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
Jan 30, 2018	2017_689586_0014	021025-17	Resident Quality Inspection

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

JESSICA PALADINO (586), DIANNE BARSEVICH (581), LISA VINK (168)

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): December 15, 18, 19 and 20, 2017.

The following on-site Inquiries were conducted concurrently with the RQI:
014169-17 - Personal Support Services;
018898-17 - Responsive Behaviours; and,
027001-17 - Falls Prevention & Management.

The following Follow Up Inspections were conducted concurrently with the RQI:
024483-17 - Personal Support Services;
024488-17 - Falls Prevention & Management; and,
024490-17 - Nutrition & Hydration.

The following Complaint Inspections were conducted concurrently with the RQI:
025211-17 - Falls Prevention & Management; Personal Support Services; and,
020781-17 - Continence Care & Bowel Management; Dining Observation; Personal Support Services; Falls Prevention & Management; Reporting & Complaints.

The following Critical Incident System (CIS) Inspection was conducted concurrently with the RQI:
027279-17 - Falls Prevention & Management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Resident Assessment Instrument (RAI) Co-ordinator, Office Manager, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspectors observed the provision of care and services, toured the home, reviewed relevant policies and procedures, meeting minutes and clinical health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council

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)**

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
O.Reg 79/10 s. 33. (1)	CO #001	2017_661683_0009	168
LTCHA, 2007 s. 6. (7)	CO #002	2017_661683_0009	168

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 LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A. The MDS assessment indicated resident #025's level of bladder functioning. The Point of Care (POC) documentation for the past 30 days noted that the resident was incontinent of bladder a particular number of times.

Staff were observed to provide continence care to the resident. A review of the plan of care did not include a focus statement related to bladder functioning. Interview with the RAI Co-ordinator verified the expectation that if there was an actual need, that a focus statement would be included in the plan of care and confirmed that the resident did not have a focus statement for bladder functioning, which was planned care for the resident, following a review of the clinical record. (168).

B. A review of the plan of care for resident #010 was completed.

i) The plan of care identified their level of bladder functioning and need for continence products. Interview with PSW #113 and review of the Resident Prevail Worksheet revealed that the resident wore a specific continence product on all shifts. Interview with the ADRC also confirmed this and confirmed it was not documented in the written plan of care.

ii) Review of the MDS assessment for resident #010 identified their level of bladder functioning. Review of the written plan of care did not identify a bladder continence focus, goals or interventions. Interview with the RAI Co-ordinator confirmed their level of functioning as well as assistance required related to this care area and confirmed that bladder incontinence was planned care for the resident and was not documented in the written plan of care.

C. On an identified date in 2017, resident #040 fell and sustained an injury. Review of the home's investigation notes identified that one of the resident's falls interventions were in place at the time. Interview with the DRC and PSW #113 both verified that the resident had the intervention in place when the fall occurred and that it was properly functioning. Interview with the DRC following review of the plan of care confirmed that the application of the falls intervention was planned care for the resident and was not documented in the written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to

the resident as specified in the plan.

As per resident #009's clinical health record, they were encouraged to receive two particular interventions at meals due to their nutritional risk. During a meal service in one of the dining rooms during the RQI, the resident was not offered or given either of the nutritional interventions. Resident #009 was not provided the care set out in their plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of the plan of care for resident #040 included an intervention that they were on a restorative program for falls prevention, which included specific goals; however, review of the Restorative Care Assessment identified that the resident was discharged from the restorative ambulation program in 2017. Interview and review of the plan of care with the RAI Co-ordinator confirmed that the plan was not updated when the care set out in the plan was no longer necessary after they were discharged from the restorative care ambulation program. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

As indicated in inspection order report #2017_661683_0009, residents #002, #008, and #009 all required specific interventions at meal time; however, at times would refuse. The DRC had confirmed that there were no interventions in place for when the residents refused.

In an interview with the DRC and ADRC during the RQI, they acknowledged that these residents would still refuse at times if the interventions were in place. They indicated that the care plans were to have been updated to include interventions for refusal that were appropriate for each resident, and listed specific interventions that could be used.

Review of each resident's documented plan of care with the ADRC identified that no interventions had been put in place for when the residents refused. This was also confirmed by the RAI Co-ordinator. The licensee did not ensure that residents #002, #008 and #009 were reassessed and their plans of care reviewed and revised when the

care set out in the plan of care was not effective. [s. 6. (10) (c)]

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. 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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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.

On request the home provided copies of medication incident reports for the past six months for review. Review of the incident reports identified that not all incidents included a record that they were reported to all required parties.

i) A Medication Incident report identified that resident #054 was involved in an incident in 2017, which was identified and reported the following month. Interview with the DRC verified that the resident was their own decision-maker; however, there was no documentation in the record to indicate that they were notified of the error, and the incident report, which was completed by the pharmacy noted "not applicable" for resident/POA (Power of Attorney) notification.

ii) A Medication Incident report identified that resident #055 was involved in an incident in 2017, which was identified and reported the following month. Interview with the DOC verified that the resident was their own decision-maker; however, there was no documentation in the record to indicate that they were notified of the error, and the incident report, which was completed by the pharmacy noted "not applicable" for resident/POA notification. [s. 135. (1)] (168) [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything as required.

On request the home provided a copy of all medication incident and adverse drug reaction reports for the past six months. A review of the reports identified that not all incidents were reviewed, analyzed or corrective action taken as necessary.

i). An incident report identified that resident #054 was involved in a medication incident in 2017, which was identified the following month. According to the DRC, a medication was ordered by the physician, the order was included on the electronic Medication Record (eMAR); however, was not filled by the pharmacy, and therefore not administered to the resident.

The report included a hand-written statement that this was a "pharmacy error" and included comments by the pharmacist that "procedures would be reviewed with involved pharmacy staff".

A review of the eMAR records for identified dates in 2017, noted the medication, the dosage and that it was to be given at a particular time each day. Registered staff documented on the eMAR that they gave the medication, as ordered and recorded on the eMAR from the date that it was ordered, until the error was identified approximately three weeks later. Interview with the DRC verified that they did not review or analyze the error to determine the role that nursing staff had in relation to the error and that as a result, corrective action had not been taken by the home related to the incident.

ii) An incident report identified that resident #054 was involved in a medication incident in 2017, which was identified the following month. According to the DRC, a medication with a dosage of multiple tablets was ordered by the physician, this order was included on the electronic eMAR; however, the dosage was not accurately recorded in a second location, where it was identified as one tablet only, and as a result an incorrect, lower, dosage was administered by the pharmacy.

A review of the eMAR records for identified dates in 2017, noted the medication, the correct dosage of multiple tablets, and that it was to be given at a particular time each day. Registered staff documented on the eMAR that they gave the medication, as ordered and recorded on the eMAR from the date that it was ordered, until the error was identified approximately one month later. Interview with the DRC verified that they did not review or analyze the error to determine the role that nursing staff had in relation to the error and that as a result corrective action had not been taken by the home related to the incident. [s. 135. (2)] (168) [s. 135. (2)]

3. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything as required.

Interview with the DRC identified that the home completed a quarterly review of all medication incidents and adverse drug reactions as part of their Professional Advisory Committee (PAC) meeting, that a representative from the pharmacy attended the meeting and prepared a report for this meeting.

A review of the most recent PAC meeting minutes and Pharmacy Report for the meeting identified that the home discussed medication incidents. This discussion included but was not limited to: the number of errors, types of errors, and how errors occurred, which

was confirmed by the DRC.

The most recent PAC meeting minutes did not include documentation that the review included a discussion related to specific actions to reduce or prevent incidents, nor any changes or improvement identified. Interview with the DRC, following a review of the meeting minutes, verified that the PAC meeting included a fulsome discussion related to the incidents and improvements; however, this was not reflective in the meeting minutes as required. The DRC identified that, in addition to the PAC meetings, medication incidents were also discussed corporately at monthly DRC meetings, which pharmacy was also involved. A review of recent DRC meeting minutes, included comments about medication incidents; however, did not include documentation to support specific actions to reduce or prevent incidents, nor any changes or improvement identified. [s. 135. (3)] (168) [s. 135. (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 that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything as required; and, to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything as required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff used equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The manufacturer's warning label attached to a specific treatment in the home indicated the following,
"WARNING: KEEP EQUIPMENT UPRIGHT AT ALL TIMES!"; and,
"REMEMBER: Ensure adequate ventilation for use and storage".

On an identified date in 2017, resident #030 sustained an injury when utilizing the equipment.

In an interview with the DRC and ADRC during the RQI, they confirmed the incident, identifying the errors in monitoring and maintaining the equipment which lead to the injury. The DRC and ADRC acknowledged that the equipment was not used in accordance with the manufacturer's instructions. [s. 23.]

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 all staff used equipment, supplies, devices, assistive aids and positioning aids in the home are used in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy, "Head Injury" (reference No.: 005200.00), indicated that any resident who potentially may have sustained an injury to the head (abrasion, cut, swelling, bump or sudden onset of vomiting) following a fall or impact with an object, would be promptly assessed and have head injury routine (HIR) initiated and all unwitnessed resident falls would be assessed for a potential head injury. The HIR would be completed every 15 minutes for the first hour, every 30 minutes for the next two hours, every hour for the next four hours, every two hours for the next eight hours, every four hours for the next 12 hours and every shift for 24 hours.

On an identified date in 2017, resident #040 had an unwitnessed fall and sustained multiple injuries. Review of the HIR identified that neurological vital signs were not documented consistently every 15 minutes for the first hour and consistently every 30 minutes for the next two hours. Interview with the RAI Co-ordinator and review of the HIR documentation confirmed that all neurological vital signs were not completed at every interval as required by the home's policy. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD).

The licensee did not comply with the conditions to which the licensee was subject in relation to the completion of the RAP assessment summary for non-triggered clinical conditions.

A. Resident #009 was identified in an MDS assessment from 2017 that they had pain symptoms. A review of the clinical record did not include a non-triggered RAP for pain, following the assessment, which was confirmed during a review of the clinical record by the RAI Co-ordinator.

The following MDS assessment identified that the resident experienced pain. A review of the clinical record did not include a non-triggered RAP for pain, following the assessment, which was confirmed during a review of the clinical record by the RAI Co-ordinator.

The RAI Coordinator verified the expectation that a non-triggered RAP for pain be completed if a resident was on regular analgesic and/or if they were coded for pain in the MDS assessment and that this was not completed for resident #009. (168).

B. Resident #015 was coded in their Quarterly MDS assessment from 2017, with no pain. They were coded in their Annual MDS Assessment with pain. A review of the clinical record did not include any RAPs for the non-triggered condition of pain, which was confirmed during an interview with the RAI Co-ordinator.

Interview with the RAI Co-ordinator identified their awareness of their need to complete non-triggered RAPs and that there should have been RAPs completed for non-triggered clinical conditions including pain for the resident. [s. 101. (4)]

Issued on this 31st day of January, 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) :	JESSICA PALADINO (586), DIANNE BARSEVICH (581), LISA VINK (168)
Inspection No. / No de l'inspection :	2017_689586_0014
Log No. / No de registre :	021025-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 30, 2018
Licensee / Titulaire de permis :	DELHI NURSING HOME LTD 750 GIBRALTAR STREET, DELHI, ON, N4B-3B3
LTC Home / Foyer de SLD :	DELHI LONG TERM CARE CENTRE 750 GIBRALTAR STREET, DELHI, ON, N4B-3B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeremy Zinger

To DELHI NURSING HOME LTD, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_661683_0009, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall reassess residents #002, #008 and #009 and review and revise their plan of care to include resident-specific interventions based on the assessed needs and preferences of those residents.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with Ontario Regulation 79/10 s. 229, in respect of the potential for harm toward residents #002, #008 and #009, the scope of the issue being widespread, and the Licensee's history of ongoing non-compliance of a (CO) during the August 2017 Complaint Inspection, as well an additional previous (CO) that was cleared, related to reassessment of resident plans of care when the care set out in the plan was not effective.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

As indicated in inspection order report #2017_661683_0009, residents #002, #008, and #009 all required specific interventions at meal time; however, at times would refuse. The DRC had confirmed that there were no interventions in place for when the residents refused.

In an interview with the DRC and ADRC during the RQI, they acknowledged that these residents would still refuse at times if the interventions were in place. They indicated that the care plans were to have been updated to include interventions for refusal that were appropriate for each resident, and listed specific interventions that could be used.

Review of each resident's documented plan of care with the ADRC identified that no interventions had been put in place for when the residents refused. This was also confirmed by the RAI Co-ordinator. The licensee did not ensure that residents #002, #008 and #009 were reassessed and their plans of care reviewed and revised when the care set out in the plan of care was not effective. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 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 30th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

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