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
Jul 9, 2021	2021_792659_0014	003760-21, 003761-21, 003882-21, 007470-21, 007787-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village at University Gates
250 Laurelwood Drive Waterloo ON N2J 0E2

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

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 1, 2, 3, 4, 7, 9, 10, 11, 12 and 14, 2021.

The following intakes were included in this inspection:
Log #003882-21\Critical Incident System (CIS) report #3048-000007-21, related to a resident transfer to hospital with injury
Log #007787-21\CIS report #3048-000017-21, related to a resident fall with injury
Log #007470-21\CIS report #3048-000016-21, related to a resident fall with injury
Log #003760-21\Follow up to Compliance order (CO) #001 from inspection #2021_800532_0004, related to plan of care
Log #003761-21\ Follow up to CO #002 from inspection #2021_800532_0004 related to review and revision of plan of care

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Environmental Service Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN)s, Personal Support Workers (PSWs), Housekeepers and residents.

Observations were completed of Infection Prevention and Control (IPAC) practices, air temperatures, medication administration, resident dining and snack service, staff to resident interactions, and general care and cleanliness. A review of clinical records including but not limited to care plans, progress notes, assessments, electronic Medication Administration records (eMARs), electronic Treatment records (eTARs), relevant policies and procedures and audits was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #002	2021_800532_0004	659

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for a resident, related to falls and transfers was followed.

A resident was at high risk for falls, had an unsteady gait and a history of falls with injury.

The resident’s plan of care for falls said staff were to ensure the resident wore their assistive aid. In addition, the resident required extensive assistance from two staff for transfers.

Inspector #659 observed one staff member exit the resident’s room with the resident in a wheelchair. The staff member acknowledged they transferred the resident without assistance from another staff member. The resident was also not wearing their assistive aid.

There was potential risk for injury to the resident, when staff did not follow the resident's plan of care related to falls and transfers.

Sources: CI, observations, resident’s plan of care, fall risk assessments, interview with staff. [s. 6. (7)]

2. The licensee failed to ensure that staff followed the plan of care for a resident related to care of their altered skin integrity.

A resident sustained an injury resulting in an area of altered skin integrity. Their plan of care directed staff to provide treatment to the wound as prescribed.

The electronic Medication Administration Record (eMAR) for the resident said to cover the area with a composite dressing and change it once a day. The resident's electronic Treatment Administration Record (eTAR) said a prescribed ointment was to be applied to the area one time a day on bath days.

Over a two month period, there were 15 days that the resident's dressing had not been changed and nine days when the prescribed ointment had not been applied to the resident's skin concern. On a specified date, the weekly skin assessment documented that the wound healing had stalled.

The ADOC acknowledged there had been days when wound care had not been provided to the resident as per their plan of care.

The potential risk of not following the plan of care related to altered skin integrity for the

resident was slower wound healing and potential infection.

Sources: observation, eMAR, eTAR, progress notes, interview with ADOC. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that three residents who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

A resident sustained a full thickness laceration which required sutures.

The home's skin and wound app on PointClick Care (PCC), showed that two weekly skin and wound assessments were not completed over a two week period for the resident's

area of altered skin integrity.

ADOC #105 said the resident's wound was still open and weekly assessments of the wound should have been ongoing.

Sources: observation, skin and wound app, resident's progress notes, plan of care, eMAR, interviews with ADOC #105 and staff. [s. 50. (2) (b) (iv)]

2. A resident was observed with wound dressings to their upper extremities, that had serous drainage visible through the dressings.

The resident was at risk for skin integrity issues, and had four wounds to their upper and lower extremities.

There was no documented assessment to the resident's lower extremity over a three week period.

There was no weekly assessment for a wound to the resident's upper limb over an 11 day period. Later it was documented the the area of altered skin integrity's healing had stalled.

Staff acknowledged that some weekly wound assessments had not been completed.

Sources: Observation, Skin and Wound app, plan of care, progress notes, eTAR, interview with staff. [s. 50. (2) (b) (iv)]

3. A resident had an injury and sustained an area of altered skin integrity. Within a month of the injury, assessments documented the area was deteriorating.

The resident's clinical record showed that weekly skin and wound assessments were not completed six times over a two month period.

Staff said they assessed the resident's wound every Wednesday, however a staff member reviewed PCC and said they could not locate weekly skin and wound assessments for the timeframes indicated above.

Not completing weekly skin and wound assessments for the three residents, may have limited the home's ability to review and update interventions to promote wound healing.

Sources: Progress notes, Skin and wound app, eTAR, interviews with staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On two consecutive days, Inspector #659 observed a resident seated at the dining room table. They had medications on the table in front of them on one day and a tablet the following day. Registered staff were not present in the dining area at either time.

The home's policy for medication administration said "never leave medication for the resident to administer to him/herself unless there was a physician's order allowing that person to self-medicate or is listed in their care plan", remain with the resident until the medication has been swallowed, unless otherwise indicated in the resident's plan of care.

The resident's plan of care did not include self administration of medications. The resident's clinical records did not show a physician's order for self medication administration.

Staff said they made a mistake, as they thought the resident could self administer medications.

The ADOC said a quarterly assessment of residents' was required for medication self administration, as well as a physician's order.

Leaving a resident unattended with medication could have resulted in a medication error, putting this resident and other residents at risk for harm.

Sources: Observations, resident's chart, assessments, care plan, policy Administration of Medications, tab 05-03, interviews with ADOC #105 and staff. [s. 131. (5)]

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 no resident administers a medication to himself or herself, unless the resident has been assessed and approved for self medication administration and a physician has ordered the resident may self medicate, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to implement a hand-hygiene program in accordance with evidence-based practices. Specifically, the home's hand hygiene program did not include hand hygiene procedures for residents.

As per Public Health Ontario, Just Clean Your Hands Long-Term Care Home Implementation Guide, staff are to encourage and assist residents to perform hand hygiene before and after meals and snacks.

Observations on four of six home areas showed staff had not reminded, encouraged or assisted residents with hand hygiene prior to, or following their snacks or their meal. On one day, a male resident was observed to have their fingers in a bird cage. They were then provided their snack without any encouragement or assistance to clean their hands prior their snack.

Staff acknowledged they had gone from resident to resident at snack time and had not reminded, encouraged or assisted residents with hand hygiene prior to, or following their snack and they had not cleansed their own hands between residents.

By not following best practice for hand hygiene, staff and residents were at increased risk for disease transmission.

Sources: Observations, Just Clean Your Hands Long Term Care Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014, policy Hand hygiene - I-D 002, last revised January 2019, interview with staff and Administrator. [s. 229. (9)]

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 home's hand hygiene program is reviewed and updated to include best practice for resident hand hygiene, and that staff will encourage or assist with residents with hand hygiene in accordance with best practice, to be implemented voluntarily.

Issued on this 26th day of July, 2021

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) :	JANETM EVANS (659)
Inspection No. / No de l'inspection :	2021_792659_0014
Log No. / No de registre :	003760-21, 003761-21, 003882-21, 007470-21, 007787-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 9, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village at University Gates 250 Laurelwood Drive, Waterloo, ON, N2J-0E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Edwards-Dick

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_800532_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6.7 of the LTCHA

Specifically, the licensee shall ensure that:
1. The plan of care for a resident related to falls prevention interventions and transfers will be provided to the resident as specified in their plan of care.
2. The plan of care for a resident related to skin and wound management interventions will be provided to the resident as specified in their plan of care.

Grounds / Motifs :

1. Compliance order (CO) #001 related to s. 6.7 from inspection 2021_800532_004 issued on March 3, 2021, with a compliance due date of May 4, 2021, is being re-issued as follows:

The licensee failed to ensure that the plan of care for a resident related to falls and transfers was followed.

A resident was at high risk for falls, had an unsteady gait and a history of falls with injury.

The resident's plan of care for falls said staff were to ensure the resident wore their assistive aid. In addition, the resident required extensive assistance from two staff for transfers.

Inspector #659 observed one staff member exit the resident's room with the resident in a wheelchair. The staff member acknowledged they transferred the

resident without assistance from another staff member. The resident was also not wearing their assistive aid.

There was potential risk for injury to the resident, when staff did not follow the resident's plan of care related to falls and transfers.

Sources: CI, observations, resident's plan of care, fall risk assessments, interview with staff. [s. 6. (7)]
(659)

2. The licensee failed to ensure that staff followed the plan of care for a resident related to care of their altered skin integrity.

A resident sustained an injury resulting in an area of altered skin integrity. Their plan of care directed staff to provide treatment to the wound as prescribed.

The electronic Medication Administration Record (eMAR) for the resident said to cover the area with a composite dressing and change it once a day. The resident's electronic Treatment Administration Record (eTAR) said a prescribed ointment was to be applied to the area one time a day on bath days.

Over a two month period, there were 15 days that the resident's dressing had not been changed and nine days when the prescribed ointment had not been applied to the resident's skin concern. On a specified date, the weekly skin assessment documented that the wound healing had stalled.

The ADOC acknowledged there had been days when wound care had not been provided to the resident as per their plan of care.

The potential risk of not following the plan of care related to altered skin integrity for the resident was slower wound healing and potential infection.

Sources: observation, eMAR, eTAR, progress notes, interview with ADOC. [s. 6. (7)]

This order was made taking the following into consideration
Severity: There was potential risk of harm to two residents when their plans of

care related to falls prevention and skin and wound management, respectively were not followed.
Scope: The scope was isolated. One of three residents was impacted related to their skin and wound plan of care and one of three residents was impacted related to their fall prevention and transfer plan of care.
Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 6.7 of the LTCHA. This subsection was issued as a CO on March 3, 2021, during inspection #2021_800532_0004, with a compliance due date of May 4, 2021. In the past 36 months, two other COs were issued related to different sections of the legislation, both of which have been complied. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The Licensee must be compliant with s. 50. (2) (b) (iv) of O. Reg 79/10.

Specifically: the licensee will ensure that:
1. When three identified residents exhibit altered skin integrity, including but not limited to skin breakdown, pressure ulcers, skin tears or wounds, they will have a skin assessment completed at least weekly by a member of the registered nursing staff, if clinically indicated.
2. Ensure that a monthly auditing process is developed and fully implemented to to ensure residents with altered skin integrity are receiving the correct treatment and are also reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
This auditing process must include at a minimum, the auditing schedule,the name of the manager or designate conducting the audit, the resident's name, a list of the resident's current areas of altered skin integrity, the date of their last skin assessment, the current status of the skin concern, if further reassessments are clinically indicated and any action taken, including disciplinary.
The audits shall continue for a period of four months or until the home believes they have come into compliance with the legislation. The written audit must be kept available in the home.

Grounds / Motifs :

1. The licensee failed to ensure that three residents who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

A resident sustained a full thickness laceration which required sutures.

The home's skin and wound app on PointClick Care (PCC), showed that two weekly skin and wound assessments were not completed for the resident's area of altered skin integrity.

ADOC #105 said the resident's wound was still open and weekly assessments of the wound should have been ongoing.

Sources: observation, skin and wound app, resident's progress notes, plan of care, eMAR, interviews with ADOC #105 and staff. [s. 50. (2) (b) (iv)] (659)

2. A resident was observed with wound dressings to their upper extremities, that had serous drainage visible through the dressings.

The resident was at risk for skin integrity issues, and had four wounds to their upper and lower extremities.

There was no documented assessment to the resident's lower extremity over a three week period.

There was no weekly assessment for a wound to the resident's upper limb over an 11 day period. Later it was documented the the area of altered skin integrity's healing had stalled.

Staff acknowledged that some weekly wound assessments had not been completed.

Sources: Observation, Skin and Wound app, plan of care, progress notes, eTAR, interview with staff. [s. 50. (2) (b) (iv)] (659)

3. A resident had an injury and sustained an area of altered skin integrity. Within a month of the injury, assessments documented the area was deteriorating.

The resident's clinical record showed that weekly skin and wound assessments were not completed six times over a two month period.

Staff said they assessed the resident's wound every Wednesday, however a staff member reviewed PCC and said they could not locate weekly skin and wound assessments for the timeframes indicated above.

Not completing weekly skin and wound assessments for the three residents, may have limited the home's ability to review and update interventions to promote wound healing.

Sources: Progress notes, Skin and wound app, eTAR, interviews with staff. [s. 50. (2) (b) (iv)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

An order was made taking the following into consideration:
Severity: There was minimal risk of harm to the residents when their skin concerns were not assessed weekly by a member of the registered nursing staff.

Scope: The scope of this non-compliance was widespread because three out of three residents reviewed had not received weekly assessments of their altered skin integrity by a member of the registered nursing staff.
Compliance history: Four Written notifications (WN), five Voluntary Plans of Correction (VPC), and three Compliance orders (CO) were issued to home related to different sections of the legislation in the past 36 months. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 06, 2021

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

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 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 9th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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