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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2016_268604_0020	029430-16	Resident Quality Inspection

Licensee/Titulaire de permis

HILLCREST VILLAGE INC.
255 RUSSELL STREET MIDLAND ON L4R 5L6

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

HILLCREST VILLAGE CARE CENTRE
255 RUSSELL STREET MIDLAND ON L4R 5L6

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

SHIHANA RUMZI (604), JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 5, 6, 11, 12, 13, and 14, 2016.

The following intakes were inspected concurrently with the Resident Quality Inspection (RQI):
Critical Incident Report (CIS) intakes related to:

Improper/Incompetent treatment of a resident:
- CIS report number 2828-000035-15, log #035630-15

Improper care Abuse/Neglect
- CIS report number 2828-000021-15, log #024129-15 - Staff to Resident
- CIS report number 2828-000023-15, log #025520-15 - Staff to Resident

Incident with injury/hospital transfer with significant change in status
- CIS report number 2828-000047-13, log #019172-15

Other (Behaviours)
- CIS report number 2828-000040-13, log #019178-15

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Care Facilitator (RCF), Residents, Substitute Decision Makers (SDMs), Presidents of Residents' and Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

4 WN(s)
1 VPC(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from physical and verbal abuse by the licensee or staff in the home.

a) The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The home submitted an identified Critical Incident System (CIS) report, on an identified date, to the Ministry of Health and Long-Term Care (MOHLTC). The CIS report indicated a resident's family member informed the home that the resident did not like an identified staff member and that the staff member would yell at the resident. The resident had informed his/her family member that it makes the resident feel small and degraded and that the staff member used foul language to describe the resident's family member.

An interview conducted with PSW #116 indicated he/she did care for resident #017 and that there was an incident where he/she was questioned by the management of the home related to a complaint from resident #017's family member. The PSW stated the family member had informed the home that he/she had used foul language to describe the resident's family member. The PSW further stated that he/she did not use foul language but was suspended for three days at the conclusion of the home's investigation. The PSW further indicated that if a staff member in the home did use foul language to describe the resident's family it would be inappropriate and verbally abusive.

Resident #017 was unable to be interviewed due to cognitive decline.

An interview with the DOC indicated that during the home's investigation resident #017 was able to recall at that time the situation multiple times and insisted PSW #116 had made the statements indicated above. The home confirmed from their investigation that the incident had occurred and PSW #116 was disciplined and constituted this incident to be verbal abuse.

b) The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

The home submitted an identified CIS report on an identified date to the MOHLTC. The CIS report indicated the Resident Care Facilitator (RCF), on days received a report from the day Registered Practical Nurse (RPN) at an identified date and time that resident #016 had a mark on an identified location of his/her body and the cause was unknown.

The MOHLTC Actionline, received a call from a family member on an identified date, indicating resident #016 was abused at the long term care home on an identified date. The family member indicated that the resident has since passed away, however, wanted to know if the Ministry of Health (MOH) was looking into the abuse and if the home had reported to the MOH of the incident.

An interview with PSW #113 confirmed he/she worked on an identified date and shift on an identified home are. PSW #113 indicated he/she assisted PSW #111 and #118 when providing care to resident #016 while in an identified area of the home. PSW #113 indicated that PSW #118 proceeded to provide care to resident #016 while he/she and PSW #111 held the residents hand gently. PSW #113 further indicated that during the care to resident #016 the resident continued to shake his/her head and attempted to refuse the care. The resident was provided the identified care measure and proceeded to take the resident out of an identified location and into another identified location of the home. PSW #113 indicated that he/she reported the above mentioned incident to RPN #119 because the incident did not feel right and the resident had a red mark in an identified location of the resident’s body. The PSW ended by stating that he/she was disciplined for being involved in the incident and the incident constituted as physical abuse.

An interview with RN/RCF #114 confirmed he/she worked on an identified date and time, and was informed of the incident above. The RCF indicated that she/he was unable to recall the incident or if resident #016 had any injuries as the incident was so long. The RCF indicated he/she constituted the incident to be physical abuse.

An interview with the DOC confirmed the above incident did occur and three PSW staff were suspended after the home’s investigation was completed. The DOC stated PSW #118 was terminated shortly due to the progression of discipline. The DOC indicated resident #016 had a mark on an identified area of his/her body. The DOC indicated though the home’s investigation confirmed that resident #016 was the recipient of physical abuse.

The severity of the non-compliance and the severity of harm and risk is actual as resident #017 felt that the PSW’s comments made him/her feel small and degraded, resident #016 sustained a mark on an identified area of his/her body as a result of three staff attempting to provide care to the resident.

The scope of the non-compliance is a pattern.

A review of the compliance history revealed that there has been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. s.19. (1).

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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 :

The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The home submitted an identified CIS report on an identified date to the MOHLTC, indicating that a resident had been served an inappropriate diet type resulting in a change in the resident’s health status. The CIS further indicated that the Personal Support Worker (PSW) did not refer to the therapeutic diet sheets, and provided the resident with an incorrect diet type.

Clinical records reviewed and indicated that resident #006 had been deemed at high nutritional risk and was ordered an identified diet as resident was at risk for an identified health condition. The resident required constant supervision in an identified location of the home.

PSW #117 indicated during an interview that he/she had worked at the time of the above mentioned incident and provided the resident with an incorrect diet type. The PSW stated that he/she did not have time to refer to an identified document when he/she carried out the identified task in an identified location of the home. PSW #117 further

indicated that resident #006 required an identified diet type which was indicated in his/her plan of care and on the day of the incident resident #006 had been provided with an incorrect diet type which caused a change in the resident's health status.

An interview with RN #109 indicated that an identified report is considered part of the residents' plan of care, and is to be referred to by all staff prior to any food or fluid being served to a resident to ensure all residents are given the correct food or fluid texture to avoid risk of harm to residents.

An interview with ADOC confirmed the above incident and further indicated that an identified report is expected to be referred to by all staff prior to serving any food or fluid as diet and fluids types and consistency can frequently change and is considered as part of the residents' plan of care. The ADOC further confirmed that the care set out in the residents plan of care had not been provided as indicated in the plan and as a result the resident was at risk of being harmed.

The severity of the non-compliance and the severity of harm and risk is actual. Resident #006 was provided the incorrect diet type by the PSW staff resulting in the resident's change in resident's status.

A review of the home's compliance history revealed previous non-compliances related to the Long-Term Care Homes Act O.Reg. s. 6. (7)

1) July 9, 2015, Inspection Number 015_299559_0015, VPC related to Skin and Wound Care.

The scope of the non-compliance was isolated.

Additional Required Actions:

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

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

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home submitted an identified CIS report on an identified date to the MOHLTC, indicating that a resident had been served an inappropriate diet type resulting in a change in the resident's health status. The CIS further indicated that the Personal Support Worker (PSW) did not refer to the therapeutic diet sheets, and provided the resident with an incorrect diet type.

A review of the homes' policy titled "Dining Room Service Policy & Procedure", approved January 2005, and revised September 9, 2015, stated that prior to serving any resident food or fluid, the meal service report is to be referred to in order to ensure the correct diet type, texture, fluid consistency, likes, dislikes and special menu items are provided to residents.

Clinical records reviewed indicated that resident #006 had been deemed at high nutritional risk and was ordered an identified diet as resident was at risk for an identified health condition. The resident required constant supervision in an identified location of the home.

PSW #117 indicated during an interview that he/she had worked at the time of the above mentioned incident and provided the resident with the incorrect diet type. The PSW stated that he/she did not have time to refer to an identified document when he/she carried out the identified task in an identified location of the home. PSW #117 further indicated that resident #006 required an identified diet type which was indicated in his/her plan of care and on the day of the incident resident #006 had been provided with an

incorrect diet type which caused a change in the resident's health status.

During a lunch dining observation by inspector #647 on an identified date, it had been observed that PSW #110 served four tables without referring to the identified report to ensure the correct diet texture and fluid consistency had been served to residents.

During an interview with PSW #110, he/she acknowledged the above mentioned policy and procedure however, stated he/she works all the time and is aware of the residents' meal type.

An interview with RN #109 indicated that an identified report is to be referred to by all staff prior to any food or fluid being served to a resident to ensure all residents are given the correct food or fluid texture to avoid risk of harm. The RN further indicated that diet orders including fluid texture changes can change frequently and staff are required to check the identified report to ensure the correct diet and texture are being served.

Interviews with both the ADOC and DOC confirmed that staff had knowledge of the policy and procedure as mentioned above, received education upon hire and annually thereafter, and are expected to comply with the above mentioned policy.

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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The home has failed to ensure that the person who has reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reports the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The home submitted an identified CIS report on an identified date to the MOHLTC. The CIS report indicated RCF on days received a report from the day RPN on an identified date and time that resident #016 had a mark on an identified location of his/her body and the cause was unknown.

An interview with the DOC stated the above incident did occur on the identified date, and a CIS report was submitted to the MOHLTC on an identified date and was five days late. The DOC stated the home's investigation concluded abuse had occurred to resident #016 and three PSW staff where suspended and one PSW was terminated shortly due to progressive discipline. The DOC confirmed the CIS report was five days late and did not report as per the MOH legislation.

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.

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) :	SHIHANA RUMZI (604), JENNIFER BROWN (647)
Inspection No. / No de l'inspection :	2016_268604_0020
Log No. / Registre no:	029430-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 21, 2017
Licensee / Titulaire de permis :	HILLCREST VILLAGE INC. 255 RUSSELL STREET, MIDLAND, ON, L4R-5L6
LTC Home / Foyer de SLD :	HILLCREST VILLAGE CARE CENTRE 255 RUSSELL STREET, MIDLAND, ON, L4R-5L6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Johnathon Ens

To HILLCREST VILLAGE INC., 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Within one week of receiving this order, the home shall provide a plan to the inspector on February 28, 2017, the plan shall include:

1) Provide education to staff on all forms of abuse afforded under the legislation.

The education shall include staff recognition of all forms of abuse and the immediate reporting of such.

The plan shall be submitted to shihana.rumzi@ontario.ca within one week of receipt of this order.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from physical and verbal abuse by the licensee or staff in the home.

a) The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The home submitted an identified Critical Incident System (CIS) report, on an identified date, to the Ministry of Health and Long-Term Care (MOHLTC). The CIS report indicated a resident's family member informed the home that the resident did not like an identified staff member and that the staff member would yell at the resident. The resident had informed his/her family member that it makes the resident feel small and degraded and that the staff member used foul

language to describe the resident's family member.

An interview conducted with PSW #116 indicated he/she did care for resident #017 and that there was an incident where he/she was questioned by the management of the home related to a complaint from resident #017's family member. The PSW stated the family member had informed the home that he/she had used foul language to describe the resident's family member. The PSW further stated that he/she did not use foul language but was suspended for three days at the conclusion of the home's investigation. The PSW further indicated that if a staff member in the home did use foul language to describe the resident's family it would be inappropriate and verbally abusive.

Resident #017 was unable to be interviewed due to cognitive decline.

An interview with the DOC indicated that during the home's investigation resident #017 was able to recall at that time the situation multiple times and insisted PSW #116 had made the statements indicated above. The home confirmed from their investigation that the incident had occurred and PSW #116 was disciplined and constituted this incident to be verbal abuse.

b) The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

The home submitted an identified CIS report on an identified date to the MOHLTC. The CIS report indicated the Resident Care Facilitator (RCF), on days received a report from the day Registered Practical Nurse (RPN) at an identified date and time that resident #016 had a mark on an identified location of his/her body and the cause was unknown.

The MOHLTC Actionline, received a call from a family member on an identified date, indicating resident #016 was abused at the long term care home on an identified date. The family member indicated that the resident has since passed away, however, wanted to know if the Ministry of Health (MOH) was looking into the abuse and if the home had reported to the MOH of the incident.

An interview with PSW #113 confirmed he/she worked on an identified date and shift on an identified home are. PSW #113 indicated he/she assisted PSW #111 and #118 when providing care to resident #016 while in an identified area of the

home. PSW #113 indicated that PSW #118 proceeded to provide care to resident #016 while he/she and PSW #111 held the residents hand gently. PSW #113 further indicated that during the care to resident #016 the resident continued to shake his/her head and attempted to refuse the care. The resident was provided the identified care measure and proceeded to take the resident out of an identified location and into another identified location of the home. PSW #113 indicated that he/she reported the above mentioned incident to RPN #119 because the incident did not feel right and the resident had a red mark in an identified location of the resident's body. The PSW ended by stating that he/she was disciplined for being involved in the incident and the incident constituted as physical abuse.

An interview with RN/RCF #114 confirmed he/she worked on an identified date and time, and was informed of the incident above. The RCF indicated that she/he was unable to recall the incident or if resident #016 had any injuries as the incident was so long. The RCF indicated he/she constituted the incident to be physical abuse.

An interview with the DOC confirmed the above incident did occur and three PSW staff were suspended after the home's investigation was completed. The DOC stated PSW #118 was terminated shortly due to the progression of discipline. The DOC indicated resident #016 had a mark on an identified area of his/her body. The DOC indicated though the home's investigation confirmed that resident #016 was the recipient of physical abuse.

The severity of the non-compliance and the severity of harm and risk is actual as resident #017 felt that the PSW's comments made him/her feel small and degraded, resident #016 sustained a mark on an identified area of his/her body as a result of three staff attempting to provide care to the resident.

The scope of the non-compliance is a pattern.

A review of the compliance history revealed that there has been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. s. 19. (1). (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

Within one week of receiving this order, the home shall provide a plan to the inspector on February 28, 2017, the plan shall include:

1) Direct care staff shall be educated on the home's policy titled, Dining Room Service Policy & Procedure, approved January 2005, and revised September 9, 2015.

2) Direct care staff will be educated on using the meal service report prior to serving residents in the dining room.

3) Ensure that resident #006 receives the proper therapeutic diet ordered by the RD.

The plan shall be submitted to shihana.rumzi@ontario.ca within one week of receipt of this order.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The home submitted an identified CIS report on an identified date to the MOHLTC, indicating that a resident had been served an inappropriate diet type resulting in a change in the resident's health status. The CIS further indicated that the Personal Support Worker (PSW) did not refer to the therapeutic diet sheets, and provided the resident with an incorrect diet type.

Clinical records reviewed and indicated that resident #006 had been deemed at

high nutritional risk and was ordered an identified diet as resident was at risk for an identified health condition. The resident required constant supervision in an identified location of the home.

PSW #117 indicated during an interview that he/she had worked at the time of the above mentioned incident and provided the resident with an incorrect diet type. The PSW stated that he/she did not have time to refer to an identified document when he/she carried out the identified task in an identified location of the home. PSW #117 further indicated that resident #006 required an identified diet type which was indicated in his/her plan of care and on the day of the incident resident #006 had been provided with an incorrect diet type which caused a change in the resident's health status.

An interview with RN #109 indicated that an identified report is considered part of the residents' plan of care, and is to be referred to by all staff prior to any food or fluid being served to a resident to ensure all residents are given the correct food or fluid texture to avoid risk of harm to residents.

An interview with ADOC confirmed the above incident and further indicated that an identified report is expected to be referred to by all staff prior to serving any food or fluid as diet and fluids types and consistency can frequently change and is considered as part of the residents' plan of care. The ADOC further confirmed that the care set out in the residents plan of care had not been provided as indicated in the plan and as a result the resident was at risk of being harmed.

The severity of the non-compliance and the severity of harm and risk is actual. Resident #006 was provided the incorrect diet type by the PSW staff resulting in the resident's change in resident's status.

A review of the home's compliance history revealed previous non-compliances related to the Long-Term Care Homes Act O.Reg. s.6. (7)

1) July 9, 2015, Inspection Number 015_299559_0015, VPC related to Skin and Wound Care.

The scope of the non-compliance was isolated.
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 2017

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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