Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 7, 2019	2019_593573_0020	001034-19, 011887-19, 013635-19, 014081-19	Complaint

Licensee/Titulaire de permis

Villa Marconi Long Term Care Center
1026 Baseline Road OTTAWA ON K2C 0A6

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

Villa Marconi
1026 Baseline Road OTTAWA ON K2C 0A6

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

ANANDRAJ NATARAJAN (573), EMILY BROOKS (732)

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): July 11, 12, 15 -19 and 22 -26, 2019

This inspection was conducted in reference to complaint Logs #001034-19, 011887-19, 013635- 19 and 014081-19 related to resident care/ services and concerns in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Services (DRS), the Director of Care (DOC), the Assistant Director of Care (ADOC), Physician, Psychiatrist - Geriatric Outreach Team, Registered Occupational Therapist (OT), Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapy Assistant, The Behavioural Supports Ontario (BSO) Champion, Personal Support Workers (PSW), Housekeeping Staff, residents and family members.

During the course of the inspection, the inspector reviewed resident's health care record and home's internal investigation documentation, as applicable. Reviewed licensee's relevant policies/ procedures, staff training materials and attendance records. In addition, the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interaction.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

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

- **2 WN(s)**
- **1 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of resident #004 was included in the resident's plan of care.

A complaint was submitted to the Director of the Ministry of Long-Term Care, related to resident #004's care and services.

On a specified date, a Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care related to an incident that caused an injury to resident #004 for which the resident was taken to hospital and resulted in significant change in the resident's health status. Further, the CIR indicated that resident #004 was found by a staff member, that the resident had slid out from their mobility device with a identified external device around the resident's specific body part.

Inspector #573 was informed that resident #004 was deceased on a specified date.

During an interview with Inspector #573, housekeeping staff #114 stated that on a specified date, upon entering to an identified unit, they heard a alarm that was ringing. When the housekeeping staff went to check the alarm in a resident's room, they found that resident #004 had slid out from their mobility device and unresponsive. Furthermore, the housekeeping staff stated that they immediately called for staff assistance in the unit and PSW #113 responded immediately.

During an interview with Inspector #573, PSW #113 stated that on a specified date, during their shift, housekeeping staff #114 called for immediate staff assistance for resident #004. PSW #113 indicated that they found resident #004 with their lower body on the floor and their upper body against the mobility device. PSW #113 stated that they found resident #004 unresponsive and the identified external device was around the

resident's specific body part. PSW #113 stated to the inspector that they released the external device and immediately responded as per the resident's medical directive.

Inspector #573 spoke with RPN #111, who indicated that on a specified date and time, PSW staff on the unit paged the RPN. RPN #111 indicated that they called the 911, paramedics arrived and latter the resident was transferred to the hospital for further management.

On July 12, 2019, Inspector #573 interviewed PSW #112 who was working on a specified date, on the unit and provided care to resident #004. PSW #112 stated that after lunch hours, resident #004 was transferred to a loaner mobility device and applied the identified external device in the mobility device. PSW #112 stated to the inspector that they always applied the identified external device when the resident was in the mobility device. PSW #112 indicated that the identified external device was applied to the resident as a safety measure to prevent resident #004 from falls.

During this inspection, Inspector #573 conducted a separate interview with PSW #113, PSW #115 and PSW #117 regarding resident #004 and the use of the identified external device in the mobility device. The PSWs indicated to the inspector that they always applied the external device when resident #004 was in the mobility device for their safety. Further, the PSWs stated that resident #004 could not release the identified external device on their own.

Inspector #573 interviewed RPN #111, RPN #121 and RN #122 regarding resident #004 and the use of the identified external device in the mobility device. The registered nursing staff stated that PSW staff members were not to apply the identified external device to resident #004. The registered nursing staff indicated that resident #004 was not able to release the identified external device on their own. Furthermore, they indicated that the use of the identified external device for resident #004 would be considered a restraint.

Inspector #573 observed resident #004's loaner mobility device and their identified external device in the presence of the Occupational Therapist (OT). The OT indicated to the inspector that the identified external device can be easily altered/ compromised and was not recommended for positioning nor restraining purposes.

Inspector #573 reviewed resident #004's recent MDS assessment dated on a specified date, which identified that no physical devices/ restraints used for the resident.

Inspector #573 reviewed the written plan of care in place for resident #004. Under resident's locomotion, the written plan of care indicated that resident #004 required a identified mobility device to mobilize with one-person physical assistance. Furthermore, there was no information that indicated the resident required the use of the identified external device as a restraint. A review of resident #004's health care records indicated that there was no physician order, no consent from the resident nor from the resident's substitute decision maker for the use of the identified external device as a restraint. The restraining of resident #004 by the identified external device was not included in the resident's plan of care.

On July 22, 2019, the Director of Care (DOC) stated to Inspector #573 that resident #004's plan of care did not have the identified external device restraint and PSW staff members were not to apply the identified external device restraint to resident #004.

As such, the restraining of resident #004 by the identified external device was not included in the resident's plan of care. (Log #014081-19) [s. 31. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care for resident #004 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with each other.

On a specified date, a Critical Incident Report (CIR) was submitted to the Director, regarding an incident that caused an injury to resident #004 for which the resident was sent to the hospital and resulted in a significant change in health status.

Inspector #573 reviewed resident #004's recent MDS assessment, which identified that the resident required total dependence with one-person physical assist for locomotion on the unit. Furthermore, the assessment identified a specified mobility device as the primary mode of locomotion.

On July 11, 2019, Inspector #573 reviewed the written plan of care in place for resident #004. For locomotion, the written plan of care indicated that resident #004 required a specified mobility device to mobilize with one-person physical assistance.

On July 12, 2019, Inspector #573 interviewed PSW #112 who was working on a specified date, during the day time and provided care to resident #004. PSW #112 stated that on the specified day, as per the resident's family request, resident #004 was transferred

from mobility device (A) to mobility device (B). PSW #112 stated that PSW #126 provided with the mobility device (B) to resident #004. Furthermore, PSW #112 stated that they did not inform the RPN on the unit before nor after transferring the resident in the mobility device (B).

During an interview with PSW #126, they indicated that on a specified date, during morning hours, the in-charge RN #125 requested a loaner mobility device for resident #004. The PSW indicated that both the staff members found mobility device (B) for resident #004 from the storage room, brought to the floor and kept in the unit. Furthermore, PSW #126 stated that RN #125 called resident #004's SDM and left voice message regarding the trial of the mobility device (B) for the resident. PSW #126 indicated that around noon hours, the DOC approached the PSW and informed them they wanted to trial the mobility device (B) for resident #004. PSW #126 stated that after the lunch hour, resident #004 was transferred from the mobility device (A) to mobility device (B). PSW #126 stated that they informed the DOC that resident #004 was transferred to the mobility device (B).

In an interview with RN #125, they stated that on a specified date, the resident #004's SDM informed that they were waiting to hear from the Occupational Therapist regarding resident #004's mobility/ seating assessment and their needs. Further, resident #004's SDM reported to RN #125 that the resident's mobility device (A) was not good for resident's feeding and requested a loaner mobility device for the resident. RN #125 stated to the inspector that they informed the DOC regarding resident #004's SDM request for a loaner mobility device. RN #125 indicated that the DOC requested them to get a loaner mobility device for resident #004. The RN indicated that they found loaner mobility device (B) for resident #004 from the storage room, brought to the floor and kept in the unit. Furthermore, RN #125 stated that they called resident #004's SDM and left voice message regarding the needs and preferences for the loaner mobility device for resident #004.

Inspector #573 spoke with RPN #111, who stated that they were the unit in- charge nurse on the specified date. Furthermore, the RPN stated that they were not informed by the staff, either before nor after transferring resident #004 in the loaner mobility device (B).

Inspector #573 spoke with Occupational Therapist (OT), who indicated that they completed resident #004's seating and mobility assessment on a specified date. The OT stated that based on their assessment, resident #004 required a specified type of mobility

device for their mobility needs. The OT indicated that the loaner mobility device (B) is not the appropriate mobility device for the resident needs. Furthermore, the OT stated that they were not consulted nor informed by the staff regarding the use of the mobility device (B) as a trail for resident #004.

On June 17, 2019, Inspector #573 spoke with the Director of Care (DOC) who stated that on a specified date, RN #125 informed them regarding resident #004's SDM request for a loaner mobility device. The DOC indicated to the inspector that they directed their staff to find a loaner mobility device and to trail for resident #004. The DOC stated that no registered staff member assessed nor approved the loaner mobility device (B) for resident #004. Furthermore, the DOC stated that the OT was not consulted nor informed by the staff regarding the use of mobility device (B) as a trail for resident #004.

As such, the staff and others involved in the different aspects of care did not collaborate with each other in the implementation of resident #004's plan of care related mobility needs, so that they were integrated and consistent with each other.(Log #014081-19) [s. 6. (4) (b)]

2. The licensee has failed to ensure that resident #001's nutrition and hydration intake was documented as set out in the plan of care.

Resident #001 had identified risks related to nutrition and hydration, as well as a significant weight loss identified on a specified date. Resident #001's plan of care directed staff to monitor resident #001's intake.

The Director of Resident Services (DRS) told Inspector #732 that any residents, intake is monitored and documented by PSW staff using the dietary flow sheet on Point of Care. The DRS informed the inspector that the expectation is that all resident food and fluid intake is documented each shift. The Dietitian told Inspector #732 that they use the Dietary Flow sheet to evaluate a resident's nutrition and hydration needs.

Inspector #732 reviewed resident #001's dietary flow sheet for a specified month in 2019, the month prior to resident #001's identified significant weight loss. Upon review, it was noted that no food or fluid intake had been documented for three days out of the month for breakfast, six days out of the month for lunch, and seven days out of the month for dinner.

Inspector #732 then reviewed resident #001's dietary flow sheet for a identified month in

2019. Inspector noted that, no food or fluid intake had been documented in resident #001's dietary flow sheet seven out of the seventeen days for breakfast, eight out of the seventeen days for lunch, and four out of the seventeen days for dinner.

In an interview with Inspector #732, the Dietitian acknowledged the lack of food and fluid intake documentation for the identified month of 2019. The Dietitian explained that it is hard to obtain true calculations if the food and fluid intake of a resident is not documented. In an interview with the DRS , they told Inspector #732 that they were made aware of the lack of documentation for resident #001's food and fluid intake by the Dietitian, and acknowledged that the resident's intake was not being monitored as per the plan of care.(Log #011887-19) [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with each other, to be implemented voluntarily.

Issued on this 8th day of August, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANANDRAJ NATARAJAN (573), EMILY BROOKS (732)
Inspection No. / No de l'inspection :	2019_593573_0020
Log No. / No de registre :	001034-19, 011887-19, 013635-19, 014081-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 7, 2019
Licensee / Titulaire de permis :	Villa Marconi Long Term Care Center 1026 Baseline Road, OTTAWA, ON, K2C-0A6
LTC Home / Foyer de SLD :	Villa Marconi 1026 Baseline Road, OTTAWA, ON, K2C-0A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gaetan Grondin

To Villa Marconi Long Term Care Center, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 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. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

The licensee must be compliant with s. 31 (1) of the LTCHA.

Specifically, the licensee shall:

1. Ensure that if residents are restrained by a physical device as described in paragraph three of subsection 30 (1), the restraining device of the resident is included in their plan of care.

2. Ensure that, for all residents restrained by a physical device, the restraining is included in the resident's plan of care only if all the following are satisfied:

A. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

B. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in item 2 A.

C. The method of restraining is reasonable, considering the resident's physical and mental condition and personal history and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in item 2 A.

D. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

E. The restraining of the resident has been consented to by the resident or, if the

resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

F. The plan of care provides interventions to ensure that:

(i) The resident is monitored while restrained, in accordance with the requirements provided for in the regulations;

(ii) The resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;

(iii) The resident's condition is reassessed, and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;

3. Ensure that all staff that provide direct care to residents are educated/ re-educated on the process of restraining residents and on their roles and responsibilities regarding the application of physical devices including but not limited to a specified external device.

4. Ensure that a documented record of the educational program is kept, that includes the date, subject heading, educational content and the staff name who have been educated.

5. Implement a system to monitor and evaluate that all physical devices used to restrain a resident are applied according to manufacturer's instructions. Take immediate corrective action if any discrepancies are discovered.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the restraining of resident #004 was included in the resident's plan of care.

A complaint was submitted to the Director of the Ministry of Long-Term Care, related to resident #004's care and services.

On a specified date, a Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care related to an incident that caused an injury to

resident #004 for which the resident was taken to hospital and resulted in significant change in the resident's health status. Further, the CIR indicated that resident #004 was found by a staff member, that the resident had slid out from their mobility device with a identified external device around the resident's specific body part.

Inspector #573 was informed that resident #004 was deceased on a specified date.

During an interview with Inspector #573, housekeeping staff #114 stated that on a specified date, upon entering to an identified unit, they heard a alarm that was ringing. When the housekeeping staff went to check the alarm in a resident's room, they found that resident #004 had slid out from their mobility device and unresponsive. Furthermore, the housekeeping staff stated that they immediately called for staff assistance in the unit and PSW #113 responded immediately.

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Inspector #573 spoke with RPN #111, who indicated that on a specified date and time, PSW staff on the unit paged the RPN. RPN #111 indicated that they called the 911, paramedics arrived and latter the resident was transferred to the hospital for further management.

On July 12, 2019, Inspector #573 interviewed PSW #112 who was working on a specified date, on the unit and provided care to resident #004. PSW #112 stated that after lunch hours, resident #004 was transferred to a loaner mobility device and applied the identified external device in the mobility device. PSW #112 stated to the inspector that they always applied the identified external device when the resident was in the mobility device. PSW #112 indicated that the identified external device was applied to the resident as a safety measure to

prevent resident #004 from falls.

During this inspection, Inspector #573 conducted a separate interview with PSW #113, PSW #115 and PSW #117 regarding resident #004 and the use of the identified external device in the mobility device. The PSWs indicated to the inspector that they always applied the external device when resident #004 was in the mobility device for their safety. Further, the PSWs stated that resident #004 could not release the identified external device on their own.

Inspector #573 interviewed RPN #111, RPN #121 and RN #122 regarding resident #004 and the use of the identified external device in the mobility device. The registered nursing staff stated that PSW staff members were not to apply the identified external device to resident #004. The registered nursing staff indicated that resident #004 was not able to release the identified external device on their own. Furthermore, they indicated that the use of the identified external device for resident #004 would be considered a restraint.

Inspector #573 observed resident #004's loaner mobility device and their identified external device in the presence of the Occupational Therapist (OT). The OT indicated to the inspector that the identified external device can be easily altered/ compromised and was not recommended for positioning nor restraining purposes.

Inspector #573 reviewed resident #004's recent MDS assessment dated on a specified date, which identified that no physical devices/ restraints used for the resident.

Inspector #573 reviewed the written plan of care in place for resident #004. Under resident's locomotion, the written plan of care indicated that resident #004 required a identified mobility device to mobilize with one-person physical assistance. Furthermore, there was no information that indicated the resident required the use of the identified external device as a restraint. A review of resident #004's health care records indicated that there was no physician order, no consent from the resident nor from the resident's substitute decision maker for the use of the identified external device as a restraint. The restraining of resident #004 by the identified external device was not included in the resident's plan of care.

On July 22, 2019, the Director of Care (DOC) stated to Inspector #573 that resident #004's plan of care did not have the identified external device restraint and PSW staff members were not to apply the identified external device restraint to resident #004.

As such, the restraining of resident #004 by the identified external device was not included in the resident's plan of care. (Log #014081-19)

The decision to issue a compliance Order is based on the following factors: The severity of this issue was determined to be as there was actual risk of harm to the resident. The scope of the issue was identified as an isolated incident affecting one resident. The compliance history is with previous non-compliance to a different subsection.

(573)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 7th day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Anandraj Natarajan

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