Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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Amended Public Copy/Copie modifiée 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
Mar 25, 2019	2019_665551_0001 (A1)	022902-18, 027592-18, 027901-18, 032983-18	Complaint

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

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

Amended by MEGAN MACPHAIL (551) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This order has been closed due to the fact that the licensee is no longer responsible for the management of this long-term care home as of April 1, 2019. The new licensee will be responsible to ensure compliance with the Long-Term Care Homes Act, 2007 as per the conditions of their licence.

Issued on this 25th day of March, 2019 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

Amended by MEGAN MACPHAIL (551) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): On-site: January 31, February 1, 6, 11 and 14, 2019 and Off-site: February 5, 7, 12, 13, 26, 28 and March 4 and 5, 2019.

The following logs were inspected:

022902-18 related to staffing levels and provision of care to residents

027592-18 and 027901-18 related to staffing

032983-18 related to a bed refusal

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, the RAI coordinator, the Manager of Payroll and Scheduling, the Manager of Quality Improvement and Risk, the Director of Resident Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed staff schedules, medication administration records, health care records and the Pain Management policy; and observed a supper meal service.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Critical Incident Response
Dining Observation
Medication
Pain
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

According to the home's staffing plan, on the day shift, there is one (1) Registered Nurse (RN) and 1 Registered Practical Nurse (RPN) each on the first and second floors. According to the Manager of Quality Improvement and Risk, the RPN is responsible for administering drugs and completing the majority of the treatments. On a specified day on a specific shift, there was 1 RN and no RPN on the second floor. In the absence of an RPN, RN #112 was tasked with medication administration.

On a specific shift of a specified date, the majority of residents on a specific floor did not receive their drugs as prescribed. This included important drugs used to treat serious medical conditions.

According to the Administrator, they were not made aware of the medication omissions until three (3) days later, when a hand written note was received.

A Medication Administration List (Overdue) was provided by the Administrator. This list also indicated that medications were not administered as prescribed on a different shift on the same day.

Information received from the Administrator, indicated that Medication Incident reports were completed for 4 residents. Of the 4 residents listed in the incident reports, specific medications for 3 of those residents were not included in the Medication Administration List (Overdue).

As required under O. Reg 79/10, s. 135 (1), the licensee did not ensure that every medication incident from the specified date was documented, along with a record of the immediate actions taken to assess and maintain the health of those residents involved, and did not ensure that SDM's were contacted (see WN #5).

Additionally as required under LTCHA, s. 24 (1), the licensee did not report the improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident to the Director (see WN #6). [s. 131. (2)]

Additional Required Actions:

(A1)
The following order(s) have been rescinded: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #005 so that their assessments were integrated, consistent with and complimented each other.

In a progress note written on the day that resident #005 was admitted to the home, an area of skin impairment was noted. According to the resident's Medication/Treatment Administration Record (M/TAR), a specified analgesic medication was ordered.

On the day of admission, RN #112 completed a referral to the physician in the form of an SBAR form (S: clinical situation; B: background and clinical information; A: assessment/clinical issue; R: recommendation/clinical need)

requesting an increase in pain control.

Two days later, a progress note entry stated that the resident was in a great deal of pain.

Five days after resident #005 was admitted, RN #112 sent a fax to the attention of the resident's physician. The RN asked for a stronger medication to manage the resident's pain.

Twelve days after resident #005 was admitted, an SBAR form was completed and noted that the resident was complaining of pain.

On a specified date, RN #112 wrote a late entry stating that on the day prior, the resident's family was asking if the physician had been in with regards to getting pain medication for their parent. The RN indicated that the physician was on holidays. Two additional progress note entries indicated that the resident's family was in and inquiring if the physician had assessed the resident.

Almost 3 weeks after the resident was admitted, an SBAR form was completed by RN #106 stating that the resident required a pro re nata (prn or as needed) for pain. The following day, the physician ordered ordered a new pain medication to be given as needed for resident #005. According to the M/TAR, the resident received one (1) dose of this prn medication.

The following day, the physician discontinued the order and ordered a stronger pain medication to be given as needed.

According to the Administrator, in the absence of the unit's regular physician, nursing staff could have contacted another of the home's physician's to obtain pain medication for the resident.

Staff and others did not collaborate with each other as assessments completed on 4 occasions, including on the day of admission, indicated that resident #005's pain control was inadequate, and changes were not made to resident #005's pain medication management until almost 3 weeks after the resident was admitted to the home. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and compliment each other, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As per O. Reg 79/10, s. 8 (1) where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with

In accordance with O. Reg 79/10, s. 52 (1), the licensee is required to have a pain management program.

The licensee's Pain and Symptom Management policy (LTC-RCM-G-30.10) directs the registered staff to:
1. Conduct and document a pain assessment electronically when specific criteria is met, including
• when pain management strategies are ineffective

Resident #005 was admitted to the home on a specified date with an area of skin impairment. According to the resident's Medication/Treatment Administration Record (M/TAR), a specified analgesic medication was ordered.

In the MDS assessment completed on admission, resident #005 was coded as having pain daily of moderate intensity.

On 3 occasions following the resident's admission, SBAR forms were completed noting that the resident was experiencing pain, and on a specified date, a fax was sent to the attention of the physician stating that resident #005 was in pain and requested a stronger medication to manage it.

On a specified date, the physician ordered ordered a new pain medication to be given as needed for resident #005. According to the M/TAR, the resident received one (1) dose of this prn medication, and a follow-up note stated that the medication was effective.

The following day, the physician discontinued the order and ordered a stronger pain medication to be given as needed. According to the M/TAR, several doses of this prn medication were administered.

- on one occasion, a follow-up note was written but did not address the effectiveness of the medication.
- on one occasion, a follow-up note was written and stated the resident had received very little effect from the administration of the medication.

A review of the resident's health care record showed that a pain assessment was not conducted and documented as stated in the policy when:

- The resident's pain management was ineffective as noted with the completion of SBAR forms on 3 occasions and once when a fax was sent to the attention of the physician.
- On a specified date when a progress note entry stated that the resident was in a great deal of pain.
- On a specified date when it was charted that the resident had received very little effect from the administration of a prn medication for pain. [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 to ensure that the Pain and Symptom Management policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in specific areas.

As per section 76 (1) of the Act, every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

As per section 74 (2) of the Act, "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party.

According to the Administrator, starting in June 2018, the home has relied on agency staff to fill vacant PSW, RPN and RN positions. The agencies used were Ottawa Home Care and Source Momentum. According to the Administrator, Source Momentum is no longer used due a lack of availability of staff.

According to the staff scheduler, between November 2018 and January 2019, Ottawa Home Care worked the following number of shifts at the home:
November 2018: RN: 6. RPN: 4: PSW: 74
December 2018: RN: 16. RPN: 16. PSW: 72
January 2019: RN: 3. RPN: 21. PSW: 51

According to the Administrator, Ottawa Home Care is responsible for the training of agency staff, and the licensee does not provide any materials to the agency for training purposes, including the long-term care home's mission statement, the policy to promote zero tolerance of abuse and neglect of residents, the policy to minimize the restraining of residents, fire prevention and safety, emergency and evacuation procedures or infection prevention and control.

In an interview with the Manager of Quality Improvement and Risk, they stated that the licensee does not provide training to agency staff on the above topics.

All staff at the home have not received training as required by this section prior to performing their responsibilities. [s. 76. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff at the home have received training as required by this section prior to performing their responsibilities., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and that the incident was reported to the resident's substitute decision maker (SDM).

On a specific shift of a specified date, the majority of residents on a specific floor did not receive all or some of their medications as prescribed. A Medication Incident/Near Miss report was only partially filled out, and not signed by RN #112. It did not list any resident's names or immediate actions taken to assess and maintain the resident's health. Administrator #113 could not confirm that the report was ever faxed to pharmacy as the Pharmacist did not recall receiving the report. Administrator #113 was not made aware of the medication incident until 3 days later when a hand written note was received. This note listed the resident's

names who missed medications and the times that the medications were missed. There was no record of any immediate actions taken to assess or maintain the health of any of the residents who missed medications on this note.

Administrator #113 informed Inspector #732 that they made a phone call to pharmacy to obtain a record of all the residents who did not receive their medications on the specified date. Pharmacy sent a document entitled "Pharmacy Report" that indicated those residents who were scheduled for medications but did not receive them. It contained no record of the immediate actions taken to assess and maintain the resident's health.

Inspector #732 reviewed the progress notes for the specific shift of a specified date. Inspector #732 was unable to locate any notes written by RN #112 regarding the medication incidents, and no record of actions taken to assess and maintain the health for those residents who were involved in the medication incidents.

In an interview on February 26, 2019, Administrator #113 told Inspector #732 that RN #112 did not contact any SDM's for the residents who did not receive medications. Administrator #113 stated that some RPN's had made calls to some family members. Inspector #732 requested documents from Administrator #113 related to the medication incidents. Review of these documents showed that medication incident forms were filled out for only 4 residents. The form showed that the SDM of those four residents had been notified over 1 week after the incident, in regards to the medications that were not administered. Administrator #113 confirmed in an email that other residents SDM's were not contacted due to lack of time.

The licensee has failed to ensure that every medication incident was documented, along with a record of the immediate actions taken to assess and maintain the health of those residents involved. As well, the licensee failed to ensure that SDM's were contacted for every resident who missed medications on a specified date. [s. 135. (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 every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and that the incident is reported to the resident's substitute decision maker (SDM), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

On a specific shift of a specified date, the majority of residents on a specific floor did not receive their drugs as prescribed or treatments as ordered. This included important drugs used to treat serious medical conditions.

In a interview with the Administrator, they indicated that they should have submitted a CIS after becoming aware that the majority of residents on a specific floor had not received their medications and treatments as ordered on a specified date, but failed to do so. [s. 24. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that applicant #001's rejection to the home was for a reason authorized by the legislation.

On a specified date, the Director of Resident Care (DRC) sent a rejection letter to the Placement Manager of the South East Local Health Integration Network stating that the home could not approve applicant #001's admission. The letter stated that the home lacked the physical facilities necessary to meet the applicant's care requirements specific to bathing.

The rejection letter stated that the home had 4 bathing suites, and this was confirmed through observation and on the home's floor plan therefore the home does not lack the physical facilities necessary to meet the applicant's care requirements as they relate to bathing. [s. 44. (7)]

Issued on this 25th day of March, 2019 (A1)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MEGAN MACPHAIL (551) - (A1)
Inspection No. / No de l'inspection :	2019_665551_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022902-18, 027592-18, 027901-18, 032983-18 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 25, 2019(A1)
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Perth Community Care Centre 101 Christie Lake Road, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummins

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 Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

(A1)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

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).

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 25th day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MEGAN MACPHAIL (551) - (A1)

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