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 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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 28, 2018	2018_420643_0016	022169-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Credit Valley Hospital and Trillium Health Centre
150 Sherway Drive ETOBICOKE ON M9C 1A5

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

McCall Centre Long Term Care Interim Unit
140 Sherway Drive ETOBICOKE ON M9C 1A4

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

ADAM DICKEY (643), CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 21-24, and 27, 2018.

Inspector #727 Joanna White attended this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), personal support workers (PSW), Residents' Council Representative, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

This item is included for inspection due to a stage one trigger of skin and wound inspection completed for residents #003, #007 and #008.

Resident #003 was identified as having a new area of altered skin integrity on an identified date. No documentation was found to identify that the area of altered skin integrity had resolved.

Review of resident #003’s clinical record did not include any documentation of assessments, reassessments, interventions or response to interventions related to the identified area of altered skin integrity for 12 identified weeks over a five month period.

Resident #007 was identified as having a new area of altered skin integrity on an identified date. Resident #007's area of altered skin integrity was ongoing at the time of inspection.

Review of resident #007’s clinical records did not include any documentation of assessments, reassessments, interventions or response to interventions related to the identified area of altered skin integrity for four identified weeks over a two month period.

Resident #008 was identified as having a new area of altered skin integrity on an identified date. A progress note from three months after the identification of the area of altered skin integrity, documented that the area had healed.

Review of resident #008’s clinical records did not include any documentation of assessments, reassessment, interventions or response to interventions for four identified weeks over the three month period.

Interview with RPN #104, who is also the home’s wound care champion, identified that weekly skin/wound assessments were conducted for residents #003, #007 and #008 as required during the identified periods that the residents were exhibiting altered skin integrity, and that they documented their findings on a word document or in their note pad. RPN #104 identified that due to time constraints they do not always document on the assessments in the resident records. RPN #104 was not able to produce their word documents of completed assessments for review, however they did confirm that all of the above mentioned residents had received weekly re-assessment of their identified areas

of altered skin integrity.

The DOC acknowledged that weekly skin or wound assessments are to be documented in the resident's medical records, and acknowledged that the weekly assessments had not been documented as required for the above mentioned residents. [s. 30. (2)]

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

This inspection item was identified during skin and wound inspections for resident #003.

Record review identified that resident #003 was admitted to the home with an existing area of altered skin integrity.

Record review identified that weekly wound assessments were not included in resident #003's plan of care, specifically the Electronic Treatment Administration Record (e-TAR), until 25 days following admission.

Interview with RPN #104, who was also the home's wound care champion, indicated that they maintain an ongoing list of the residents requiring weekly skin and wound assessments, and that resident #003 was receiving the assessments as required, although they were not included on resident #003's e-TAR.

Interview with the DOC indicated that any registered staff who identifies a resident with altered skin integrity that requires scheduled assessments should input that into the e-TAR so that it is included in the resident's plan of care, and that the scheduled, weekly wound assessments would be reflected or included on the e-TAR. [s. 6. (1) (c)]

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

Resident #009 was triggered for nutrition interventions absent and underweight from staff interview in stage one. As a result, Nutrition and Hydration was inspected during stage two of the RQI.

Review of resident #009's health records showed they had been admitted to the home with identified medical diagnoses. Review of resident #009's physician orders indicated that the resident was scheduled to receive an identified intervention twice daily with medication administration to increase hydration. Review of resident #009's daily food and fluid intake record for an identified month showed they had an identified daily fluid target. The daily food and fluid intake record showed resident #009 did not meet the fluid target for periods of three consecutive days, 12 consecutive days and five consecutive days during the identified month. Review of resident #009's health records failed to reveal any assessment related to their hydration during the above mentioned identified month.

In an interview, RPN #103 stated that it was difficult to get resident #009 to accept the intervention to increase hydration during medication administration. RPN #103 indicated that this intervention not being provided had not been discussed with the RD. RPN #103 additionally indicated that resident #009’s fluid status had not been assessed in the month of August related to not meeting their individual fluid target.

In an interview, RD #110 indicated that they assessed a resident's hydration status by reviewing food and fluid intake records as well as looking at any additional fluids provided to the resident as ordered. The RD indicated that for resident #009 the documentation in the electronic medication administration record (EMAR) indicated that they were receiving the above mentioned intervention to increase hydration as ordered and did not discuss with the registered staff as it appeared the intervention was administered. RD #110 indicated they would collaborate with the registered staff if they had communicated that the intervention was not working for resident #009. RD #110 acknowledged that the registered staff had not collaborated with the RD 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 the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #009 was triggered for nutrition interventions absent and underweight from staff interview in stage one. As a result, Nutrition and Hydration was inspected during stage two of the RQI.

Review of resident #009’s health records showed they had been admitted to the home with identified medical diagnoses. Review of resident #009’s physician orders indicated that the resident was scheduled to receive an identified intervention twice daily with medication administration to increase hydration. Review of resident #009’s daily food and fluid intake record for an identified month of showed they had an identified daily fluid target.

In an interview, RN #101 indicated that resident #009 did not drink fluids without encouragement and were at risk for an identified health condition as a result. RN #101 indicated that generally residents would be provided with a specified volume of water during medication administration and this amount was not documented on the food and fluid intake records.

In an interview, RPN #103 stated that resident #009 was administered their medication with an identified meal, and would provide medications by mouth while PSW staff assisted with feeding. RPN #103 indicated that they did not provide additional fluids with medication administration and would not administer the above mentioned intervention to increase hydration as ordered.

In an interview, RD #110 indicated that resident #009 was at risk related to hydration as their intake was unstable and had an identified intervention in place with medication administration to minimize this risk. RD #110 indicated that as RPN #103 had not been providing the intervention to increase hydration at an identified medication administration time, the care that was set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or

otherwise put in place was complied with.

As required by the Regulations (O. Reg. 79/10, s. 68 (2)) every licensee shall ensure that the organized program for nutrition and hydration includes the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures related to nutrition care and dietary services and hydration.

Resident #009 was triggered for nutrition interventions absent and underweight from staff interview in stage one. As a result, Nutrition and Hydration was inspected during stage two of the RQI.

Review of the home's policy titled "Food and Fluid Intake Monitoring" policy number RC-18-01-01 last updated February 2017, showed that registered staff were to review fluid intake records daily and compare to individualized fluid targets. The policy instructed registered staff that if a resident consumed less than their individualized fluid target for three consecutive days, the nurse must take into account additional fluids and if still not meeting fluid target for three consecutive days initiate a Nursing Hydration Assessment.

Review of resident #009's health records showed they had been admitted to the home with identified medical diagnoses. Review of resident #009's daily food and fluid intake record for an identified month showed they had an identified daily fluid target. The daily food and fluid intake record showed resident #009 did not meet the fluid target for periods of three consecutive days, 12 consecutive days and five consecutive days during the identified month. Review of resident #009's health records failed to reveal any assessment related to their hydration during the above mentioned identified month.

In an interview, RPN #103 indicated that the night shift registered staff would complete the totals for fluids on the daily food and fluid intake records and flag any residents who were not meeting their individual fluid targets as established by the RD. RPN #103 indicated that there was not an assessment of resident #009's hydration related to below target fluid consumption completed in the above mentioned identified month as per the home's policy.

In an interview, RD #110 indicated that it was the policy of the home that when a resident had fluid intake below their target for three consecutive days the nurses should complete a hydration assessment in the electronic documentation system, and if the resident showed signs of dehydration they would refer to the RD. RD #110 acknowledged that the

food and fluid intake record for resident #009 indicated they did not meet their identified fluid target for periods of three consecutive days, 12 consecutive days and five consecutive days during the identified month. RD #110 indicated that they had not received a referral regarding resident #009's hydration status, and a hydration assessment had not been conducted during the identified month. RD #110 acknowledged the home's policy was not complied with regarding resident #009's hydration assessment. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policies and procedures related to nutrition care and dietary services and hydration as required by the Regulations (O. Reg. 79/10, s. 68 (2)) are complied with, to be implemented voluntarily.

WN #4: 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 has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home.

This inspection was initiated due to stage one trigger for skin and wound for resident #007.

Record review revealed that resident #007 was identified to have a new area of altered skin integrity on an identified date. Review of resident #007's clinical records did not include any referral to the RD related to the identified area of altered skin integrity.

In an interview, RPN #104 indicated that a referral to the RD would not be required for an identified type of altered skin integrity, and that resident #007's identified area of altered skin integrity did not meet the requirement for a RD referral.

Interview with RD #110 identified that they should receive referrals for residents exhibiting altered skin integrity, including the type of altered skin integrity exhibited by resident #007 . RD #110 indicated they did not receive a referral regarding resident #007's identified area of altered skin integrity, and had not completed a nutrition assessment related to the area of impaired skin integrity. [s. 50. (2) (b) (iii)]

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 residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is, (a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)

(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the last two years for the long term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

During the initial tour of the home Inspector #618 observed one inspection report, #2017_654605_0017, was posted on a bulletin board located beside the unit elevators. The inspector did not identify a copy of public report 2016_382596_0017, with a report date of December 15, 2016, to be posted in the home.

An interview with the DOC and observation of the bulletin board on August 24, 2018, confirmed that the above identified report was the only one posted, and that inspection report #2016_382596_0017, was not posted as required. [s. 79. (3)]

Issued on this 28th day of September, 2018

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

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

Ministére de la Santé et des Soins de longue durée

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) :	ADAM DICKEY (643), CECILIA FULTON (618)
Inspection No. / No de l'inspection :	2018_420643_0016
Log No. / No de registre :	022169-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 28, 2018
Licensee / Titulaire de permis :	The Credit Valley Hospital and Trillium Health Centre 150 Sherway Drive, ETOBICOKE, ON, M9C-1A5
LTC Home / Foyer de SLD :	McCall Centre Long Term Care Interim Unit 140 Sherway Drive, ETOBICOKE, ON, M9C-1A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bahar Karimi

To The Credit Valley Hospital and Trillium Health Centre, 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 :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The licensee must be compliant with s. 30. (2) of O. Reg. 79/10.

Specifically, the licensee must:
For residents #003, #007, #008 and all other residents who are exhibiting altered skin integrity:

1. Ensure that all assessments, reassessments, interventions and the resident's responses to interventions are documented in the medical record for residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

2. Implement an auditing process to ensure the above documentation is completed by a member of the staff of the home in each resident's medical record.

3. Maintain a written record of audits conducted of documentation related to residents exhibiting altered skin integrity. The written record must include the date of the audit, the resident's name, location of area of altered skin integrity, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The Licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

This item is included for inspection due to a stage one trigger of skin and wound

inspection completed for residents #003, #007 and #008.

Resident #003 was identified as having a new area of altered skin integrity on an identified date. No documentation was found to identify that the area of altered skin integrity had resolved.

Review of resident #003's clinical record did not include any documentation of assessments, reassessments, interventions or response to interventions related to the identified area of altered skin integrity for 12 identified weeks over a five month period.

Resident #007 was identified as having a new area of altered skin integrity on an identified date. Resident #007's area of altered skin integrity was ongoing at the time of inspection.

Review of resident #007's clinical records did not include any documentation of assessments, reassessments, interventions or response to interventions related to the identified area of altered skin integrity for four identified weeks over a two month period.

Resident #008 was identified as having a new area of altered skin integrity on an identified date. A progress note from three months after the identification of the area of altered skin integrity, documented that the area had healed.

Review of resident #008's clinical records did not include any documentation of assessments, reassessment, interventions or response to interventions for four identified weeks over the three month period.

Interview with RPN #104, who is also the home's wound care champion, identified that weekly skin/wound assessments were conducted for residents #003, #007 and #008 as required during the identified periods that the residents were exhibiting altered skin integrity, and that they documented their findings on a word document or in their note pad. RPN #104 identified that due to time constraints they do not always document on the assessments in the resident records. RPN #104 was not able to produce their word documents of completed assessments for review, however they did confirm that all of the above mentioned residents had received weekly re-assessment of their identified areas of altered skin integrity.

The DOC acknowledged that weekly skin or wound assessments are to be documented in the resident's medical records, and acknowledged that the weekly assessments had not been documented as required for the above mentioned residents.

The severity of this issue was determined to be a level one as there was minimal risk to the residents. The scope of the issue was a level three as it related to three of three residents reviewed. The home had a level 2 compliance history as they had prior unrelated noncompliance. (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 28th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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