Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Jun 20, 2019	2019_787640_0018	013377-18, 028787-18, 004268-19, 010209-19	Critical Incident System

Licensee/Titulaire de permis

peopleCare Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

peopleCare Hilltop Manor Cambridge
42 Elliott Street CAMBRIDGE ON N1R 2J2

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

HEATHER PRESTON (640)

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): June 4, 5, 6, 7, 10 and 11, 2019.

The following Critical Incident (CI) reports were reviewed:

CI log #013377-18 related to unexpected death
CI log #028787-18 related to fall resulting in fracture
CI log #004268-19 related to medication administration
CI log #010209-19 related to unexpected death

During the course of the inspection the Inspector toured the home, observed the provision of care, reviewed policy and procedure and conducted interviews.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Pharmacy Technician, Nursing Staff Manager, Directors of Resident Care (DRC), Executive Director of Nursing Care (EDOC) and the Executive Director.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Personal Support Services
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. 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).

s. 131 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use as specified by the prescriber.

On an identified date in February 2019, resident #001 was administered their 0700 hour morning medications for that day and the following day at the same time.

The resident received twice the amount as ordered by the prescriber.

RPN #100 was the preceptor to student nurse #102. Student nurse #102 was administering medications on an identified date in February 2019 during the day shift. RPN #100 said they had observed the nurse for a previous medication administration and felt comfortable with their abilities.

During the medication pass, RPN #100 was called away from observing the student nurse. When they returned, they noticed that resident #001's medication bin was empty, and it should have contained the following mornings medication pouches. Upon

investigation, they noted that two days of the morning medication pouches were empty and in the discard bin.

Based on the type and amount of medications that were administered, the resident was sent to the hospital for assessment and observation.

The licensee failed to ensure that drugs were administered to resident #100 as directed by the prescriber. [s. 131. (2)]

2. The licensee failed to ensure that a nursing student was trained by a member of the registered nursing staff in the written policies and protocols for the medication management system in the home prior to administration of medication.

On an identified date in February 2019, resident #001 was administered their 0700 hour morning medications for that day and the following day at the same time by student nurse #102.

They told RPN #100, their preceptor, they had not reviewed the contents or the expected dates and times of administration on both pouches. They had administered the two pouches of medications to the resident during their morning medication administration.

RPNs #100 and #101 both informed the LTCH Inspector that they had not trained or reviewed the home's policies and protocols for medication management system with the student prior to them administering medications to residents.

Director of Resident Care #103 told the LTCH Inspector the home did not have a policy directing staff as preceptors and that the home had not provided training to the student nurse on policies and protocols for the medication management system in the home.

The licensee failed to ensure that student nurse #102 was trained in the written policies and procedures for the medication management system. [s. 131. (4.1) (b)]

Additional Required Actions:

CO # - 001, 002 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 failed to ensure that the care set out in the plan of care was provided to resident #003, as specified in the plan.

On an identified date in June 2018, resident #003 was provided a drink and a muffin for evening snack. They were in their room. The drink and muffin were left with the resident to enjoy at a later time and they were not observed when consuming the items. Later that evening, a PSW entered the resident room to assist them with bed time care, and found the resident on the floor and unresponsive. Staff had noted food lodged in the resident's throat.

Recreation staff said they were assisting the PSWs that evening and served the evening snacks to the residents. There was no labeled snack for resident #003. PSW #114 said they did not stay with the resident when they had their evening snack.

The Registered Dietitian had assessed the resident and noted in resident #003's plan of care that they were to be supervised during eating and drinking. Their evening snack was to be a specific labeled item.

The EDOC said the resident had not been supervised with the eating of their snack and they had not been served the correct snack that evening.

The licensee failed to ensure that resident #003's care was provided as specified in their plan of care. [s. 6. (7)]

2. The licensee failed to ensure that when a resident's care needs changed that they were reassessed and the plan of care reviewed and revised.

a) Resident #003 was admitted to the home in May 2018, and had multiple diagnoses.

They had a physician order for a specific intervention as needed.

The home's policy "Measuring Vital Signs", reference number 005340.00, with no revised date, directed staff to measure vital signs upon any return from a hospital admission on each shift for a period of 72 hours and with any change in condition or following an incident.

On an identified date in May 2018, the resident had an acute episode.

On an identified date in June 2018, resident #003 was found by staff and were non-responsive. No vital signs were documented. The oxygen saturation was low. The resident was transferred to the hospital.

Resident #003 returned to the home the same day. There was no documented assessment, vital signs or oxygen saturation done following return from hospital.

RPN #104, the nurse on evenings, told the LTCH Inspector they had not documented vital signs nor had they completed an assessment or revised the plan of care for this resident when they returned from the hospital.

There were no revisions to the plan of care related to the episodes, the taking of vital signs to include oxygen saturations, monitoring or other care related items.

DRC #103 acknowledged there were no inclusions in the plan of care related to the taking of vitals signs. They said there was no assessment upon return from the hospital and no revisions made to the plan of care related to the residents change in condition.

b) Resident #002 fell on an identified date in May 2019, and sustained a head injury. Head Injury Routine (HIR) was initiated. The resident's condition declined over a period of three days.

The LTCH Inspector reviewed the progress notes which stated that the Respiratory Therapist found the resident with a specific intervention in place.

DRC #113 said the plan of care in place at the time was not reviewed and revised to reflect the changes to the resident's care needs. They said the home's policy directed that the plan of care and the MAR was to be reviewed and revised with the change in resident's care needs.

The licensee failed to ensure that resident #002 and #003 were reassessed and the plan of care reviewed and revised when their care needs changed. [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 the licensee must ensure that:
a) the care set out in the plan of care is provided as specified in the plan and,
b) the resident is reassessed and the plan of care is reviewed and revised when a resident's care needs change., 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 where the Act or Regulation required the licensee of

a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that the medication management program included policies to ensure accurate administration of all drugs used in the home.

a) Specifically, staff did not comply with the licensee's policy "Medication Administration", reference #011015.00 with a last review date of May 23, 2019, that directed that nursing personnel who were licensed to administer medications included Registered Nurses, Registered Practical Nurses and Nurse Practitioners. Secondly, the home's pharmacy service provider's policy "Medication Administration, General Guidelines", policy #IIA01 directed that medications were administered only by registered staff.

RPN #100 told the LTCH Inspector that they were the preceptor for student nurse #102 and they had assigned them medication administration.

They had administered the two pouches of medications to the resident during their morning medication administration.

b) Specifically, staff did not comply with the licensee's policy "Oxygen Therapy", reference number 0012060.00 with a published date of March 5, 2018, that directed staff to include in the written plan of care:
- the oxygen therapy with flow rate, method and duration and,
- measures to be taken to provide specific safety measures, client related personal care and teaching.

The policy also directed registered staff to document the oxygen and flow rate in the eMARS each shift.

1) Resident #002 had oxygen therapy initiated on an identified date in May 2019. The oxygen was not included in the resident's plan of care and was not documented in the eMARS. There were not entries in the eMAR for staff to document the use of oxygen each shift.
2) Resident # 003 had oxygen therapy initiated upon admission to the home. They did not have an entry included in the eMAR for staff to document the use of the oxygen each shift. Their plan of care did not include the specific safety measures, related personal care and teaching.

3) Resident #004 had oxygen therapy initiated on an identified date in October 2018. The oxygen was not included in the resident's plan of care and was not documented in the eMARS. There were no entries in the eMAR for staff to document the use of oxygen each shift.
4) Resident # 005 had oxygen therapy initiated upon admission to the home. They did not have an entry included in the eMAR for staff to document the use of the oxygen each shift. Their plan of care did not include the specific safety measures, related personal care and teaching.

The EDOC, DRC #103 and DRC #113 told the LTCH Inspector that staff had not followed the Oxygen Therapy policy when they implemented the use of oxygen for residents #002, #003, #004 and #005.

The licensee failed to ensure that the "Medication Administration" ,"Medication Administration, General Guidelines" and "Oxygen Therapy" policy were complied with. [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 the licensee must ensure that policies related to medication administration are complied with, to be implemented voluntarily.

WN #4: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that student nurse #102 received training prior to performing their responsibilities.

Student nurse #102 was assigned to a preceptor at the home in January 2019. In February 2019, they were assigned a second preceptor and were to participate in the provision of care and medication administration to residents.

The LTCH Inspector requested training records to include medication management and required training that was provided to the student nurse prior to being assigned to provide care.

The EDOC said that the student nurse had not been provided any required training and that the home accepted student nurses from a local college and had not included the required training as part of the program.

The licensee failed to ensure that the student nurse had received the required training. [s. 76. (2)]

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 the licensee must ensure that all staff receive training prior to performing their responsibilities, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review of all medication incidents that had occurred in the home since the last quarter was undertaken, in order to reduce and prevent medication incidents from occurring.

The LTCH Inspector reviewed the medication incident report related to a medication incident that occurred in February 2019 and found all components had been completed as required. The quarterly medication incident spreadsheet was reviewed. The LTCH Inspector was not able to identify that the quarterly medication incidents had been reviewed to identify what changes or improvements could be made to reduce or prevent medication incidents from occurring.

The EDOC told the LTCH Inspector that the pharmacist consultant, the Medical Director and themselves, review the spreadsheet of information, as provided by their pharmacy, following their quarterly PAC meeting. They do review each incident however, they do not review them seeking change or improvements to the system to reduce or prevent medication incidents. The EDOC said they do not keep record of any discussions held at this time.

The licensee failed to ensure that medication incidents were reviewed quarterly in order to reduce or prevent medication incidents from occurring. [s. 135. (3)]

Issued on this 24th day of June, 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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2019_787640_0018
Log No. / No de registre :	013377-18, 028787-18, 004268-19, 010209-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 20, 2019
Licensee / Titulaire de permis :	peopleCare Inc. 735 Bridge Street West, WATERLOO, ON, N2V-2H1
LTC Home / Foyer de SLD :	peopleCare Hilltop Manor Cambridge 42 Elliott Street, CAMBRIDGE, ON, N1R-2J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve Pawelko

To peopleCare Inc., 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 :

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 must:

1) Ensure that the licensee's nursing staff are trained in and comply with their responsibilities when providing preceptorship support to student nurses and,
2) Ensure that drugs are administered as specified by the prescriber.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use as specified by the prescriber.

On an identified date in February 2019, resident #001 was administered their 0700 hour morning medications for that day and the following day at the same time.

The resident received twice the amount as ordered by the prescriber.

RPN #100 was the preceptor to student nurse #102. Student nurse #102 was administering medications on an identified date in February 2019 during the day shift. RPN #100 said they had observed the nurse for a previous medication administration and felt comfortable with their abilities.

During the medication pass, RPN #100 was called away from observing the student nurse. When they returned, they noticed that resident #001's medication bin was empty, and it should have contained the following mornings medication pouches. Upon investigation, they noted that two days of the

morning medication pouches were empty and in the discard bin.

Based on the type and amount of medications that were administered, the resident was sent to the hospital for assessment and observation.

The licensee failed to ensure that drugs were administered to resident #100 as directed by the prescriber.

The severity of this issue was determined to be level 3, actual harm or actual risk. The scope of the issue was determined to be level 1, isolated. The compliance history was determined to be level 3 with previous non-compliance to the same section and sub-section as follows:

- VPC issued for s. 131 (2) under inspection #2018_735659_0010 issued June 12, 2018.

(640)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2019

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

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 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 131 (4).

Specifically, the licensee must:
1) Develop policies related to the inclusion of nursing students as part of the nursing program to include the training required and other responsibilities of the preceptor, nursing student and the licensee, and,
2) ensure that all nursing students are provided training on the licensee's written policies and procedures for it's medication management system prior to the administration of drugs to residents.

Grounds / Motifs :

1. The licensee failed to ensure that a nursing student was trained by a member of the registered nursing staff in the written policies and protocols for the medication management system in the home prior to administration of medication.

On an identified date in February 2019, resident #001 was administered their 0700 hour morning medications for that day and the following day at the same time by student nurse #102.

They told RPN #100, their preceptor, they had not reviewed the contents or the expected dates and times of administration on both pouches. They had administered the two pouches of medications to the resident during their morning medication administration.

RPNs #100 and #101 both informed the LTCH Inspector that they had not trained or reviewed the home's policies and protocols for medication management system with the student prior to them administering medications to residents.

Director of Resident Care #103 told the LTCH Inspector the home did not have a policy directing staff as preceptors and that the home had not provided training to the student nurse on policies and protocols for the medication management system in the home.

The licensee failed to ensure that student nurse #102 was trained in the written policies and procedures for the medication management system.

The severity of this issue was determined to be level 3, actual harm or actual risk. The scope of the issue was determined to be level 1, isolated. The compliance history was determined to be level 2 with previous unrelated non-compliance in the previous three full years. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2019

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

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 20th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

Service Area Office /
Bureau régional de services : Central West Service Area Office