resident should have been referred to the RD for an assessment when the wound was identified by registered staff. There was minimal risk to the resident, as they received appropriate care for the wound, assessments of the wound were completed as required by legislation, and it improved.

Sources: Resident's progress notes, wound assessments, electronic Treatment Administration Record (eTAR), electronic Medication Administration Record (eMAR), and physician orders; photographs taken by resident's substitute decision maker (SDM); and interviews with the RD, an RPN, and the DOC. [s. 50. (2) (b) (iii)]

WN #5: 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 medications were administered to a resident in accordance with the directions for use specified by the prescriber.

Two supplements were not administered to a resident when they were admitted to the home. An RPN entered two supplements on the New Admission Order Form, that the resident had been receiving prior to admission to the home based on the admission records. The form indicated 'Continue' for both of the supplements based on the review with the Physician by telephone, and the form was later signed by the physician. The supplements were supposed to be entered by registered staff on the resident's eMAR, because they were from the home's stock supply. The RPN was aware of this, but forgot in this instance. The resident did not receive any doses of these supplements in the home because they were not included on the eMAR or Physician Orders. There was minimal risk to the resident, as the drugs involved were supplements.

Sources: Resident's New Admission Order Form, admission documentation, eMAR and Order Summary; interviews with the RPN and DOC. [s. 131. (2)]

Issued on this 9th day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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) :	COREY GREEN (722)
Inspection No. / No de l'inspection :	2020_816722_0017
Log No. / No de registre :	012869-20, 016850-20, 017722-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 24, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	Erin Mills Lodge Nursing Home 2132 Dundas Street West, MISSISSAUGA, ON, L5K-2K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sutha Vinayaga

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Schlegel Villages Inc., 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. 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 comply with s. 8(1)(b) of O.Reg. 79/10.

Specifically, the licensee must ensure that:

1. Current medication orders for residents #007 and #008 are reviewed based on interdisciplinary assessments by registered staff, the physician, and allied health professionals as appropriate to ensure that the residents are receiving the appropriate medications. Ensure that records are retained that document the assessments, new medication orders, and discussions with the residents or their family members as appropriate related to the reconciliation of their medications.

2. Audit resident #007 and #008's assessments, Physician Orders and electronic Medication Administration Records once monthly to ensure that physician orders are accurately transcribed, and the residents are receiving all medications as ordered, until the Compliance Due Date, or until four consecutive audits identify no errors in transcriptions and/or medication administration. Retain all records related to the audit, including dates completed, staff completing the audits, any errors identified in medication transcription and/or administration, and actions taken as a result of any errors identified.

3. Provide re-training to RPNs #115 and #118 related to the licensee's policy concerning medication reconciliation when new residents move into the home; including sources of information that should be used for medication

reconciliation, and how to appropriately complete the New Admission Order Form. Retain records of the content included in the training, who provided the training, as well as documentation of the date and time that the staff participated in the training.

4. Audit the New Admission Order Forms completed by RPNs #115 and #118 for each new admission that they're responsible for, until they achieve 100% compliance with the medication reconciliation policy requirements on at least four consecutive admissions. Keep all records pertaining to the audits, including the dates they were completed, the staff member completing the audits, any errors or non-compliance with the policy, and actions taken to resolve any medication reconciliation errors.

5. Provide all documentation related to Items #1-4 above to the inspector when requested during the follow-up inspection for this compliance order.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Medication Reconciliation policy was complied with for residents #001, #007, and #008 when they moved into the home.

Under s. 114. (1) of O. Reg. 79/10, the licensee was required to have an interdisciplinary medication management system that provided safe medication management for residents. Under s. 114. (2) of O. Reg. 79/10, the licensee was required to ensure that policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, and administration of all drugs used in the home.

The home's Medication Reconciliation policy (Tab 05-28) indicated the following:
- For residents being admitted from hospital, registered staff were expected to use at least two sources of information to complete the New Admission Order Form on admission, including any two of the following: discharge list from the hospital, consultation with the resident or their family member, medication vials/containers brought by resident or family member, and the family physician.
- Registered staff were expected to compare the two lists, along with speaking to the resident or their substitute decision-maker (SDM), and note any discrepancies; these discrepancies were to be discussed with the physician to

determine which medication orders to continue.
- The status of each medication entered on the New Admission Order Form was to be checked off as 'Continue', 'Discontinue' or 'Hold', upon verification of the orders with the physician.

(A) RPN #115 completed the New Admission Order Form for resident #001 when they were admitted to the home. The RPN used one source of information to identify the resident's medications when they were completing the form, which showed that a drug was to be held/stopped. They did not enter the drug onto the New Admission Order Form, and did not notify the physician that the resident had been receiving the drug, so the resident never received the drug when they were admitted. There were several other medication lists and assessments among the admission documents that indicated the resident had received the drug up until the day prior to admission to the home. The Physician said that they would have continued any medications that the resident had received up until admission to the home, and then discussed stopping any medications with the family member. The DOC said that the home's Medication Reconciliation policy required registered staff to use two sources of information when identifying resident's medications on admission, and that all medications should be written on the New Admission Order Form and reviewed with the physician by telephone. There was minimal risk of harm to the resident because, although they did not receive the medication, they were being routinely monitored and assessed by registered staff, the physician, and other allied health professions when they moved into the home.

Sources: Resident's New Admission Order Form, medication lists, and other health records received on admission to the home; the home's Medication Reconciliation policy (Tab 05-20); and interviews with the resident's SDM, the RPN, the Physician, and the DOC.

(B) RPN #118 completed the New Admission Order Form for resident #007 when they were admitted to the home. The RPN did not not enter a check mark on the form to show if four drugs on the form should be 'Held', 'Continued' or 'Discontinued'; the form was blank where the RPN should have entered the date/time they discussed the medication orders with the physician; and the RPN did not use two sources of information to identify the resident's medications when they completed the form. The DOC indicated that according to the home's

Medication Reconciliation policy, the RPN should have specified the appropriate action for all drugs entered on the form, the date/time that the admission orders were reviewed with the physician should have been entered, and at least two sources of information should have been used to identify the resident's medications on admission.

Sources: Resident's New Admission Order Form, medication lists, and other health records received on admission to the home; the home's Medication Reconciliation policy (Tab 05-20); and interviews with the RPN, Physician, and the DOC.

(C) RPN #118 completed the New Admission Order Form for resident #008 when they were admitted to the home. The RPN did not enter a check mark to show if three drugs on the form should be 'Held', 'Continued' or 'Discontinued'. There was a slash mark through these medications on the form, and the RPN said that the actions for these drugs were not checked off because they were part of the home's medical directives. The DOC said the registered staff should always fill in the boxes for each medication entered on the form after talking to the physician. The RPN missed three medications, including a cardiac medication, because they used one source of information to identify the resident's medications on admission. The DOC said that registered staff should always use at least two sources of information when identifying resident drugs on admission and completing the New Admission Order Form.

Sources: Resident's New Admission Order Form, medication lists, and other health records received on admission to the home; the home's Medication Reconciliation policy (Tab 05-20); and interviews with the RPN, the Physician, and the DOC. [s. 8. (1) (b)]

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

Severity: There was minimal risk to residents #001, #007, and #008 related to this non-compliance, as they were being assessed and monitored by registered staff and the physician on the days following their admission. This was primarily an administrative error, and most medications involved were supplements or captured in medical directives.

Scope: The scope was widespread as there were issues with implementation of the Medication Reconciliation policy for three residents reviewed.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs), and one compliance order (CO) were issued to the home related to different sections of the legislation in the past 36 months. During this period, two WNs were issued to the home for s. 8(1) of O.Reg. 79/10; one specifically related to Medications. (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 12, 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 24th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Corey Green

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