Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2019	2019_725522_0013	016180-19	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

JULIE LAMPMAN (522)

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): September 5, 6, 9, 10, 11, 12, and 13, 2019.

This inspection was completed concurrently with Complaint Inspection IL-69336-LO/ Log #015971-19.

During the inspection, Critical Incident System report #2628-000025-19/Log #016180-19 related to resident to resident abuse was inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, a Registered Nurse, a Registered Practical Nurse and Personal Support Workers.

The inspector also observed resident to resident interactions, the provision of resident care, reviewed resident clinical records and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 the provision of care set out in the plan of care was documented.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had witnessed the incident between resident #001 and #002.

The CIS report noted the residents were separated and specific interventions were initiated for both residents to prevent further incidents.

In an interview, Personal Support Worker (PSW) #103 stated that they had witnessed the incident between resident #001 and #002. PSW #103 stated specific interventions were put in place for both residents and PSWs documented the interventions in Point of Care (POC).

A) In an interview, Registered Nurse (RN) #102 stated that resident #001 had one ongoing intervention in place related to the incident and another specific intervention was in place over a nine day period.

Review of resident #001's electronic kardex in Point Click Care (PCC) noted that the

ongoing intervention for resident #001 had to be documented at specific timeframes.

i) Review of resident #001's charting for the nine day intervention in POC noted partial documentation on all of the nine days.

ii) Review of resident #001's documentation over a 23 day period in POC for the ongoing intervention noted partial documentation on 14 out 23 days (60.8%).

B) In an interview, RN #102 stated that resident #002 had an ongoing intervention in place related to the incident.

Review of resident #002's electronic kardex in PCC noted that the ongoing intervention for resident #002 had to be documented at specific timeframes.

Review of resident #002's documentation over a 23 day period in POC for the ongoing intervention noted partial documentation on 10 out of 23 days (43.4%).

C) In an interview, Registered Practical Nurse (RPN) #105 stated that resident #005 had interventions in place that required time specific documentation in POC.

Review of resident #005's electronic kardex in PCC noted the documentation was to be completed on resident #005 during a specific shift.

Review of resident #005's documentation for the specific intervention in POC for a two month period noted the absence of documentation on the specific shift on four occasions.

In an interview, Director of Care (DOC) #101 reviewed POC documentation for resident #001, resident #002 and resident #003 with inspector. DOC #101 acknowledged that documentation was missing for specific interventions for resident #001, resident #002 and resident #005.

The licensee has failed to ensure that the provision of care set out in the plans of care for resident #001, resident #002 and resident #005 was documented. [s. 6. (9) 1.]

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

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had witnessed the incident between resident #001 and #002.

A) The CIS report noted a specific intervention was put in place for resident #002 to prevent further incidents between resident #001 and resident #002.

On a specific date, observation of resident #002's room noted the specific intervention was in place.

Review of resident #002's plan of care noted no reference to use of the specific intervention.

In an interview, Personal Support Worker (PSW) #103 stated they had witnessed the incident between resident #001 and #002 and a specific intervention was put in place for resident #002 to prevent further incidents between resident #001 and resident #002. PSW #103 stated that use of the specific intervention was not in resident #002's plan of care.

In an interview, Director of Care (DOC) #101 reviewed resident #002's plan of care with inspector and acknowledged that the use of the specific intervention for resident #002 was not included in resident #002's plan of care. DOC #101 stated that when interventions were implemented to prevent further incidents between resident #001 and resident #002, resident #002's plan of care should have been updated.

The licensee has failed to ensure that resident #002's plan of care was reviewed and revised to include specific interventions that were in place.

B) The CIS report noted a specific intervention was put in place for resident #001.

In an interview, Personal Support Worker (PSW) #103 stated they had witnessed the incident between resident #001 and #002. PSW #103 stated they had witnessed resident #001 mistake resident #002 for another resident. PSW #103 stated after the incident a specific intervention was put in place for resident #001.

In an interview, Assistant Director of Care (ADOC) #104 stated that they thought resident #001 confused their room with resident #002's room.

On a specific date, observation of resident #001's room noted the specific intervention in place.

Review of resident #001's plan of care noted no reference to use of the specific intervention for resident #001 and no reference that resident #001 would mistake resident #002's room as their own and that resident #001 would mistake resident #002 for another resident.

In an interview, Registered Nurse #102 reviewed resident #001's plan of care and acknowledged that the specific intervention was not included in resident #001's plan of care.

In an interview, Director of Care (DOC) #101 acknowledged that they thought resident #001 mistook resident #002 for another resident. DOC #101 stated that information and the use of a specific intervention should be in resident #001's plan of care. DOC #101 updated resident #001's plan of care to include this.

The licensee has failed to ensure that the resident #001's plan of care was reviewed and revised when resident #001's care needs changed. [s. 6. (10) (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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had had witnessed the incident between resident #001 and #002.

A review of the home's "Prevention of Abuse & Neglect of a Resident" policy VII-G-10.00 revised April 2019, noted the following:

"All investigative information is kept in a separate report from the resident's record."

Attached to the policy was a "Nursing Checklist for Investigating Alleged Abuse of a Resident by Family or Team Member or Visitor or Volunteer or Another Resident" VII-G-10.00(b) dated April 2019, which noted: "This checklist is to be used with any issues of suspected or actual abuse of a resident. Please refer to the Policy and Procedure for details..."

In an interview, inspector requested the Nursing Checklist for Investigating the Alleged Abuse of a Resident for the incident between resident #001 and resident #002. Director of Care (DOC) #101 stated that they could not find the Nursing Checklist for Investigating Alleged Abuse of a Resident for the incident between resident #001 and resident #002. DOC #101 stated they had spoken with the nurse who completed the investigation and the nurse had not completed the checklist, as per the home's policy.

2.A CIS report was submitted to the Ministry of Long-Term Care related to an incident of abuse between resident #005 and resident #007.

Review of the CIS report noted the incident between resident #005 and resident #007 was witnessed by a Personal Support Worker.

In an interview, inspector requested the Nursing Checklist for Investigating the Alleged Abuse of a Resident for the incident between resident #005 and resident #007. Director of Care (DOC) #101 stated that they could not find the Nursing Checklist for Investigating

Alleged Abuse of a Resident for the incident between resident #005 and resident #007. DOC #101 stated that it was possible that the Nursing Checklist might have been filed in resident #007's clinical record as they had been discharged.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the initial plan of care was developed within 21 days of the admission.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of resident #001's electronic clinical record in Point Click Care (PCC) noted that resident #001 was admitted to the home on a specific date.

Review of resident #001's plan of care noted a specific focus and interventions were not personalized for the resident.

In an interview, Registered Nurse (RN) #102 stated that when a resident was admitted to the home registered staff were responsible to ensure the resident's care plan was completed within 21 days from admission. RN #102 stated that registered staff had a Move In Checklist that was to be completed after admission which stated the resident's care plan or plan of care was to be completed and personalized by day 21.

RN #102 reviewed resident #001's plan of care with inspector. RN #102 acknowledged a specific focus and interventions for resident #001 had not been completed and personalized. RN #102 stated that the plan of care for resident #001 should have been completed to date as the resident had been in the home longer than 21 days.

In an interview, Director of Care (DOC) #101 reviewed resident #001's Move In Checklist with inspector. DOC #101 acknowledged that the Move In Checklist did not indicate that resident #001's plan of care had been completed and personalized. DOC #101 reviewed resident #001's plan of care and acknowledged that resident #001's initial plan of care had not been completed within 21 days of admission. DOC #101 stated that registered staff were responsible to ensure resident #001's initial plan of care was completed.

The licensee has failed to ensure that resident #001's initial plan of care was developed within 21 days of resident #001's admission. [s. 25. (1) (b)]

2. Review of resident #004's electronic clinical record in PCC noted that resident #004 was admitted to the home on a specific date.

Review of resident #004's care plan in PCC noted specific interventions were not personalized for the resident.

In an interview, RN #102 reviewed resident #004's care plan with inspector. RN #102 acknowledged that the interventions were not completed and personalized for resident #004. RN #102 stated resident #004's care plan should be completed as resident #004 had been in the home longer than 21 days.

In an interview, Director of Care (DOC) #101 reviewed resident #004's plan of care and acknowledged that resident #004's initial plan of care had not been completed within 21

days of admission. DOC #101 stated that registered staff were responsible to ensure resident #004's initial plan of care was completed.

The licensee has failed to ensure that resident #004's initial plan of care was developed within 21 days of resident #004's admission. [s. 25. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the initial plan of care is developed within 21 days of the admission, to be implemented voluntarily.

Issued on this 2nd day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_725522_0013
Log No. / No de registre :	016180-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 2, 2019
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JoAnn Zomer

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Vigour Limited Partnership on behalf of Vigour General Partner 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 :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6 (10) of LTCHA 2007.

Specifically, the licensee must ensure:
a) The plan of care for resident #001 is reviewed and revised.
b) The plan of care for resident #002 is reviewed and revised.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had witnessed the incident between resident #001 and #002.

A) The CIS report noted a specific intervention was put in place for resident #002 to prevent further incidents between resident #001 and resident #002.

On a specific date, observation of resident #002's room noted the specific intervention was in place.

Review of resident #002's plan of care noted no reference to use of the specific intervention.

In an interview, Personal Support Worker (PSW) #103 stated they had witnessed the incident between resident #001 and #002 and a specific intervention was put in place for resident #002 to prevent further incidents between resident #001 and resident #002. PSW #103 stated that use of the specific intervention was not in resident #002's plan of care.

In an interview, Director of Care (DOC) #101 reviewed resident #002's plan of care with inspector and acknowledged that the use of the specific intervention for resident #002 was not included in resident #002's plan of care. DOC #101 stated that when interventions were implemented to prevent further incidents between resident #001 and resident #002, resident #002's plan of care should have been updated.

The licensee has failed to ensure that resident #002's plan of care was reviewed and revised to include specific interventions that were in place.

B) The CIS report noted a specific intervention was put in place for resident #001.

In an interview, Personal Support Worker (PSW) #103 stated they had witnessed the incident between resident #001 and #002. PSW #103 stated they had witnessed resident #001 mistake resident #002 for another resident. PSW #103 stated after the incident a specific intervention was put in place for resident #001.

In an interview, Assistant Director of Care (ADOC) #104 stated that they thought resident #001 confused their room with resident #002's room.

On a specific date, observation of resident #001's room noted the specific intervention in place.

Review of resident #001's plan of care noted no reference to use of the specific intervention for resident #001 and no reference that resident #001 would mistake resident #002's room as their own and that resident #001 would mistake

resident #002 for another resident.

In an interview, Registered Nurse #102 reviewed resident #001's plan of care and acknowledged that the specific intervention was not included in resident #001's plan of care.

In an interview, Director of Care (DOC) #101 acknowledged that they thought resident #001 mistook resident #002 for another resident. DOC #101 stated that information and the use of a specific intervention should be in resident #001's plan of care. DOC #101 updated resident #001's plan of care to include this.

The licensee has failed to ensure that the resident #001's plan of care was reviewed and revised when resident #001's care needs changed.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 3 as it was a widespread. The home had a level 3 history of previous noncompliance to the same subsection of LTCHA 2007. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019

Order # / Ordre no : 002

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. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must comply with s. 6 (9) of LTCHA 2007.

Specifically the licensee must ensure the provision of care set out in the plan of care for resident's #001, #002, #005 and all other residents is documented.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had witnessed the incident between resident #001 and #002.

The CIS report noted the residents were separated and specific interventions were initiated for both residents to prevent further incidents.

In an interview, Personal Support Worker (PSW) #103 stated that they had witnessed the incident between resident #001 and #002. PSW #103 stated specific interventions were put in place for both residents and PSWs documented the interventions in Point of Care (POC).

A) In an interview, Registered Nurse (RN) #102 stated that resident #001 had

one ongoing intervention in place related to the incident and another specific intervention was in place over a nine day period.

Review of resident #001's electronic kardex in Point Click Care (PCC) noted that the ongoing intervention for resident #001 had to be documented at specific timeframes.

i) Review of resident #001's charting for the nine day intervention in POC noted partial documentation on all of the nine days.

ii) Review of resident #001's documentation over a 23 day period in POC for the ongoing intervention noted partial documentation on 14 out 23 days (60.8%).

B) In an interview, RN #102 stated that resident #002 had an ongoing intervention in place related to the incident.

Review of resident #002's electronic kardex in PCC noted that the ongoing intervention for resident #002 had to be documented at specific timeframes.

Review of resident #002's documentation over a 23 day period in POC for the ongoing intervention noted partial documentation on 10 out of 23 days (43.4%).

C) In an interview, Registered Practical Nurse (RPN) #105 stated that resident #005 had interventions in place that required time specific documentation in POC.

Review of resident #005's electronic kardex in PCC noted the documentation was to be completed on resident #005 during a specific shift.

Review of resident #005's documentation for the specific intervention in POC for a two month period noted the absence of documentation on the specific shift on four occasions.

In an interview, Director of Care (DOC) #101 reviewed POC documentation for resident #001, resident #002 and resident #003 with inspector. DOC #101 acknowledged that documentation was missing for specific interventions for

resident #001, resident #002 and resident #005.

The licensee has failed to ensure that the provision of care set out in the plans of care for resident #001, resident #002 and resident #005 was documented.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 3 as it was a widespread. The home had a level 3 history of previous noncompliance to the same subsection of LTCHA 2007. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 2nd day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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