Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 20, 23, 2011 and June 21, 22, 2011 JL	2011_054133_0003	Complaint

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6

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

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, a Registered Nurse, a Registered Practical Nurse, ten (10) Personal Support Workers, a laundry services staff person, three (3)residents and a resident's visitor.

During the course of the inspection, the inspector(s) conducted a walk-through of all resident home areas and various common areas, observed residents, observed lifting slings, observed the portable ceiling lift units and reviewed documentation related to the ceiling lift units and the lifting slings.

The following Inspection Protocols were used in part or in whole during this inspection:

Accommodation Services - Maintenance

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 15. Accommodation services

Specifically failed to comply with the following subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 sayants :

1. For ceiling lifts the home has BHM Medical Inc "KWIKtraks" installed in 14 of 24 resident's bedrooms. The home has BHM Medical V3 portable track lifts for use on the KWIKtraks. There are 4 V3 units designated for use during the day shift (D1-4) and 4 V3 units designated for use on the evening shift (E1-4).

The V3 portable lift units are not maintained in a good state of repair. There are widespread reports of the lift units failing while residents are being transferred. The failure is related to a lack of battery power.

During the inspection, on June 20th at 1pm, a lift unit failed while staff were attempting to transfer a resident. At 3:30pm, another lift unit failed while staff were attempting to transfer a different resident.

A resident reported to the inspector that on June 18th they were being transferred from their bed and the lift unit stopped working. The resident reported that staff went and got 2 or 3 more units and they also would not work. The resident indicated that the portable lift units fail regularly.

A PSW reported to the inspector that the last time she had experienced the failure of one of the V3 portable lift units was when she was attempting to transfer a resident on June 18th. The PSW reported that the lift brought the resident up to a sitting position but then wouldn't work any further.

Another PSW reported to the inspector that the last time she had experienced the failure of one of the V3 portable lift units was on June 16th when she was attempting to transfer a resident.

Another PSW reported to the inspector that the last time she had experienced the failure of one of the V3 portable lift units was on June 19th when she was attempting to transfer a resident. The unit failed as the PSW was lifting the resident up from their chair.

A resident's visitor reported to the inspector that they have witnessed the failure of a lift unit while a transfer is occurring on many occasions. This person stated that the most recent example occurred on June 19th when the resident they were visiting was being transferred. This person reports that staff were able to begin the lifting process but then the unit started beeping and stopped working. This person also noted that a red light was illuminated on the unit. The red light indicates the unit needs service.

When the inspector arrived at the home on June 20th, the home's Environmental Services Manager (ESM) demonstrated the use of a V3 portable lift unit (unit D1). This unit was on a cart in the North hallway and had been used by staff that morning. When the ESM began to work the unit, it was noted that the red service light was illuminated and also that the lift strap was frayed at the edges. The ESM removed the unit from service and replaced the strap. On June 21st, the inspector noted that the strap in the E2 unit was frayed at the edges and was also missing the hand control device. The ESM and the Director of Care were notified. The ESM informed the inspector that there is no process in place requiring staff to remove a lift unit from service when the red service light is illuminated.

2. .

When the portable V3 units stop working or staff note they are beeping which indicates that the battery is low, the units are brought to a charging station which has been set up in the vestibule of the North office. There are four chargers set up. On June 21st, when the Director of Care (DOC) and the inspector were looking at the units that were charging, the DOC's hand grazed the charger cord for charger #4 that was plugged into one of the lift units. This caused the yellow charger indicator light to turn off. When the DOC manipulated the cord, it was noted that the light came on and off depending on how the cord was held. When the charging indicator light is off, it is to be assumed that the unit that was plugged in is fully charged. Staff interviewed by the inspector indicate that the units they take off the chargers do not always work, despite the fact that the charging indicator light is off. The ESM removed charger #4 from service.

On June 20th, the inspector found a blue and white BHM "quick-fit" sling on a Broda chair in the West hallway on which the stitching along a small area which interfaces the padded leg area and the top of the sling has come undone. Also, stitching throughout the padded leg area is loose and the actual padding beneath the mesh is cracked and worn. The inspector also found a green Liko Hygiensele Maxlast sling hanging in the vestibule of the North office on which the side material is heavily frayed and some of the stitching holding one of the main straps together has come undone. Both slings were brought to the DOC who removed them from service.

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. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits sayants :

1. In the BHM Medical Inc Operating Manual for the V3 Portable Ceiling Lift System (Mar 2005 (rev.3, #001.16000) given to the inspector by the Environmental Services Manager (ESM), it is indicated on page 11 "To prolong the batteries life, plug the charger to the lift whenever the lift is not in use. The batteries will not overcharge if left in the charger". On the same page it is indicated that the V3 unit batteries should not be completely drained before recharge. Finally, it is written "Connect the charger to the lift when the lift is not in use. At minimum, charge the batteries until the light is yellow before using the lift again. This will extend the life of the batteries." The process in place at Hilltop Manor is such that staff use the V3 units until the unit starts beeping which indicates it requires charging. Then staff bring the units to the vestibule of North office where a charging center has been set up. It is expected that the units charge for 12 hours before they are used again. This process is not in line with the manufacturer specifications which require the V3 unit be connected to the charger when the lift is not in use.

In the same user manual referenced above, on page 43, a warning statement reads "Do not attempt to open the V3 portable. Only a certified technician is authorized to open this lift. Alterations made to the V3 portable by someone other than a certified technician may cause serious injury". The home's ESM opens the V3 portable units. He is not a certified technician and there is no records maintained of the work that the ESM has done on the portable lift units.

In the same user manual referenced above, on page 41 in the strap inspection section, it is noted "If the strap is damaged and shows signs of wear, the acceptable load before rupture can drop rapidly and can endanger the patient of the caregiver. BHM Medical recommends thoroughly inspecting the strap every two (2) months". The Home's ESM indicates that he inspects the straps when the red wrench symbol illuminates on a V3 unit, which indicates the lift unit needs service. The units are set to indicate they require service every 4500 ft of lifting. On June 21st, the inspector noted that the strap attached to the E2 unit is showing signs of side wear. The ESM and Director of Care (DOC)were advised. As well, when the inspector first arrived at the home on June 20th, the ESM showed the inspector how to use one of the lift units (D1) and when he began to demonstrate the process it was noted that the unit's strap was showing signs of side wear and that the red wrench symbol was illuminated. This unit had been in use in the North hallway and the ESM removed it from service.

2. .

In the BHM Medical Inc "Sling application guide" (#001.03680 REV.5) provided to the inspector by the DOC, on page 3, it is noted that "A documented monthly inspection program should be established to formally inspect all slings to ensure the safest possible transfer of a client". Following discussion with nursing staff and the DOC, it is noted that there is no formal sling inspection program in place at Hilltop Manor.

3. .

In the guide referenced above, on page 4, the process to conduct a visual inspection of a sling is detailed. Point #3 states "Check the stitching of the entire sling, looking for any fraying or loose stitching". Following the 7 inspection points, it is written "failure to pass your inspection in any one of the above areas, demands for safety reasons you remove the sling from service". Following discussion with a laundry services staff person and the ESM, it is noted that there is an informal process in place whereby if that laundry services staff person notices fraying or loose stitching on a sling, she will bring the sling home and repair it. This is not in keeping with the manufacturer specifications to remove the sling from service when such a thing is detected. There is no record of which slings have been repaired in this way.

On June 20th, the inspector found a blue and white BHM "quick-fit" sling on a Broda chair in the West hallway on which the stitching along a small area which interfaces the padded leg area and the top of the sling has come undone. Also, stitching throughout the padded leg area is loose and the actual padding beneath the mesh is cracked and worn. The inspector also found a green Liko Hygiensele Maxlast sling hanging in the vestibule of the North office on which the side material is heavily frayed and some of the stitching holding one of the main straps together has come undone. Both slings were brought to the DOC who removed them from service.

Additional Required Actions:

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

Issued on this 24th day of June, 2011

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

Jessica Lapensée

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2011_054133_0003
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jun 20, 23, 2011 and June 21, 22, 2011 JL
Licensee / Titulaire de permis :	HILLTOP MANOR NURSING HOME LIMITED 82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6
LTC Home / Foyer de SLD :	HILLTOP MANOR NURSING HOME LIMITED 1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER CRATE

To HILLTOP MANOR NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee must ensure that all V3 portable lift units, all portable lift unit battery charging systems, all lifting slings and all other mechanical lifts and lift accessories in use at the home are maintained in a safe condition and in a good state of repair.

Grounds / Motifs :

1.
For ceiling lifts the home has BHM Medical Inc "KWIKtraks" installed in 14 of 24 resident's bedrooms. The home has BHM Medical V3 portable track lifts for use on the KWIKtraks. There are 4 V3 units designated for use during the day shift (D1-4) and 4 V3 units designated for use on the evening shift (E1-4).

The V3 portable lift units are not maintained in a good state of repair. There are widespread reports of the lift units failing while residents are being transferred. The failure is related to a lack of battery power.

During the inspection, on June 20th at 1pm, a lift unit failed while staff were attempting to transfer a resident. At 3:30pm, another lift unit failed while staff were attempting to transfer a different resident.

A resident reported to the inspector that on June 18th they were being transferred from their bed and the lift unit stopped working. The resident reported that staff went and got 2 or 3 more units and they also would not work. The resident indicated that the portable lift units fail regularly.

A PSW reported to the inspector that the last time she had experienced the failure of one of the V3 portable lift units was when she was attempting to transfer a resident on June 18th. The PSW reported that the lift brought the resident up to a sitting position but then wouldn't work any further.

Another PSW reported to the inspector that the last time she had experienced the failure of one of the V3 portable lift units was on June 16th when she was attempting to transfer a resident.

Another PSW reported to the inspector that the last time she had experienced the failure of one of the V3 portable lift units was on June 19th when she was attempting to transfer a resident. The unit failed as the PSW was lifting the resident up from their chair.

A resident's visitor reported to the inspector that they have witnessed the failure of a lift unit while a transfer is occurring on many occasions. This person stated that the most recent example occurred on June 19th when the resident they were visiting was being transferred. This person reports that staff were able to begin the lifting process but then the unit started beeping and stopped working. This person also noted that a red light was illuminated on the unit. The red light indicates the unit needs service.

When the inspector arrived at the home on June 20th, the home's Environmental Services Manager (ESM) demonstrated the use of a V3 portable lift unit (unit D1). This unit was on a cart in the North hallway and had been used by staff that morning. When the ESM began to work the unit, it was noted that the red service light was illuminated and also that the lift strap was frayed at the edges. The ESM removed the unit from service and replaced the strap. On June 21st, the inspector noted that the strap in the E2 unit was frayed at the edges and was also missing the hand control device. The ESM and the Director of Care were notified. The ESM informed the inspector that there is no process in place requiring staff to remove a lift unit from service when the red service light is illuminated.

(133)
2. When the portable V3 units stop working or staff note they are beeping which indicates that the battery is low, the units are brought to a charging station which has been set up in the vestibule of the North office. There are four chargers set up. On June 21st, when the Director of Care (DOC) and the inspector were looking at the units that were charging, the DOC's hand grazed the charger cord for charger #4 that was plugged into one of the lift units. This caused the yellow charger indicator light to turn off. When the DOC manipulated the cord, it was noted that the light came on and off depending on how the cord was held. When the charging indicator light is off, it is to be assumed that the unit that was plugged in is fully charged. Staff interviewed by the inspector indicate that the units they take off the chargers do not always work, despite the fact that the charging indicator light is off. The ESM removed charger #4 from service.

On June 20th, the inspector found a found a blue and white BHM "quick-fit" sling on a Broda chair in the West hallway on which the stitching along a small area which interfaces the padded leg area and the top of the sling has come undone. Also, stitching throughout the padded leg area is loose and the actual padding beneath the mesh is cracked and worn. The inspector also found a green Liko Hygiensele Maxlast sling hanging in the vestibule of the North office on which the side material is heavily frayed and some of the stitching holding one of the main straps together has come undone. Both slings were brought to the DOC who removed them from service.

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

(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 27, 2011

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must ensure that all manufacturer specifications are followed in the maintenance of the V3 portable lift units, of the lifting slings and of all other mechanical lifts and lift accessories in use at the home.

Grounds / Motifs :

1. In the BHM Medical Inc Operating Manual for the V3 Portable Ceiling Lift System (Mar 2005 (rev.3, #001.16000) given to the inspector by the Environmental Services Manager (ESM), it is indicated on page 11 "To prolong the batteries life, plug the charger to the lift whenever the lift is not in use. The batteries will not overcharge if left in the charger". On the same page it is indicated that the V3 unit batteries should not be completely drained before recharge. Finally, it is written "Connect the charger to the lift when the lift is not in use. At minimum, charge the batteries until the light is yellow before using the lift again. This will extend the life of the batteries." The process in place at Hilltop Manor is such that staff use the V3 units until the unit starts beeping which indicates it requires charging. Then staff bring the units to the vestibule of North office where a charging center has been set up. Here, there is space to charge 4 V3 units at a time. It is expected that the units charge for 12 hours before they are used again. This process is not in line with the manufacturer specifications which require the V3 unit be connected to the charger when the lift is not in use.

In the same user manual referenced above, on page 43, a warning statement reads "Do not attempt to open the V3 portable. Only a certified technician is authorized to open this lift. Alterations made to the V3 portable by someone other than a certified technician may cause serious injury". The home's ESM opens the V3 portable

units. He is not a certified technician and there is no records maintained of the work that the ESM has done on the portable lift units.

In the same user manual referenced above, on page 41 in the strap inspection section, it is noted "If the strap is damaged and shows signs of wear, the acceptable load before rupture can drop rapidly and can endanger the patient of the caregiver. BHM Medical recommends thoroughly inspecting the strap every two (2) months". The Home's ESM indicates that he inspects the straps when the red wrench symbol illuminates on a V3 unit, which indicates the lift unit needs service. The units are set to indicate they require service every 4500 ft of lifting. On June 21st, the inspector noted that the strap attached to the E2 unit is showing signs of side wear. The ESM and Director of Care (DOC)were advised. As well, when the inspector first arrived at the home on June 20th, the ESM showed the inspector how to use one of the lift units (D1) and when he began to demonstrate the process it was noted that the unit's strap was showing signs of side wear and that the red wrench symbol was illuminated. This unit had been in use in the North hallway and the ESM removed it from service.

(133)

2. In the BHM Medical Inc "Sling application guide" (#001.03680 REV.5) provided to the inspector by the DOC, on page 3, it is noted that "A documented monthly inspection program should be established to formally inspect all slings to ensure the safest possible transfer of a client". Following discussion with nursing staff and the DOC, it is noted that there is no formal sling inspection program in place at Hilltop Manor.

In the guide referenced above, on page 4, the process to conduct a visual inspection of a sling is detailed. Point #3 states "Check the stitching of the entire sling, looking for any fraying or loose stitching". Following the 7 inspection points, it is written "failure to pass your inspection in any one of the above areas, demands for safety reasons you remove the sling from service". Following discussion with a laundry services staff person and the ESM, it is noted that there is an informal process in place whereby if that laundry services staff person notices fraying or loose stitching on a sling, she will bring the sling home and repair it. This is not in keeping with the manufacturer specifications to remove the sling from service when such a thing is detected. There is no record of which slings have been repaired in this way.

(133)

3.

On June 20th, the inspector found a found a blue and white BHM "quick-fit" sling on a Broda chair in the West hallway on which the stitching along a small area which interfaces the padded leg area and the top of the sling has come undone. Also, stitching throughout the padded leg area is loose and the actual padding beneath the mesh is cracked and worn. The inspector also found a green Liko Hygiensele Maxlast sling hanging in the vestibule of the North office on which the side material is heavily frayed and some of the stitching holding one of the main straps together has come undone. Both slings were brought to the DOC who removed them from service.

(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 27, 2011

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

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

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 Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 24th day of June, 2011

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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