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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2020	2020_814501_0004	002238-20, 002360-20	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

SUSAN SEMEREDY (501)

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): February 26, 27, 28, March 2, 3, 4, 5, 6, 9, 10, 11, 2020.

The following intakes related to the prevention of abuse and neglect were inspected:
#002360-20
#002238-20

This inspection was conducted concurrently with inspection #2020_718751_0005.

During the course of the inspection, the inspector(s) spoke with the Director of Regional Operations (DRO), Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Coordinators (RCCs), registered nurses (RNs), registered practical nurses (RPNs), personal care providers (PCPs), registered dietitian (RD), physician, social services worker, food and nutrition manager (FNM), residents, family members and substitute decision-makers.

During the course of inspection, the inspectors(s) conducted observations of staff and resident interactions and the provision of care, reviewed health records, home's investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #002 was added to this inspection to increase the sample size for non-compliance found with resident #001 related to nutrition and hydration. According to lists provided by Food and Nutrition Manager (FNM) #124, resident #002 received a diet with a specified consistency of fluids.

A review of resident #002's progress notes indicated the resident was admitted to the hospital and returned with a diet order for a certain fluid consistency. A speech language pathologist (SLP) assessed the resident after their return and recommended a different fluid consistency.

A review of resident #002's current written plan of care indicated the resident was to receive the fluid as recommended by the SLP. A note was also added to the written plan of care indicating the resident has refused to drink the recommended fluid consistency.

An observation indicated the resident received fluids that were not recommended. Interviews with PCP #127 and RPN #128 indicated resident #002 is offered the recommended fluid consistency and when they refuse it, they give the resident their preference. PCPs then inform the registered staff who document that the resident refused the recommended fluids.

An interview with RD #115 indicated they were aware resident #002 was refusing the recommended fluids. The RD indicated that the expectation then would be to change the fluid consistency on the diet list and in the written plan of care.

During the above interview with the RD, they confirmed the written plan of care did not provide clear direction to staff and others who provided direct care to resident #002 related to fluid consistency. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The MLTC received a complaint from a family member of resident #001 indicating that the family had not been made aware that the resident was becoming seriously ill.

An interview with the family member indicated the substitute decision-makers (SDMs) for resident #001 were aware the resident was declining but were not aware of how serious it had become. Another family member who visited the resident was shocked to see how poorly the resident appeared. This prompted one of the SDMs to request the resident be sent to the hospital.

A review of resident #001's progress notes indicated the resident was sent to the hospital and an e-connect note from the hospital found the resident to be in poor condition. The resident passed away a few days later.

Progress notes indicated Registered Dietitian (RD) #115 assessed resident #001, related to a referral for altered skin integrity. The resident was noted to be on a special diet regarding texture and fluid consistency. The assessment indicated the resident's weight history showed a significant weight loss over the past quarter which may have been related to digestive issues during an identified time period which had prompted the team to put a nutritional supplement on hold. Fluid requirements were estimated and intakes were noted to be low but likely adequate. The RD's plan was to re-implement the nutritional supplement as digestive issues had resolved and to refer to a speech language pathologist (SLP).

Review of fluid intake reports following the above assessment indicated there was a continued decline in fluid intake.

A further review of progress notes indicated referrals were sent to the RD on identified dates for poor fluid intake. For three of these referrals, the RD commented that poor fluids were addressed in their previous assessment. For the last referral, an assessment was not completed as the resident was sent to the hospital.

A review of an SLP assessment indicated a recommendation to change fluid consistency to improve hydration. According to a note written by the RD, resident #001 was unable to participate to trial this change and they would try again. According to documentation in the physician orders (hard copy and electronic copy) and the written plan of care, this recommendation was not implemented until after the resident was sent to the hospital.

For seven days prior to the resident being sent to the hospital progress notes indicated resident #001 was having continued poor food and fluid intake as well as digestive issues on 11 different occasions. There was no indication that during this time the physician was informed of resident #001's decline in intake and the return of their digestive issues.

Interviews with Personal Care Provider (PCP) #104 and #120 indicated that resident #001's intake was always variable but during resident #001's last days there was a big difference and they noticed the resident to have a change in condition. Both PCPs stated they informed registered staff of resident #001's condition and neither were aware that the resident was to receive a change in fluid consistency.

An interview with RPN #116 indicated resident #001's intake was always variable, and this was an ongoing issue. The RPN was aware the resident's fluid intake was poor and communicated to the PCPs to encourage fluid intake. The RPN was aware that resident #001's intake had declined in their last days but could not recall referring to the physician to assess the resident.

An interview with RD #115 indicated they would expect that nursing would be monitoring and noticing the resident's intake becoming poorer and poorer and notify the family and the physician to review the care expectations. The RD did not consider the resident's poor intake to be critical or life threatening. The RD stated they tried to assess the resident for recommendations from the SLP but did not follow up until after the resident went to the hospital. The RD stated that resident #001's medical condition progressed significantly, and the resident was unable to maintain their oral intake at meals. The RD stated it was up to the physician to make recommendations for alternative measures.

In separate interviews with Resident Care Coordinators (RCCs) #106 and 119, both indicated an alternative intervention could have been considered for resident #001 in their last few weeks.

During an interview with Physician #121 they indicated they were resident #001's primary physician since the resident changed units a few months previous to the resident's passing. The physician and inspector reviewed progress notes and there were no progress notes of an assessment having been completed by the physician.

Physician #121 stated that when nursing staff would like the physician to assess a resident, they make a progress note stating the reasons for such a referral. The nursing staff then make a copy of this progress note and leave it for the physician to assess during their next visit. The physician stated they were aware that resident #001 was having digestive issues but was unaware of their continued poor intake and return of their digestive issues. The physician stated they were unaware of resident #001's critical change in condition and rapid decline in the last few days.

The staff failed to collaborate with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the SDM had been provided the opportunity to

participate fully in the development and implementation of the plan of care.

The MLTC received a complaint from a family member of resident #001 indicating that the family had not been made aware that the resident was becoming seriously ill.

An interview with the family member indicated the substitute decision-makers (SDMs) for resident #001 were aware that the resident had nutritional issues but were not aware of how serious it had become. The family member indicated they were never informed how critical the situation was nor were they consulted about any other measures that were available.

The above family member stated that another family member who visited the resident was shocked to see how poorly the resident was responding which prompted one of the SDMs to request the resident be sent to the hospital. The resident was found to be unwell and passed away in the hospital a few days later.

A review of resident #001's medical record indicated an interdisciplinary care conference for resident #001 took place three months previous to their passing with Registered Practical Nurse (RPN) #116, Social Services Worker (SSW) #118 and one of the SDMs. There were no representatives from dietary, activities, physiotherapy or medicine in attendance nor were there any notes from these disciplines.

An interview with Food and Nutrition Manager (FNM) #124 indicated that they are the dietary representative who attends care conferences. According to the FNM, they were away at an off-site meeting that day.

An interview with Physician #121 indicated they did not recall attending the interdisciplinary care conference for resident #001 even though they were the resident's primary physician. According to the physician, care conferences provide an opportunity to discuss with the family palliative status and review the resident's palliative performance scale.

An interview with Registered Dietitian (RD) #115 indicated they had assessed resident #001's nutritional status and left messages for both SDMs and a voice mail for one SDM. The RD was unable to recall what they said in the voice mail and stated they did not follow up as they expected the SDMs to call back if they had any concerns.

An interview with RCC #166 indicated that when a resident is coming to the end of their

life related to a progressive medical condition, the expectation is to inform the family of a change in status and discuss the level of care or advanced directives.

An interview with Physician #121 indicated that when a resident is having indicators of a rapid decline, this should trigger a care conference so that family is aware. In the above case regarding resident #001 it was a critical time and an example of a complete fail.

An interview with Director of Regional Operations (DRO) #125 who was involved in the investigation of a complaint submitted by the family of resident #001, indicated there were missed opportunities to communicate with family. The DRO indicated the care conference that did take place did not meet the home's expectations to provide an opportunity for the SDM to participate in the resident's plan of care. As well, the DRO confirmed that when resident #001's health was declining an additional care conference should have been set up with the SDMs to discuss care directives.

The home failed to ensure that resident #001's SDMs were provided the opportunity to participate fully in the development and implementation of the plan of care related to an annual care conference and the end of life. [s. 6. (5)]

4. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at any time when the resident's care needs change.

The MLTC received a complaint from a family member of resident #001 indicating that the family had not been made aware that the resident was becoming seriously ill. The family member was also concerned about an incident a few years ago when the resident's condition changed and the staff did not recognize this as the resident having had a medical event. According to the family member, they informed the staff of this who stated the physician was aware.

Progress notes on an identified day indicated the resident was having identified signs and symptoms. A progress note a few days later indicated the resident was having more symptoms. Further notes indicated the resident was having additional symptoms. A note also indicated a family member visited.

An occurrence note written by RPN #101 on an identified day indicated resident #001 was found in an identified position and it was thought to be related to the above signs and symptoms The RCC and SDM were notified and a note was left in the physician's binder.

A progress note written by the physician indicated resident #001 was having identified symptoms and recommended sending the resident to the hospital. The resident was sent to the hospital and the SDM informed the home that the resident had had an identified medical event.

An interview with full time day RPN #123 indicated that when a resident presents with the signs and symptoms of a medical event as described above, they usually inform the physician right away. After reviewing the notes with the inspector, the RPN verified it did not appear that the physician had been notified immediately in this case.

An interview with full time evening RPN #101 who had documented many of the signs of symptoms described above indicated the physician must have been notified of resident #001's medical event immediately but in reviewing the notes with the inspector could not find any evidence of this.

An interview with DOC #109 verified that when resident #001 showed signs of a medical event, there was no indication that an assessment was completed by the RN or a call placed to the physician as would have been the expectation.

The home failed to reassess resident #001 after showing signs and symptoms of a medical event indicating the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that the SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care and to ensure that residents are reassessed and the plan of care reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's record was kept up to date at all times.

The MLTC received a complaint from a family member of resident #001 indicating that the family had not been made aware that the resident was becoming seriously ill.

A review of resident #001's progress notes indicated the resident was sent to the hospital and an e-connect note from the hospital found the resident to be unwell. The resident passed away in the hospital a few days later.

The hospital's admission note indicated that resident #001's advanced directives had expressed wishes of investigative care remaining at the home.

A review of resident #001's electronic record indicated the resident's expressed wishes were investigative care remaining at the home. A review of a hard copy form titled "Communication of Prior Expressed Wishes" in the resident's chart indicated this was reviewed three months prior their passing and appears to have the expressed wishes of transfer to the hospital for more investigative testing and if indicated, admission to hospital for treatments not available in the home.

An interview with RCC #119 indicated they were at the above care conference and verified the the resident's expressed wishes were documented on a hard copy that indicated transfer to hospital for more investigative testing. According to RCC #199, the level of care in the electronic record was incorrect and had not been updated since 2017.

An interview with DRO #115 indicated that when a resident is transferred to the hospital their level of care is communicated via a transfer/discharge report generated by the electronic record. The DRO confirmed that resident #001's transfer report that was sent with the resident to the hospital was incorrect because the resident's record was not kept up to date. [s. 231. (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 resident records are kept up to date at all times, to be implemented voluntarily.

Issued on this 9th day of June, 2020

[redacted]

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) :	SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2020_814501_0004
Log No. / No de registre :	002238-20, 002360-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 28, 2020
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Woodhaven Long Term Care Residence 380 Church Street, MARKHAM, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Belisha Ke

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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
(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).

Order / Ordre :

The licensee must be compliant with s.6 (4) of the LTCHA 2007.

Specifically, the licensee must:
1. Develop and implement strategies for all registered staff to follow when a resident's condition changes/declines including, but not limited to, collaborating with the resident's primary physician and substitute decision-makers.
2. Ensure that the above strategies are communicated to all registered staff by developing and providing an in-service that includes a means to confirm the information has been understood. Documentation of the strategies and training must be made available to the inspector when requested.
3. Ensure the registered dietitian collaborates with the team after completing a nutritional assessment for whenever a resident's health condition changes/declines which includes hydration status and any risks related to hydration.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The MLTC received a complaint from a family member of resident #001

indicating that the family had not been made aware that the resident was becoming seriously ill.

An interview with the family member indicated the substitute decision-makers (SDMs) for resident #001 were aware the resident was declining but were not aware of how serious it had become. Another family member who visited the resident was shocked to see how poorly the resident appeared. This prompted one of the SDMs to request the resident be sent to the hospital.

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Review of fluid intake reports following the above assessment indicated there was a continued decline in fluid intake.

A further review of progress notes indicated referrals were sent to the RD on identified dates for poor fluid intake. For three of these referrals, the RD commented that poor fluids were addressed in their previous assessment. For the last referral, an assessment was not completed as the resident was sent to the hospital.

A review of an SLP assessment indicated a recommendation to change fluid consistency to improve hydration. According to a note written by the RD, resident #001 was unable to participate to trial this change and they would try again. According to documentation in the physician orders (hard copy and

electronic copy) and the written plan of care, this recommendation was not implemented until after the resident was sent to the hospital.

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Interviews with Personal Care Provider (PCP) #104 and #120 indicated that resident #001's intake was always variable but during resident #001's last days there was a big difference and they noticed the resident to have a change in condition. Both PCPs stated they informed registered staff of resident #001's condition and neither were aware that the resident was to receive a change in fluid consistency.

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In separate interviews with Resident Care Coordinators (RCCs) #106 and 119, both indicated an alternative intervention could have been considered for resident #001 in their last few weeks.

During an interview with Physician #121 they indicated they were resident

#001's primary physician since the resident changed units a few months previous to the resident's passing. The physician and inspector reviewed progress notes and there were no progress notes of an assessment having been completed by the physician.

Physician #121 stated that when nursing staff would like the physician to assess a resident, they make a progress note stating the reasons for such a referral. The nursing staff then make a copy of this progress note and leave it for the physician to assess during their next visit. The physician stated they were aware that resident #001 was having digestive issues but was unaware of their continued poor intake and return of their digestive issues. The physician stated they were unaware of resident #001's critical change in condition and rapid decline in the last few days.

The staff failed to collaborate with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 history of previous noncompliance with this subsection of the Act that included:
Voluntary plan of correction (VPC) issued June 27, 2017 (2017_632502_0007)
Voluntary plan of correction (VPC) issued October 18, 2019 (2019_810654_0004)

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 28th day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Central East Service Area Office