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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Aug 29, 2019	2019_805638_0015 (A1)	006623-19	Follow up

Licensee/Titulaire de permis

Jarlette Ltd.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

The Villa Care Centre
689 Yonge Street MIDLAND ON L4R 2E1

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

Amended by SYLVIE BYRNES (627) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension to compliance order #001 is granted to allow the home to achieve sustainable compliance. The compliance due date changed to October 7, 2019.

Issued on this 29th day of August, 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

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*

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

Amended by SYLVIE BYRNES (627) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 17 - 21 and 24 - 28, 2019.

The following intake was completed in this follow up inspection:

-One log was related to compliance order #001 from inspection report #2019_771734_0006, where the home was ordered to comply with section 6 subsection 10 of the Long-Term Care Homes Act, 2007, related to the reassessment of residents and the revision of their plan of care, with a compliance due date of April 26, 2019.

A resident quality inspection #2019_805638_0014 was conducted concurrently with this follow up inspection.

PLEASE NOTE: A compliance order related to section 6 subsection 10 of the Long-Term Care Homes Act, 2007, identified in a concurrent inspection #2019_805638_0014 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Staff Educator, Resident and Family Service Coordinator, Restorative Care Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides, residents and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, relevant training and health care records.

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

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

1 WN(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

During inspection #2019_771734_0006, CO #001 was issued to the home, which ordered the licensee to;

"The Licensee must be compliant with s. 6. (10) of the Long-Term Care Home Act (LTCHA).

The licensee shall prepare, submit and implement a plan to ensure that a resident that continues to fall, has their plan of care reviewed and revised every six months, or at any other time when the care set out in the plan is not effective.

The plan must include, but is not limited, to the following:

- Ensure that resident #002 is reassessed and the plan of care reviewed and revised when the care set out in the plan is not effective;
- Review the care plans for all residents who are at high risk of falls to ensure the care plans reflect the falls prevention interventions and are reviewed and revised when the care set out in the plan has not been effective;
-Develop, implement, and maintain records for an auditing process to ensure that when a resident is identified as a high risk for falls, the plan of care is reviewed and revised when the plan of care is not effective."

The compliance due date of this order was April 26, 2019.

While the licensee complied with the sections of CO #001, additional non-compliance was identified during the course of the inspection.

During an observation Inspector #627 noted that resident #011 had a safety device applied while using their mobility aid.

Inspector #638 reviewed resident #011's health care records and was unable to identify any indication that the resident should have a specific safety device applied, at any time.

During an interview with Inspector #638, PSW #112 indicated that resident #011 used a specific safety device while using their mobility aid. The PSW indicated that this was the resident's preference and was not a restraint as the resident was able to remove the device on their own. The PSW stated that the safety device should be identified in the resident's care plan.

In an interview with Inspector #638, RPN #104 indicated that resident #011 liked having their safety device applied while in their wheelchair. The RPN reviewed the resident's plan of care and was unable to identify any orders or indication in the care plan that the resident was to have their safety device applied. The RPN indicated that the resident's plan should have been updated to include the resident's preference to use the safety device while using their mobility aid.

The home's policy titled "Resident Rights, Care and Services - Plan of Care" last revised March 13, 2018, indicated that the plan of care shall be reviewed and revised when the resident's care needs change, the care set out in the plan is no longer necessary; or the care set out in the plan has not been effective.

Inspector #638 interviewed the Administrator who indicated that resident #011 always had a specific safety device for positioning and safety. The Inspector reviewed the resident's care plan interventions with the Administrator who indicated that staff should have included the use of the safety device in the resident's care plan. [s. 6. (10) (b)]

2. During a staff interview with Inspector #627, resident #012 was identified as having a specific continence intervention.

The Inspector reviewed resident #012's health care records and identified a goal in the care plan under the foci related to continence, which stated that the resident

"Will cooperate with [their continence intervention] regime" and a second foci which stated the resident required a specific amount of assistance related to their continence intervention.

Inspector #638 observed resident #012 and was unable to identify the specific continence intervention on the resident.

The Inspector reviewed resident #012's physician orders and identified an order to discontinue the use of the specific continence intervention in 2018.

In an interview with Inspector #638, PSW #112 indicated that, as a PSW, they were responsible for monitoring and managing the specific continence intervention as part of their care routine. The PSW stated that resident #012 did not have a specific continence intervention implemented and was unsure if they ever had one.

During an interview with Inspector #638, RPN #104 stated that resident #012 had a specific level of continence and relied on staff for certain aspects of care. The RPN indicated that the resident previously had a specific continence intervention but no longer had one. The Inspector reviewed resident #012's care plan with RPN #104 who stated that when the specific continence intervention was discontinued, staff should have removed all references of the intervention from the plan.

In an interview with Inspector #638, the Administrator and Staff Educator #117 indicated that the resident's specific continence intervention was removed in 2018. The Staff Educator indicated that they had removed the interventions related to the specific continence intervention when it was discontinued. The Inspector then reviewed the goals and foci with the Staff Educator, who indicated that they may have missed these items when they discontinued the interventions. [s. 6. (10) (b)]

3. During a initial tour, Inspector #684 noted three rooms with isolation signs posted outside of the rooms. Inspector #684 spoke to RPN #123 to clarify which residents were on isolation in the above noted rooms. RPN #123 reviewed relevant resident documentation and responded there were no residents on isolation in those rooms.

Inspector #684 interviewed PSW #100 and asked how they would know when a

resident was on isolation. PSW #100 indicated there was a sign posted above the bed to indicate which resident was on isolation.

Inspector #684 noted a specific isolation precaution sign posted outside of one room. The Inspector entered the room to look for a sign which was to be posted above the bed to indicate which resident was on isolation. The Inspector was unable to identify any sign above either bed at the time of the observation.

Inspector #684 and PSW #102 went to the room and noted a specific isolation sign posted on the door to the residents' room. When asked how they know which resident is on isolation, PSW #102 indicated that there was a sign posted on the resident cork board beside the bed. PSW #102 checked both cork boards and did not note a sign on either board. PSW stated they were not sure if the signage had remained on the door from when they were in outbreak.

Inspector #684 checked the care plans for resident #016 and resident #017, who resided in the room and did not identify any care plan foci for isolation or infection.

Inspector #684 interviewed the DOC, who was the lead for the infection control program. Inspector #684 asked how staff knew who was on isolation. The DOC responded by saying “I do daily surveillance as well as an audit sheet and it lets them know anyone who is antibiotic resistant organisms (ARO). If there is another type of infection, the registered staff document the infection, set up isolation, place signs on the doors, use yellow isolation bags. Signs are put in the room if there was more than one resident in the room. This indicates which resident has an infection but does not say what type of infection it was”. Inspector #684 asked what the process was for removing a resident from isolation. The DOC responded “Documentation to indicate resident is coming off isolation, remove from the care plan and if it is an ARO update the ARO list, if during an outbreak record the resolved date. If resident is no longer on isolation the isolation sign should come down. Inspector #684 asked the DOC if the isolation signs were part of the plan of care, they responded “yes they are part of the plan of care”.

Inspector #684 asked the DOC why the room had a specific isolation sign posted, DOC stated neither resident #016 nor resident #017 were on precautions so that sign should have been removed. [s. 6. (10) (b)]

4. Resident #014 was identified as having an area of worsening skin integrity through their Minimum Data Set (MDS) assessment.

Inspector #638 reviewed resident #014's health care records and identified in the care plan that the resident had three active areas of altered skin integrity.

Upon reviewing the physician orders the Inspector identified that one of resident #014's areas of altered skin integrity was healed and staff were directed to monitor for impaired skin integrity and to initiate a new dressing protocol if necessary.

In an interview with Inspector #638, resident #014 stated that they had some wounds that staff were managing. The resident indicated that they had one that was completely healed and two which they were still treating.

During an interview with Inspector #638, PSW #108 indicated that their role related to skin and wound was to monitor the resident's skin integrity during care and report changes to the registered staff. The PSW stated that resident #014 had three problem areas, but one site had healed and was no longer an issue.

Inspector #638 interviewed RPN #114, who indicated that resident #014's area of altered skin integrity had healed a couple of months ago, but staff were still monitoring the area in case more issues arose. The Inspector reviewed resident #014's care plan with the RPN who stated that staff should have updated the resident's care plan when the area of altered skin integrity healed to identify the current care required.

In an interview with Inspector #638, the Administrator indicated that when resident #014's area of altered skin integrity was resolved, that staff should have updated the care plan to identify that the area had healed. [s. 6. (10) (b)]

Additional Required Actions:

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

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

Issued on this 29th day of August, 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 SYLVIE BYRNES (627) - (A1)
Inspection No. / No de l'inspection :	2019_805638_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006623-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 29, 2019(A1)
Licensee / Titulaire de permis :	Jarlette Ltd. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	The Villa Care Centre 689 Yonge Street, MIDLAND, ON, L4R-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jill Wismer

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 Jarlette Ltd., 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 # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_771734_0006, CO #001;

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 be compliant with s. 6 (10) of the LTCHA, 2007.

Specifically, the licensee must;

a) ensure that residents are reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective or their care needs change;

b) develop and implement a process to ensure that isolation interventions are implemented and discontinued in the plan of care, as required for residents identified as having a transmissible infection; and

c) identify a lead who will be responsible to ensure that the plan of care is reviewed and updated when isolation interventions are being implemented and discontinued.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were reassessed and the plan of

care reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

During inspection #2019_771734_0006, CO #001 was issued to the home, which ordered the licensee to;

"The Licensee must be compliant with s. 6. (10) of the Long-Term Care Home Act (LTCHA).

The licensee shall prepare, submit and implement a plan to ensure that a resident that continues to fall, has their plan of care reviewed and revised every six months, or at any other time when the care set out in the plan is not effective.

The plan must include, but is not limited, to the following:

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- Review the care plans for all residents who are at high risk of falls to ensure the care plans reflect the falls prevention interventions and are reviewed and revised when the care set out in the plan has not been effective;
-Develop, implement, and maintain records for an auditing process to ensure that when a resident is identified as a high risk for falls, the plan of care is reviewed and revised when the plan of care is not effective."

The compliance due date of this order was April 26, 2019.

While the licensee complied with the sections of CO #001, additional non-compliance was identified during the course of the inspection.

During an observation Inspector #627 noted that resident #011 had a safety device applied while using their mobility aid.

Inspector #638 reviewed resident #011's health care records and was unable to identify any indication that the resident should have a specific safety device applied, at any time.

During an interview with Inspector #638, PSW #112 indicated that resident #011

used a specific safety device while using their mobility aid. The PSW indicated that this was the resident's preference and was not a restraint as the resident was able to remove the device on their own. The PSW stated that the safety device should be identified in the resident's care plan.

In an interview with Inspector #638, RPN #104 indicated that resident #011 liked having their safety device applied while in their wheelchair. The RPN reviewed the resident's plan of care and was unable to identify any orders or indication in the care plan that the resident was to have their safety device applied. The RPN indicated that the resident's plan should have been updated to include the resident's preference to use the safety device while using their mobility aid.

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Inspector #638 interviewed the Administrator who indicated that resident #011 always had a specific safety device for positioning and safety. The Inspector reviewed the resident's care plan interventions with the Administrator who indicated that staff should have included the use of the safety device in the resident's care plan. [s. 6. (10) (b)]

2. During a staff interview with Inspector #627, resident #012 was identified as having a specific continence intervention.

The Inspector reviewed resident #012's health care records and identified a goal in the care plan under the foci related to continence, which stated that the resident "Will cooperate with [their continence intervention] regime" and a second foci which stated the resident required a specific amount of assistance related to their continence intervention.

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During an interview with Inspector #638, RPN #104 stated that resident #012 had a specific level of continence and relied on staff for certain aspects of care. The RPN indicated that the resident previously had a specific continence intervention but no longer had one. The Inspector reviewed resident #012's care plan with RPN #104 who stated that when the specific continence intervention was discontinued, staff should have removed all references of the intervention from the plan.

In an interview with Inspector #638, the Administrator and Staff Educator #117 indicated that the resident's specific continence intervention was removed in 2018. The Staff Educator indicated that they had removed the interventions related to the specific continence intervention when it was discontinued. The Inspector then reviewed the goals and foci with the Staff Educator, who indicated that they may have missed these items when they discontinued the interventions. [s. 6. (10) (b)]

3. During a initial tour, Inspector #684 noted three rooms with isolation signs posted outside of the rooms. Inspector #684 spoke to RPN #123 to clarify which residents were on isolation in the above noted rooms. RPN #123 reviewed relevant resident documentation and responded there were no residents on isolation in those rooms.

Inspector #684 interviewed PSW #100 and asked how they would know when a resident was on isolation. PSW #100 indicated there was a sign posted above the bed to indicate which resident was on isolation.

Inspector #684 noted a specific isolation precaution sign posted outside of one room. The Inspector entered the room to look for a sign which was to be posted above the bed to indicate which resident was on isolation. The Inspector was unable to identify any sign above either bed at the time of the observation.

Inspector #684 and PSW #102 went to the room and noted a specific isolation sign posted on the door to the residents' room. When asked how they know which resident is on isolation, PSW #102 indicated that there was a sign posted on the

resident cork board beside the bed. PSW #102 checked both cork boards and did not note a sign on either board. PSW stated they were not sure if the signage had remained on the door from when they were in outbreak.

Inspector #684 checked the care plans for resident #016 and resident #017, who resided in the room and did not identify any care plan foci for isolation or infection.

Inspector #684 interviewed the DOC, who was the lead for the infection control program. Inspector #684 asked how staff knew who was on isolation. The DOC responded by saying "I do daily surveillance as well as an audit sheet and it lets them know anyone who is antibiotic resistant organisms (ARO). If there is another type of infection, the registered staff document the infection, set up isolation, place signs on the doors, use yellow isolation bags. Signs are put in the room if there was more than one resident in the room. This indicates which resident has an infection but does not say what type of infection it was". Inspector #684 asked what the process was for removing a resident from isolation. The DOC responded "Documentation to indicate resident is coming off isolation, remove from the care plan and if it is an ARO update the ARO list, if during an outbreak record the resolved date. If resident is no longer on isolation the isolation sign should come down. Inspector #684 asked the DOC if the isolation signs were part of the plan of care, they responded "yes they are part of the plan of care".

Inspector #684 asked the DOC why the room had a specific isolation sign posted, DOC stated neither resident #016 nor resident #017 were on precautions so that sign should have been removed. [s. 6. (10) (b)]

4. Resident #014 was identified as having an area of worsening skin integrity through their Minimum Data Set (MDS) assessment.

Inspector #638 reviewed resident #014's health care records and identified in the care plan that the resident had three active areas of altered skin integrity.

Upon reviewing the physician orders the Inspector identified that one of resident #014's areas of altered skin integrity was healed and staff were directed to monitor for impaired skin integrity and to initiate a new dressing protocol if necessary.

In an interview with Inspector #638, resident #014 stated that they had some wounds

that staff were managing. The resident indicated that they had one that was completely healed and two which they were still treating.

During an interview with Inspector #638, PSW #108 indicated that their role related to skin and wound was to monitor the resident's skin integrity during care and report changes to the registered staff. The PSW stated that resident #014 had three problem areas, but one site had healed and was no longer an issue.

Inspector #638 interviewed RPN #114, who indicated that resident #014's area of altered skin integrity had healed a couple of months ago, but staff were still monitoring the area in case more issues arose. The Inspector reviewed resident #014's care plan with the RPN who stated that staff should have updated the resident's care plan when the area of altered skin integrity healed to identify the current care required.

In an interview with Inspector #638, the Administrator indicated that when resident #014's area of altered skin integrity was resolved, that staff should have updated the care plan to identify that the area had healed.

The severity of this issue was determined to be a level 2, as there was the potential for harm to the residents. The scope of the issue was a level 2 as it was identified as a pattern. The home had a level 4 compliance history, with ongoing noncompliance with a compliance order including a reissue of the compliance order, in the last 36 months within this section of the LTCHA 2007, that included;
-one voluntary plan of correction issued July 5, 2015 (2015_297558_0009); and
-one compliance order issued March 20, 2019 (2019_771734_0006) with a compliance due date of April 26, 2019. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2019(A1)

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:

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

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

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

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 29th day of August, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by SYLVIE BYRNES (627) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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