Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 16, 2020	2020_657681_0011	013576-20, 014957-20, 016718-20	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

STEPHANIE DONI (681)

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): August 24-28, 31, and September 1-3, 2020.

The following intakes were completed during this Critical Incident System inspection:

- One intake related to a missing or unaccounted for controlled substance.

- Two intakes related to falls that resulted in injury to the resident and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, former Administrator, former Director of Care (DOC), Co-DOC, Staff Educators, Pharmacist, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Restorative Care Aides, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.
- **7 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate isolation precautions were initiated and implemented for two residents, as per the direction of the Chief Medical Officer of Health.

The Inspector observed signage outside two resident rooms, which indicated that isolation precautions were in place for these residents. The Inspector observed that staff went into both of these resident rooms wearing only a procedural mask and gloves. No other personal protective equipment (PPE) was utilized by the staff members.

One of the residents was unwell and the other had recently returned from another facility. Both residents required isolation with droplet and contact precautions. Staff were to have utilized a gown, gloves, mask, and goggles or face shield when coming within two metres of these residents. The improper initiation of isolation precautions and improper use of PPE placed other residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes; the home’s program titled “Infection Prevention and Control”, last reviewed June 1, 2020; the resident's progress notes; and interviews with the Co-DOC and other staff members.

2. The licensee has failed to ensure that staff separated and appropriately handled soiled items.

During the inspection, the Inspector observed the following:

- Soiled briefs and soiled linens were observed on carts in the hallways of two different Home Areas. The carts also contained clean supplies, including gloves, linens, and towels.

- A PSW was observed assisting a resident to the dining room with soiled items in their hand. After leaving the resident in the dining room, the PSW disposed of the soiled items in the garbage/soiled hamper in the hall.

- Two used reusable isolation gowns were observed hanging over the hand rail in the hallway outside of a resident's room.

Staff should have promptly placed the soiled items in the appropriate bags or hampers.

The improper handling and storage of soiled items increased the risk of contact surfaces becoming contaminated.

Sources: Inspector observations; the home's program titled "Infection Prevention and Control", last reviewed June 1, 2020; and interviews with the Co-DOC and other staff members. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment belonging to three residents was kept clean and sanitary.

The Inspector observed that mobility aides belonging to three residents were visibly soiled. The Inspector noted that the staining and debris that was initially observed on the mobility aides was still present when follow-up observations were completed.

Multiple staff members indicated that residents were supposed to have their mobility aides cleaned by night shift staff on a weekly basis, but this was not being completed. Unclean equipment posed an infection prevention and control (IPAC) risk to residents because the surfaces of the equipment could become contaminated with harmful bacteria, viruses, or fungi.

Sources: Inspector observations and interviews with five staff members. [s. 15. (2) (a)]

Additional Required Actions:

CO # - 002 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 staff complied with the narcotic and controlled substances policy included in the required medication management system program.

Section 114 (2) of the Ontario Regulation 79/10 requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction, and disposal of all drugs used in the home.

Specifically, the staff member did not comply with the licensee’s policy titled "Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances", last reviewed November 2019. The policy indicated that registered staff would:
- Complete a running inventory/count for each narcotic, including amount on hand, dispensed, and remaining each time the narcotic was administered;
- Record all narcotics administered on the electronic medication administration record (EMAR); and
- Document the effectiveness of as needed (prn) narcotic medications.

During a three month period, it was identified that a staff member documented on narcotic administration records that they administered a medication to five residents on several occasions, but not all of these instances were documented in the resident’s EMAR. Documentation related to the reason for administering the medication and effectiveness of the administered medication was also missing. The improper documentation of narcotic administration put residents in the home at risk of medication errors.

Sources: The CIS Report; home's investigation notes; licensee’s policy titled "Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances", last reviewed November 2019; and interviews with the Interim Administrator, Co-DOC, and other staff members. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The home’s process was to evaluate the medication management system, including reviewing medication incidents and drug utilization trends, at quarterly professional advisory committee meetings. The interdisciplinary professional advisory committee did not meet in the first or second quarter of 2020. The Interim Administrator indicated that these meetings were missed because of COVID-19.

Sources: Professional Advisory Committee Meeting Minutes and interviews with the Interim Administrator and other staff members. [s. 115. (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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a CIS Report was amended as requested by the Director, to provide information related to the current status of the resident involved in the incident.

The Inspector reviewed the CIS Report and identified that an amendment was requested, but had not been returned. The Interim Administrator indicated that the amendment had not been submitted because of the turnover in managerial staff.

Sources: The CIS Report and an interview with the Interim Administrator. [s. 107. (4) 3. v.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were kept in a separate, double-locked stationary cupboard in a locked area.

During the inspection, the Inspector observed that certain controlled substances were kept in a single locked cupboard. Staff identified that they believed that the controlled substances were double locked because there was a lock on the cupboard and the medication room door was also locked. However, the controlled substances should have been stored in a double-locked cupboard within the locked medication room.

Sources: Inspector observations; Silver Fox Pharmacy Policy 4.1 titled "Emergency Medication Home Supply", last revised March 2020; and interviews with staff members. [s. 129. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that wasted narcotics were destroyed by a team that was composed of one member of the registered nursing staff and a physician or pharmacist.

Subsection 136 (6) of the Ontario Regulation 79/10 identifies that for the purposes of section 136, a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

The Inspector observed that two RPNs disposed of wasted narcotics by placing them in a certain container and that no action was taken to alter or denature the medication before it was put in this container. Interviews with three registered staff members indicated that their usual practice was to discard refused or wasted narcotics in that container.

Interviews with a Staff Educator, the Pharmacist, and the Co-DOC all identified different processes for how refused or wasted narcotics should be managed by registered staff on the unit. The licensee’s policy titled “Medication Management System – Narcotics and Controlled Substances” and the pharmacy policy titled “Drug Destruction: Controlled Substances” identified the process to be followed when a narcotic was discontinued or removed from active supply, but did not provide clear direction related to the process for the destruction and disposal of refused or wasted narcotics.

Sources: Inspector observations; licensee’s policy titled "Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances", last reviewed November 2019; Silver Fox Pharmacy Policy 9.2 titled “Drug Destruction: Controlled Substances”, last reviewed March 2020; and interviews with registered staff members, a Staff Educator, the Pharmacist, and the Co-DOC. [s. 136. (3) (a)]

Issued on this 17th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2020_657681_0011
Log No. / No de registre :	013576-20, 014957-20, 016718-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 16, 2020
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tricia Swartz

To Barrie Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of the Ontario Regulation 79/10.

Specifically, the licensee must:

a) Ensure that all staff in the home are retrained on isolation precautions related to COVID-19 and the appropriate use of personal protective equipment (PPE), including the correct process for putting on and taking off PPE. Documentation of this training, including who completed the training, must be maintained.

b) Develop and implement an auditing process to ensure that staff are utilizing the appropriate PPE when providing care to residents on isolation precautions. Documentation of the completed audits must be maintained. The audits must include identifying any barriers to appropriate PPE usage, as well as, any corrective action that was required. The audits must continue until no further concerns are identified with the appropriate use of PPE.

c) Develop and implement a process for ensuring that PSW staff are correctly handling soiled items, including soiled incontinence products. Documentation of the process that was implemented and action taken must be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that appropriate isolation precautions were initiated and implemented for two residents, as per the direction of the Chief Medical Officer of Health.

The Inspector observed signage outside two resident rooms, which indicated that isolation precautions were in place for these residents. The Inspector observed that staff went into both of these resident rooms wearing only a

procedural mask and gloves. No other personal protective equipment (PPE) was utilized by the staff members.

One of the residents was unwell and the other had recently returned from another facility. Both residents required isolation with droplet and contact precautions. Staff were to have utilized a gown, gloves, mask, and goggles or face shield when coming within two metres of these residents. The improper initiation of isolation precautions and improper use of PPE placed other residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes; the home's program titled "Infection Prevention and Control", last reviewed June 1, 2020; the resident's progress notes; and interviews with the Co-DOC and other staff members.

2. The licensee has failed to ensure that staff separated and appropriately handled soiled items.

During the inspection, the Inspector observed the following:

- Soiled briefs and soiled linens were observed on carts in the hallways of two different Home Areas. The carts also contained clean supplies, including gloves, linens, and towels.

- A PSW was observed assisting a resident to the dining room with soiled items in their hand. After leaving the resident in the dining room, the PSW disposed of the soiled items in the garbage/soiled hamper in the hall.

- Two used reusable isolation gowns were observed hanging over the hand rail in the hallway outside of a resident's room.

Staff should have promptly placed the soiled items in the appropriate bags or hampers. The improper handling and storage of soiled items increased the risk of contact surfaces becoming contaminated.

Sources: Inspector observations; the home's program titled "Infection Prevention and Control", last reviewed June 1, 2020; and interviews with the Co-DOC and

other staff members.

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

Severity: There was actual risk to the residents of the home when staff did not use the appropriate PPE or properly handle soiled items.

Scope: The scope was identified as a pattern because two of the three residents reviewed did not have the correct isolation precautions in place, nor were staff utilizing the appropriate PPE with these residents.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 229 (4) and a Voluntary Plan of Correction (VPC) was issued to the home. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with s. 15 (2) of the Long-Term Care Homes Act.

Specifically, the licensee must:

a) Develop and implement a process to ensure that resident equipment, including wheelchairs and walkers, are being cleaned on a regular basis.

b) Conduct audits to ensure that equipment is being cleaned as per the process that was developed. Documentation of the audits must be maintained and must include identifying any corrective action that was required. The audits must continue until no further concerns are identified with unclean wheelchairs or walkers.

Grounds / Motifs :

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

1. The licensee has failed to ensure that equipment belonging to three residents was kept clean and sanitary.

The Inspector observed that mobility aides belonging to three residents were visibly soiled. The Inspector noted that the staining and debris that was initially observed on the mobility aides was still present when follow-up observations were completed.

Multiple staff members indicated that residents were supposed to have their mobility aides cleaned by night shift staff on a weekly basis, but this was not being completed. Unclean equipment posed an infection prevention and control (IPAC) risk to residents because the surfaces of the equipment could become contaminated with harmful bacteria, viruses, or fungi.

Sources: Inspector observations and interviews with five staff members.

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

Severity: There was minimal risk to the residents of the home when their equipment was not kept clean or sanitary.

Scope: The scope was identified as a widespread because three of the three residents reviewed had unclean mobility aides.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 15 (2) and a Voluntary Plan of Correction (VPC) was issued to the home. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 30, 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:

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 16th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stephanie Doni

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