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
Mar 26, 2018	2018_694166_0005	001759-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

CAROLINE TOMPKINS (166), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), DENISE BROWN (626), SAMI JAROUR (570), SARAH GILLIS (623)

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): February 5,6,7,8, 9,12,13,14,15,16, 20,22,23, 2018

Critical Incidents-(CIR)
log #021210-17, related to reporting a disease outbreak,
log# 000036-18, related to a mechanical breakdown,
log #021670-17, related to allegations of resident to resident abuse,
log# 027982-17, related to allegations of resident to resident abuse,

log #022326-17, related to allegations of staff to resident abuse
log #025587-17, related to allegations of staff to resident abuse
log #028502-17, related to allegations of staff to resident abuse
log #032172-17, related to allegations of staff to resident abuse,
log #003241-18, related to allegations of staff to resident abuse,
log #027012-17, related to falls
log #02809-17, related to falls
log #002371-18, related to falls
log #002546-18, related to falls,
Complaint log #027205-17, related to resident care
Complaint log #001472-17, related to resident care
Follow up to order #001, log #026760-17,
Follow up to order #002, log #026761-17,
Follow up to order #003, log #026762-17,
Follow up to order #004, log #026763-17,
Follow up to order #005, log #026764-17,
The above listed were inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, representatives from the Residents' and Family Council, the Social Worker(SW), Occupational Therapist(OT), Physiotherapist Assistant(PTA), Program Manager, Environmental Manager, Resident Assessment Instrument Coordinator(RAI), Behaviourial Support Ontario team member(BSO), Personal Support Workers (PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), Resident Care Area Managers(RCAM), Director of Care(DOC), Director of Clinical Care, Director of Quality, Executive Director(ED) Corporate Nursing Consultant and Corporate Regional Directors.
During the course of this inspection, the inspectors toured common and resident home areas, observed meal and snack services, staff to resident interactions during the provision of care, resident to resident interactions, observed medication administration, infection control practices. The inspectors reviewed clinical records, educational records, staffing compliment records, the licensees' investigations documentation and the licensee's policies related to zero tolerance for abuse, medication orders and administration, skin and wound and staffing.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **1 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. 20. (1)	CO #005	2017_643111_0013	194
O.Reg 79/10 s. 245.	CO #002	2017_643111_0013	570
O.Reg 79/10 s. 48. (1)	CO #003	2017_643111_0013	166
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2017_643111_0013	624
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #001	2017_643111_0013	166

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of three high risk medication incidents for the month of August 2017 (discussed at the Professional Advisory Committee Meeting in September 2017) and three high risk medication incidents for the month of January 2018 were inspected by inspector #194.

Review of a medication incident report involving resident #054 indicated RPN #142 did not administer a prescribed medication to resident #054. The medication incident report indicated there was no negative outcome to resident #054 as a result of the medication error.

Review of resident #054's physician's orders indicated the medication was ordered to be administered every 8 hours.
Review of resident #054's Medication Administration Record (MAR) indicated there was no registered nurse signature to indicate that the medication was administered to the resident.

RPN # 142 was interviewed by inspector #194 and indicated an unawareness that a medication error involving resident #054 had occurred.

Review of a medication incident report involving resident #057 indicated that an incorrect dosage for a medication ordered by the physician was administered to resident #057. The medication incident indicated resident #057 did not have negative outcome as a result of the medication error.

Review of a medication incident report involving resident #073 indicated a prescribed medication was not administered to resident #073 for four consecutive days.
RPN,s #108, #143, #144 and #145 were identified as being the staff involved in the medication incident. The medication incident report indicated there was no negative outcome to resident #073 as a result of the incident.

Interview with RPN #108 and RPN #143, indicated RCAM #117 reviewed the 8 rights of medication administration, post medication incident with the registered staff involved. [r.131.(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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #022, who demonstrated responsive behaviours, the strategies that had been developed were implemented to respond to these behaviours,

Related to log#028502-17

A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident abuse.
Review of the CIR documentation indicated, PSW #130 was walking by resident #022's room and observed resident #022 displaying responsive behaviours.
The PSW covered the resident with a sheet and left to assist in the dining room. When PSW #130 returned to provide care, resident #022 continued to display responsive behaviours. The PSW continued to provide resident care even as the resident continued to display responsive behaviours,
The plan of care for resident #022, related to responsive behaviours indicated resident #022, was cognitively impaired, and displayed resistive behaviours towards staff when care was provided.
Interventions for the responsive behaviours for resident #022, indicated that staff were to leave the resident when redirection was ineffective and return in 10 minutes, and if behaviours continued staff were to have another staff attempt the care.
Interview with PSW #130, conducted by inspector #194, related to care provided to resident #022, indicated that care continued to be provided while resident #022 was agitated.
PSW #130, indicated that care was provided by holding the resident's hands with co worker PSW #131 present to ensure that hygienic care was provided prior to the resident receiving visitors.
PSW #130 indicated being aware of the resident's responsive behaviours and the strategies identified in the plan of care but continued to provide care to resident #022, while the resident displayed responsive behaviour contrary to the strategies that had been developed related to resident's responsive behaviour management strategies. [s. 53. (4) (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 the strategies that have been developed related to the management of responsive behaviours for resident #022 are carried out, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee has has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.
On November 15, 2017, compliance order (CO)#003, made under O.Reg.79/10, s.48(1) during Inspection #2017_643111_0013 was served.
The licensee must be compliant with s.48(1)2
Specifically:
1) All RCAMs, RNs, and RPNs are retrained on the licensee's skin and wound program. The compliance date was December 15, 2017.
Review of the education program schedule, the registered staff compliment, interview with registered staff and interview with the Director of Care indicated at the time of this inspection there were 51 registered staff employed in the home. There were 8 out of 51(16%) staff left to be trained.

The licensee has failed to complete section #1 of CO#003, all RCAMs, RNs, and RPNs are retrained on the licensee's skin and wound program. [s. 101. (3)]

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 compliance with the LTCHA , specifically, section 1 of CO #003, related to the retraining on the licensee's skin and wound program for all RCAMs, RPNs and RNs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident is reported with immediate action taken to assess the resident's health. All medication incidents are reported to the resident, the resident's Substitute Decision Maker(SDM), the DOC, the Physician and the pharmacy.

The Executive Director and the Director of Care, who were aware of the medication incidents are no longer at the home and unable to speak to the identified incidents.

Review of a medication incident report involving resident #054 indicated RPN #142 did not administer a prescribed medication to resident #054. The medication incident report indicated there was no negative outcome to resident #054 as a result of the medication error.
Review of the resident's clinical health record did not provide evidence, the resident's SDM, Physician or pharmacy had been notified of the medication error.

RPN #142 was interviewed by inspector #194 and indicated the RPN had not been informed of the medication error involving resident #054. RPN # 142 indicated that neither RCAM #146 or the former DOC addressed the medication error.

RCAM #146 indicated to inspector #194 being able to recall the medication incident report and that mentoring related to review of the 8 rights to medication administration would have been reviewed, RCAM #146 indicated having not documented any of the education on the medication incident report.

Review of a medication incident report involving resident #056 indicated, two tablets of a controlled medication were found in a medication cup in the medication cart. Review of the Medication Administration Record for resident #056 indicated the controlled medication had been signed off by a registered staff as being administered to the resident.
The medication incident report indicated RPN #128 and #127 were both interviewed during the licensee's investigation and it was undetermined which RPN did not administer the medication that was found in the medication cart.

During an interview with inspector #194, RPN # 128 indicated being informed of the medication error by RCAM #137. RPN #128 indicated that no education or mentoring took place and no one else followed up with the RPNs related to the medication incident.

Review of the medication incident report involving resident #056 indicated no evidence to support that corrective action was initiated related to the medication incident. [s. 135. (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 ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written care plan for resident #052 sets out the planned care for the resident related to the use of commode chair for toileting.

Related to Log #002546-18

A Critical Incident Report (CIR) was submitted to the Director reporting that resident #052 had fallen and had sustained an injury.
Review of the CIR indicated, PSW #138 noted resident #052 was leaning forward while sitting on a commode . The resident was lowered to the floor by PSWs #138 and #119.
The plan of care reviewed did not reveal that the resident used a commode chair. In addition, there was no indication of any directions to staff regarding using the commode chair.

During separate interviews, PSW #112 and #138 both indicated to Inspector #570 that they had used the commode chair resident #052 once or twice a week. The PSWs indicated that about two weeks prior to the resident's fall, RPN #111 informed them not to use the commode chair for resident #052 due to safety concerns.
During an interview, RPN #111 confirmed to Inspector #570 that the written plan of care for resident #052 did not include the use of the commode chair for the resident.

The licensee did not ensure that the written care plan for resident #052 set out the planned care for the resident, specific to the use of a commode chair. [s. 6. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Related to Log #028091-17

Critical Incident Report was submitted to the Director reporting that resident #041 had fallen an had sustained an injury.

Review of the CIR indicated, resident #041 was found on the floor and was transferred to hospital for further assessment.
Resident #041 had a significant change in level of care post fall.

During an interview, the DOC confirmed to Inspector #570 that the Critical Incident Report relating to resident #041's fall was not submitted to the Director within one business day.
The licensee did not notify the Director of the incident involving resident #041 until two days after the resident's significant change in level of care related to the incident.

Related to Log #002371-18

Critical Incident Report was submitted to the Director reporting that resident #043 had fallen an had sustained an injury.
Review of the CIR indicated resident #043 was found on the floor. The resident had sustained an injury, complained of severe discomfort and was transferred to the hospital for further assessment.
The DOC confirmed to Inspector #570 that the CIR was not submitted to the Director within one business day.

The licensee did not notify the Director of the incident involving resident #043 until two business days after the resident's significant change in condition due to the incident. [s. 107. (3)]

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

Issued on this 3rd day of April, 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) :	CAROLINE TOMPKINS (166), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), DENISE BROWN (626), SAMI JAROUR (570), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_694166_0005
Log No. / No de registre :	001759-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 26, 2018
Licensee / Titulaire de permis :	CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lesreen Thomas

To CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP, 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. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131 of O. Reg. 79/10
- Ensure that resident #054, #056, #057 and all other residents are administered medications in accordance with the directions for use specified by the prescriber.

- Daily shift audits are completed to prevent medication errors if alternate Medication Administration Records are used.
- Re-education of Registered staff related to Medication Administration practices
- the management company must immediately provide nursing leadership and play an active role in supporting the home in implementing effective response in the analysis of the medication audits, staff education related to medication administration, corrective action as pertains to medication administration practices, including and not limited to medication incidents.

Grounds / Motifs :

1. Licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of three high risk medication incidents for the month of August 2017 (discussed at the Professional Advisory Committee Meeting in September 2017) and three high risk medication incidents for the month of January 2018 were inspected by inspector #194.

Review of a medication incident report involving resident #054 indicated RPN #142 did not administered a prescribed medication to resident #054. The medication incident report indicated there was no negative outcome to resident #054 as a result of the medication error.

Review of resident #054's physician's orders indicated the medication was ordered to be administered every 8 hours.
Review of resident #054's Medication Administration Record (MAR) indicated there was no registered nurse signature to indicate that the medication was administered to the resident.

RPN #142 was interviewed by inspector #194 and indicated an unawareness that a medication error involving resident #054 had occurred.

Review of a medication incident report involving resident #057 indicated that an incorrect dosage for a medication ordered by the physician was administered to resident #057. The medication incident report indicated resident #057 did not have negative outcome as a result of the medication error.

Review of a medication incident report involving resident #073 indicated a prescribed medication was not administered to resident #073 for four consecutive days.
RPN,s #108, #143, #144 and #145 were identified as being the staff involved in the medication incident. The medication incident report indicated there was no negative outcome to resident #073 as a result of the incident.

Interview with RPN #108 and RPN #143, indicated RCAM #117 reviewed the 8 rights of medication administration, post medication incident with the registered staff involved.

The severity of this issue was determined to be a level 2 with potential for actual harm. The scope of the issue was a level 2 where a pattern was identified. The home had a level 3 compliance history with non compliance that included:
- Compliance order (CO) issued February 8, 2017, (2016_119626_0032), complied on May 8, 2017
- Voluntary Plan of Correction (VPC) issued August 11, 2017 (2017_643111_0013)

(194)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 01, 2018

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 26th day of March, 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 : CAROLINE TOMPKINS

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