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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Dec 10, 2019	2019_821640_0030	012528-19, 012529-19, 020191-19	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): November 4, 5, 6, 7, 14 and 15, 2019.

During the course of the inspection, the Long-Term Care Homes (LTCH) Inspector toured the home, interviewed residents, staff and families, reviewed clinical records, policy and procedure.

The following Critical Incident (CI) report was reviewed during the inspection:

Log #020191-19 related to a fall with injury

The following Follow Up inspections were reviewed during the inspection:

Log #012529-19 related to CO #001 from Inspection #2019_787640_0018 related to medication management program and,
Log #012528-19 related to CO #002 from Inspection #2019_787640_0018 related to student nurses and medication administration.

PLEASE NOTE: This inspection was conducted concurrently with Complaint Inspection #2019_821640_0029.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Environmental Support staff, RN in Charge of Admissions, RAI Coordinator, Fall Program Lead, Directors of Resident Care (3), Acting Staffing clerk, Executive Director of Nursing Care (EDONC) and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (4.1)	CO #002	2019_787640_0018	640

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. 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).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

According to a Critical Incident Report submitted to the Ministry of Long Term Care (MLTC) on an identified date in October 2019, by the licensee, resident #001 fell forward. The resident was left unattended when they required monitoring at all times for a specific process. As a result of the fall, the resident required transfer to hospital with significant injury.

Minimum Data Set (MDS) assessment assessed the resident to have a Cognitive Performance Scale (CPS) of five (5) and required extensive assistance of two or more persons for bed mobility, transfer and toileting.

The plan of care in place at the time of the fall, directed that the resident was to receive assistance with toileting related to cognitive impairment. The intervention was extensive to total dependent assistance with toileting.

Registered Nurse (RN) #101 and the Director of Nursing Care (DNC) said it was expected that when a resident was assessed to have a CPS score of 5 or higher, that they were always to have a staff member with them during a specific process.

Personal Support Worker (PSW) #110 told the DNC, during their investigation, that they had left the resident unattended and when they returned, the resident was found on the floor and injured.

The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to comply with compliance order #001 from inspection #2019_787640_0018 issued June 20, 2019, with a compliance due date of September 20, 2019.

The licensee was ordered to:

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.

The licensee failed to complete either steps in the order.

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

a)Resident #002 was admitted to the home on an identified date in October 2019. On that date, the pharmacy service provider completed the “Best Possible Medication History – BPMH”. The BPMH was based on the resident’s medication administration record (MAR) from their previous home and the admission package from the Local Health Integration Network (LHIN).

Medication reconciliation for resident #002 was not completed on admission and had been completed five days later. At that time, it was discovered that two routine medications had been overlooked by the service provider.

The pharmacy service provider’s policy “Medication Reconciliation on Admission, Re-Admission, Transfer and Discharge”, with no date or policy number, directed that at admission, the BPMH document was to be checked by two nurses and signed by the prescriber.

RN #102 and the EDONC said it was an expectation that the medication reconciliation be completed by two nurses the day of admission and prior to any medications being administered. They acknowledged this had not occurred for resident #002.

b) According to RN #101, RPNs #103 and #106, one home area of 30 residents, was without a nurse to provide medications and treatments. The licensee implemented their contingency plan wherein all other nurses on the five other home areas assisted in the provision of medications and treatments following the administration of medications to their assigned residents on their assigned home areas.

The LTCH Inspector randomly reviewed eight resident records between two home areas for the day identified.

A specific report was utilized by the LTCH Inspector that identified the exact time of medication and treatment administration for that day at 0800 hours. The report identified that seven of eight residents reviewed were administered their 0800 hour medications at a different time than specified by the prescriber.

RN #101 and Registered Practical Nurses (RPN) #103 and #106 acknowledged that the residents did not receive their medications as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1), in reference to s. 49, the licensee was required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls including the monitoring of residents, the review of drug regimes, the implementation of restorative approaches and the use of equipment, supplies, devices and assistive aides.

Specifically, staff did not comply with the licensee's policy “Fall Prevention and Management Program – Falls Risk Factors and Related Interventions”, reference no. 005190.00 that directed registered staff to implement a task with falls prevention strategies for residents at high risk for falls who had fallen in the previous six months.

Resident #001 fell on an identified date in October 2019. As a result of the fall, the resident required transfer to hospital with a significant injury.

Upon return to the home, resident #001 was reassessed to be at high risk for falls.

RPN #104 said that there should be a fall focus, under the category of safety, when the resident was at high risk for falling.

PSWs #107, #108 and #109 and RPN #111 said resident #001 had some fall prevention interventions in place.

RPNs #104 and #111 were unable to locate the fall prevention strategies in the plan of care following the revision based on the new assessment of the recent fall. The tasks did not include the fall focus with the fall prevention strategies. There was no focus of safety included in the plan of care or tasks.

PSWs #107, #108 and #109 were unable to locate the fall prevention interventions in their POC tasks. They were to document once per shift whether the resident had fallen that shift, the use of specific equipment for comfort and positioning and once per shift observation of the resident.

The licensee failed to ensure that their policy “Fall Prevention and Management Program - Falls Risk Factors and Related Interventions” was complied with. [s. 8. (1) (a),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 their policy " “Fall Prevention and Management Program – Falls Risk Factors and Related Interventions”, reference no. 005190.00 is complied with, to be implemented voluntarily.

WN #4: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #001, included their risk of falls.

Resident #001 fell on an identified date in October 2019 and required transfer to hospital as a result of a significant injury.

On an identified date in February 2019, the resident was assessed, using the licensee's fall risk assessment tool, to be at moderate risk for falls. The quarterly Resident Assessment Protocol (RAP), dated in May 2019, assessed the resident to be at low or moderate risk of falling. The RAP directed under the "Plan of Care" section, that no care plan was required as they were at low to moderate risk for falling.

The resident was assessed to have a Cognitive Performance Scale (CPS) of five (5) and required extensive assistance of two or more persons for bed mobility, transfer and toileting.

The LTCH Inspector reviewed the resident's clinical record and the fall risk was not included in the plan of care, Kardex or task list.

PSWs #107 and #108 and RPNs #104 and #111 said that unless a resident was assessed to be at high risk for falls or had a fall within the previous six months, the fall risk and fall prevention strategies were not required to be included in the plan of care.

The PSWs #107 and #108 said the only way they would know if a resident was at low or moderate risk of falling would be to ask the nurse. They did not have access to fall risk assessments in PCC.

RPN #111 said the only way they would be aware of a low or moderate risk of falls for any resident, would be to review the fall risk assessments individually for each of their 30 residents on their home area.

RPNs #104 and #111 acknowledged that resident #001's risk of falls was not included in the plan of care. [s. 26. (3) 10.]

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 resident's plans of care include their risk of falls, to be implemented voluntarily.

Issued on this 19th day of December, 2019

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

Ordre(s) de l’inspecteur

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

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

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) :	HEATHER PRESTON (640)
Inspection No. / No de l’inspection :	2019_821640_0030
Log No. / No de registre :	012528-19, 012529-19, 020191-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 10, 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 :	Mike Dickin

To peopleCare Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 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. 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).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA.

Specifically the licensee must ensure that resident #001 and any other resident, receives the level of assistance needed for safety when toileting as set out in the resident's plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

According to a Critical Incident Report submitted to the Ministry of Long Term Care (MLTC) on an identified date in October 2019, by the licensee, resident #001 fell forward. The resident was left unattended when they required monitoring at all times for a specific process. As a result of the fall, the resident required transfer to hospital with significant injury.

Minimum Data Set (MDS) assessment assessed the resident to have a Cognitive Performance Scale (CPS) of five (5) and required extensive assistance of two or more persons for bed mobility, transfer and toileting.

The plan of care in place at the time of the fall, directed that the resident was to receive assistance with toileting related to cognitive impairment. The intervention was extensive to total dependent assistance with toileting.

Registered Nurse (RN) #101 and the Director of Nursing Care (DNC) said it was expected that when a resident was assessed to have a CPS score of 5 or higher, that they were always to have a staff member with them during a specific

process.

Personal Support Worker (PSW) #110 told the DNC, during their investigation, that they had left the resident unattended and when they returned, the resident was found on the floor and injured.

The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided as specified in the plan. [s. 6. (7)]

The severity of this issue was determined to be level 3. Actual harm. The scope of this issue was determined to be level 1. Isolated. The compliance history was determined to be level 3. Previous non-compliance with the same subsection as follows:

WN – issue February 9, 2017 under Inspection #2017_457630_0003
VPC – issued June 20, 2019 under Inspection #2019_787640_0018

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 07, 2020

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2019_787640_0018, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1) Develop a staffing plan for the nursing department.
2) Develop a process to ensure that when short registered staff, that all residents receive their medications at the time prescribed.
3) Develop a plan to ensure that when short registered staff, staff have a process to identify high-risk medications to ensure their timely administration.
4) Provide training to all registered staff regarding the process of identifying high-risk medications and the process of timely administration of all medications when short registered staff.

Prepare, submit and implement a staffing plan that includes but is not limited to:

a) A staffing mix consistent with the assessed care and safety needs of the residents, that sets out the organization and scheduling of staff shifts, promotes continuity of care by minimizing the number of different staff providing care to each resident and includes a back-up plan for nursing and personal care staffing that addresses when staff cannot come to work

b) A process to ensure that when short registered staff, that all residents receive their medications at the time prescribed.

c) A process to ensure that when short registered staff, staff have a process to identify high-risk medications to ensure their timely administration.

d) A contingency plan for the timely administration of treatments and medications when registered staff cannot come to work.

The plan is to be submitted by December 19, 2019, to central.west.sao@ontario.ca

Grounds / Motifs :

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

a)Resident #002 was admitted to the home on an identified date in October 2019. On that date, the pharmacy service provider completed the "Best Possible Medication History – BPMH". The BPMH was based on the resident's medication administration record (MAR) from their previous home and the admission package from the Local Health Integration Network (LHIN).

Medication reconciliation for resident #002 was not completed on admission and had been completed five days later. At that time, it was discovered that two routine medications had been overlooked by the service provider.

The pharmacy service provider's policy "Medication Reconciliation on Admission, Re-Admission, Transfer and Discharge", with no date or policy number, directed that at admission, the BPMH document was to be checked by two nurses and signed by the prescriber.

RN #102 and the EDONC said it was an expectation that the medication reconciliation be completed by two nurses the day of admission and prior to any medications being administered. They acknowledged this had not occurred for resident #002.

b) According to RN #101, RPNs #103 and #106, one home area of 30 residents, was without a nurse to provide medications and treatments. The licensee implemented their contingency plan wherein all other nurses on the five other home areas assisted in the provision of medications and treatments following the administration of medications to their assigned residents on their assigned home areas.

The LTCH Inspector randomly reviewed eight resident records between two home areas for the day identified.

A specific report was utilized by the LTCH Inspector that identified the exact time of medication and treatment administration for that day at 0800 hours. The report identified that seven of eight residents reviewed were administered their 0800 hour medications at a different time than specified by the prescriber.

RN #101 and Registered Practical Nurses (RPN) #103 and #106 acknowledged that the residents did not receive their medications as specified by the

prescriber. [s. 131. (2)]

The severity of the issue was determined to be level 2. Minimal harm/minimal risk. The scope of the issue was determined to be level 3. Widespread with eight of nine residents reviewed were affected. The compliance history was determined to be level 5. Re-issue of a Compliance Order to the same subsection and four or more COs as follows:

- CO issued June 20, 2019 under Inspection #2019_787640_0018 for s. 131 (2) with a compliance due date of September 20, 2019.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2020

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure:

1) All registered staff are trained in and comply with their responsibilities when providing preceptorship support to student nurses and,
2) Ensure that all drugs are administered to residents as specified by the prescriber and,
3) All registered staff are trained in and comply with the licensee's policy regarding medication reconciliation.

Grounds / Motifs :

1. The licensee failed to comply with compliance order (CO) #001 from inspection #2019_787640_0018 issued June 20, 2019, with a compliance due date of September 20, 2019.

The licensee was ordered to:

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.

The licensee failed to complete either steps in the order.

Refer to CO#002 for further grounds related to s. 131 (2) of O. Reg. 79/10.

The compliance history was determined to be level 5. Re-issue of a Compliance Order to the same subsection and four or more COs as follows:

- CO issued June 20, 2019 under Inspection #2019_787640_0018 for s. 131 (2) with a compliance due date of September 20, 2019.

(640)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2020

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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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 10th day of December, 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