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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2016	2015_360111_0020	O-002628-15	Complaint

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

HILLSDALE ESTATES
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 30 & October 1, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator,the Director of Care(DOC), the Environmental Manager, Resident Care Coordinator(RCC), Registered Practical Nurse(RPN), Occupational Therapist (OT), Personal Support Workers (PSW).
An observation of the resident and the resident's room was completed, review of cleaning schedules,review of resident health records, review of the home's investigations and complaints, and review of medication incidents was completed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Critical Incident Response
Medication
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 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 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 a medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

A critical incident report (CIR) was received on a specified date for a medication incident that occurred approximately two months earlier. The CIR indicated Resident #001 was sent to hospital as a result of a medication incident. The home submitted the CIR on the direction of the Inspector at the time of the inspection, over two months after the incident occurred.

The licensee was issued on-going non-compliance under O.Reg. 79/10, s.107(3)on Nov.12, 2012 during inspection #2012_031194_0057, on April 29, 2014 during inspection #2014_195166_0012, on July 8, 2014 during inspection #2014_365194_0007,on Dec.8, 2014 during inspection # 2014_195166_0033, and on July 9, 2015 during inspection #2015_291552_0019 and was issued a compliance order as a result. [s. 107. (3)]

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. (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 has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; and corrective action was taken as

necessary; and a written record was kept in response to medication incidents involving Resident #001.

The SDM of Resident #001 reported to the Inspector that in a specified month, the resident was sent to hospital due to an adverse drug reaction. The SDM reported that approximately one month later, a second medication incident occurred but with a different medication. The SDM indicated a third medication incident occurred the following month with the same medication as the second incident. The SDM indicated the last incident was reported directly to the RCC.

Review of the progress notes, physician orders, and medication administration records (MARS) for Resident #001 indicated:
-the first medication incident occurred on a specified date when the physician ordered an increase to a narcotic analgesic and a second narcotic analgesic as needed for breakthrough pain. The resident was given the breakthrough narcotic analgesic for pain and began having a change in condition. Approximately five hours later,the resident received a second dose of the narcotic analgesic for breakthrough pain and shortly after, the resident began having a serious change in condition. The physician was notified of the serious change in condition and ordered the increased narcotic analgesic be discontinued. The resident's condition continued to deteriorate and was sent to hospital for assessment and treatment of a adverse drug reaction.
- the physician ordered a transdermal cardiac medication to be applied in the morning and removed at bedtime. The second medication incident occurred approximately three weeks after the first medication incident involving the transdermal cardiac medication. The resident had no adverse reactions, and the incident was reported to SDM and physician.
-there was no documented evidence of the third medication incident involving the transdermal cardiac medication in the progress notes that occurred approximately one month after the second medication incident The resident had no adverse reactions.

Review of the Medication Administration Records (MAR) during the same three month period (related to the transdermal cardiac medication) indicated: the first medication incident was recorded on the MAR to refer to progress notes. The second medication incident had no indication that there was a medication incident despite it being reported to the nurse and the RCC. The same medication also had several missing entries to indicate where the transdermal cardiac patches were applied, even after the two medication incidents occurred.

Interview of the RCC and the DOC indicated a medication incident report is to be completed after any medication incident to ensure actions are taken to prevent a recurrence. The DOC indicated no medication incident report was completed for the first medication incident where the resident had an adverse condition as a result and required hospitalization because "they never gave the wrong medication". The DOC indicated a medication incident report was completed for the second medication incident involving a transdermal cardiac medication and staff involved received re-training. They both indicated there was no Medication Incident Report completed for the second transdermal cardiac medication incident that occurred approximately one month later, despite the same staff member being involved in the first transdermal cardiac medication incident.

Therefore, two out of the three medication incidents and/or adverse drug reactions were not documented, and all three of the medication incidents were not reviewed and analyzed, and no other corrective actions were taken other than retraining of two registered nursing staff after the first cardiac medication incident. [s. 135. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was based on an assessment of the resident and the resident's needs and preferences related to oral care.

Review of the home's complaints received related to Resident #001 and review of the progress notes for Resident #001 indicated on a specified date, the family had expressed concerns regarding oral care, and lack of oral care supplies.

Review of the current plan of care for Resident #001 related to oral care indicated the oral care was to be provided by Registered Nursing staff, staff to use all specified instructions and oral care supplies (as per dentist recommendations), twice daily and as needed, and signed off on the treatment administration record (TAR).

Observation of the resident's room over a two day period indicated only one of the oral care supplies were available in the resident's room. A private care worker was with the resident at that time and indicated they provided oral care to the resident, and was only able to use a facecloth as there were no oral care supplies available. The private care worker was not aware of other directions in the plan of care related to oral care or that only the Registered Nursing staff were to complete the oral care.

Interview of the RPN on the unit indicated awareness of only one of the interventions related to oral care that was to be provided by registered nursing staff each and kept in the medication cart. The RPN indicated the private worker was only to complete the resident's personal hygiene.

A physician's order was received for registered nursing staff to apply a specified treatment prior to administering the specified oral medication twice daily.

There was no indication the plan of care was based on the resident's assessed needs related to oral care as there was no indication of all of the interventions to be implemented as per the dentist recommendation and as per the physician's order. The directions provided by the family complaint also contradicted the directions in the plan of care. There was also no direction provided in the plan of care regarding the responsibility of the private care workers regarding oral care.

2. The licensee has failed to ensure that the SDM, if any, and the designate of the resident had been provided the opportunity to participate fully in the development and implementation of the plan of care related to medications.

Review of health care record for Resident #001 indicated on a specified date in 2014, the physician prescribed an anti-depressant daily. On a specified date in 2015, the

antidepressant was discontinued. Review of progress notes had no documented evidence the SDM was notified that the antidepressant was discontinued until four months later, when the antidepressant was restarted.

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 plan of care for Resident #001 is provided based on the assessed needs of the resident related to mouth care,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment of Resident #001 was kept clean and sanitary.

On two separate dates (at various times), observation of Resident #001 medical device in the resident's room had food stains covering a portion of the medical device. Observation of the resident's mobility aide also had food stains covering a large area of the mobility aide. At the time of the observations, a private care worker was present and indicated they had just observed the housekeeper clean the medical equipment but the food stains were not removed by this cleaning process.

Interview of the RN on the unit where the resident resides, stated "housekeeping staff were responsible for cleaning of the" medical equipment and the "PSW staff were responsible on evening shift for cleaning" of the mobility aides "as per schedule and if requested, more frequently".

Interview of Environmental Manager indicated housekeeping staff are responsible for cleaning of the residents rooms which would include any medical equipment in the room. The Environmental Manager indicated the medical equipment may get missed if the equipment is not in the room when the room is being cleaned. The Environmental Manager indicated there is also a communication book at each nursing station for nursing staff to indicate any concerns related to cleaning of equipment and the book is checked daily.

Review of the maintenance communication book had no documented evidence of concerns related to food stains on medical equipment or mobility aides. Review of the mobillty aide cleaning schedules provided indicated Resident #001 mobility aide was cleaned twice a month but was not effective in removing food stains.

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 ambulation and medical equipment of Resident #001 is kept clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Observation of Resident #001 room on two separate dates (at various times) had lingering offensive odours noted upon entering the room and which resembled a urine smell.

The Environmental Manager indicated there is a communication book at each nursing station for nursing staff to indicate any concerns related to odours and the book is checked daily. The Environmental Manager was not aware of the lingering offensive odours just at the entrance of Resident #001 room.

Review of the maintenance communication book had no documented evidence of concerns related to lingering offensive odours at entrance of Resident #001 room.

WN #6: 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 the health record for Resident #001 over a three month period indicated the physician ordered a transdermal cardiac medication with a specified dose, to be administered and removed at specified times.

Interview with the SDM of Resident #001 indicated the resident had two medication incidents involving the transdermal cardiac medication. The SDM indicated the first incident occurred on a specified date and the second incident occurred approximately one month later.

Review of Medication Incident Report's for Resident #001 indicated on a specified date, the resident was found the transdermal cardiac medication not administered as prescribed. There was no negative effect on the resident. There was no medication incident report for the second medication incident that occurred approximately a month later.

Interview of RCC indicated awareness of the two medication incidents related to Resident #001 and the transdermal cardiac medication. The RCC indicated the first medication incident involving the transdermal cardiac medication involved 2 RPN's(#100 & #101). The RCC indicated the second medication incident occurred approximately one month later. The RCC indicated did not document the incident in the progress notes and no medication incident report was completed.

Issued on this 15th day of January, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2015_360111_0020
Log No. / Registre no:	O-002628-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 7, 2016
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	HILLSDALE ESTATES 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Peragine

To REGIONAL MUNICIPALITY OF DURHAM, 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 :

O.Reg 79/10, 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.
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.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
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).

Order / Ordre :

The licensee shall complete, submit and implement a corrective action plan to include the following:

1) retrain all registered nursing staff and management regarding reporting requirements for an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
2) develop a monitoring process to ensure that all incidents that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital are reported as per the requirements.

This corrective action plan is to be submitted via email to OttawaSAO.MOH@ontario.ca attention Lynda Brown by December 21, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of a medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

A critical incident report (CIR) was received on a specified date for a medication incident that occurred approximately two months earlier. The CIR indicated Resident #001 was sent to hospital as a result of a medication incident. The home submitted the CIR on the direction of the Inspector at the time of the inspection, over two months after the incident occurred.

The licensee was issued on-going non-compliance under O.Reg. 79/10, s.107(3)on Nov.12, 2012 during inspection #2012_031194_0057, on April 29, 2014 during inspection #2014_195166_0012, on July 8, 2014 during inspection #2014_365194_0007,on Dec.8, 2014 during inspection # 2014_195166_0033, and on July 9, 2015 during inspection #2015_291552_0019 and was issued a compliance order as a result. [s. 107. (3)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

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

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to include the following:
1. Review and revise the home's current process and policy regarding the use of NItro-Dur patches to ensure safe removal of all patches is completed as ordered by the prescriber.
2. Retrain all Nursing staff on the home's policy and/or process for medication incidents and adverse drug reactions, specifically related to narcotic use and Nitro-Dur patches to ensure all nursing staff are aware of their responsibility to same.
3. Review any future medication incidents and adverse drug reactions to ensure that appropriate actions are taken including re-training all nursing staff involved in the incidents.
4. Develop a monitoring process to ensure compliance by the nursing staff to the above, including who will be responsible for each action and expected date of completion.

The corrective action plan is to be submitted to Lynda Brown, LTCH Inspector (Nursing) via email to OttawaSAO.MOH@ontario.ca by Janaury 15, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; and corrective action

was taken as necessary; and a written record was kept in response to medication incidents involving Resident #001.

The SDM of Resident #001 reported to the Inspector that in a specified month, the resident was sent to hospital due to an adverse drug reaction. The SDM reported that approximately one month later, a second medication incident occurred but with a different medication. The SDM indicated a third medication incident occurred the following month with the same medication as the second incident. The SDM indicated the last incident was reported directly to the RCC.

Review of the progress notes, physician orders, and medication administration records (MARS) for Resident #001 indicated:
-the first medication incident occurred on a specified date when the physician ordered an increase to a narcotic analgesic and a second narcotic analgesic as needed for breakthrough pain. The resident was given the breakthrough narcotic analgesic for pain and began having a change in condition. Approximately five hours later,the resident received a second dose of the narcotic analgesic for breakthrough pain and shortly after, the resident began having a serious change in condition. The physician was notified of the serious change in condition and ordered the increased narcotic analgesic be discontinued. The resident's condition continued to deteriorate and was sent to hospital for assessment and treatment of a adverse drug reaction.
- the physician ordered a transdermal cardiac medication to be applied in the morning and removed at bedtime. The second medication incident occurred approximately three weeks after the first medication incident involving the transdermal cardiac medication. The resident had no adverse reactions, and the incident was reported to SDM and physician.
-there was no documented evidence of the third medication incident involving the transdermal cardiac medication in the progress notes that occurred approximately one month after the second medication incident The resident had no adverse reactions.

Review of the Medication Administration Records (MAR) during the same three month period (related to the transdermal cardiac medication) indicated: the first medication incident was recorded on the MAR to refer to progress notes. The second medication incident had no indication that there was a medication incident despite it being reported to the nurse and the RCC. The same medication also had several missing entries to indicate where the transdermal cardiac patches were applied, even after the two medication incidents occurred.

Interview of the RCC and the DOC indicated a medication incident report is to be completed after any medication incident to ensure actions are taken to prevent a recurrence. The DOC indicated no medication incident report was completed for the first medication incident where the resident had an adverse condition as a result and required hospitalization because "they never gave the wrong medication". The DOC indicated a medication incident report was completed for the second medication incident involving a transdermal cardiac medication and staff involved received re-training. They both indicated there was no Medication Incident Report completed for the second transdermal cardiac medication incident that occurred approximately one month later, despite the same staff member being involved in the first transdermal cardiac medication incident.

Therefore, two out of the three medication incidents and/or adverse drug reactions were not documented, and all three of the medication incidents were not reviewed and analyzed, and no other corrective actions were taken other than retraining of two registered nursing staff after the first cardiac medication incident. [s. 135. (2)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 12, 2016

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 7th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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