Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 6, 2015	2015_376594_0015	S-000445-14	Complaint

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road Box 179 Wawa ON P0S 1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

MONIKA GRAY (594)

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): June 01 - 04, 2015

This inspection was conducted concurrently with Follow Up Inspection 2015_376594_0014 and Critical Incident System Inspection 2015_376594_0016.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPNs)and the Director of Patient Care Services and Nursing (DOPCSN).

The inspector (s) also reviewed polices, plans of care and other documentation within the home, conducted daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
5 VPC(s)
1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident when administering a medication.

In a complaint received by the Director, it was stated resident #002 had been administered the incorrect dose of a medication resulting in a fall in 2014, when being administered a medication to manage behaviours.

In an interview with the inspector, S #101 stated they administered a medication to resident #002 in 2014 to manage the resident's responsive behaviours.

The inspector reviewed resident #002’s 2014 Medication Administration Records (MARs) and identified a medication order. The inspector observed two other Medication Reviews for resident #002, and identified the medication order documented different dosages.

The inspector interviewed the DOPCSN who stated that upon review, it was observed that in one month in 2014 the order was transcribed on the MAR, however it was not transcribed in the following month's MAR. The DOPCSN further stated to the inspector that the expectation was that the night shift nurse double check orders between the Medication Review and the MAR. The DOPCSN stated the correction had been missed over several months on a daily basis. [s. 6. (1) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of resident was complied with.

The inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy #VII-41 last reviewed July 19, 2012, which stated: A) policy evaluation is conducted annually; B) that The Lady Dunn Health Centre was committed to providing a safe and healthy environment for all residents and visitors and that it recognizes the value and dignity of each resident; and C) that Mandatory Reporting under the LTCHA section 24.(1) requires certain persons, including the Lady Dunn Health Centre and certain staff members, to make immediate reports to the Director where there is reasonable suspicion that certain incidents occurred or may occur.

A) In an interview with the inspector, the DOPCSN stated that the home's policy #VII-41, titled "Zero Tolerance of Abuse and Neglect" was last reviewed on July 19, 2012 and had not been reviewed annually.

B) In a complaint received by the Director, it was stated that the complainant witnessed verbal abuse and improper care to resident #002 by S #101 in 2013. The complainant stated they observed S #101 standing at the resident's doorway because the resident had activated the call bell and that S #101 stood at the door for at least 30 to 60 seconds. S #101 stated to the resident that they were not going into the room because they were not the only resident there.

The inspector reviewed S #101's personnel file.

When discussing an incident that occurred in 2014 with the inspector, the DOPCSN stated the resident felt disrespected as this was their home and that S #101 overstepped their boundary.

C) According to the complainant they submitted a verbal complaint to the licensee in August 2013.

The inspector reviewed reports submitted to the Director by the licensee, and failed to identify any report submitted regarding verbal abuse or improper care.

During an interview with inspector, the DOPCSN stated that on their first day in the

position families approached them and brought forward complaints, including the complainant indicated above. The DOPCSN stated to the inspector, that initially they did not feel that there was abuse and because the investigation was conducted internally there was nothing definitive to submit in a report to the Director. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with; in that the policy is evaluated annually, that anyone is to immediately report the suspicion and the information upon which it is based to the Director of any improper or incompetent care of a resident or any alleged or witness abuse of a resident; and to ensure that S #101 treats all residents with courtesy, respect and dignity, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm; or abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

In a complaint received by the Director, it was stated the complainant witnessed verbal abuse and improper care to resident #002 by S #101 in 2013. The complainant stated to the inspector that S #101 refused to provide a specific aspect of the resident's care.

The inspector reviewed reports submitted to the Director by the licensee, and failed to identify any report submitted regarding the above incident of verbal abuse or improper care.

During an interview with inspector, the DOPCSN stated that on their first day in the position families approached them and brought forward complaints, including the complainant of resident #002. The DOPCSN stated to the inspector, that initially they did not feel that there was abuse and because the investigation was conducted internally there was nothing definitive to submit in a report to the Director.

Review of the home's Zero Tolerance of Abuse and Neglect policy #VII-41 stated that Mandatory Reporting under the LTCHA section 24.(1) requires certain persons, including the Lady Dunn Health Centre and certain staff members, to make immediate reports to the MOH<C Director where there is reasonable suspicion that certain incidents occurred or may occur. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes communication of the seven-day menus to residents.

On June 03, 2015, the inspector observed the daily menu posted outside the dining room but did not observe the seven-day menu. The DOPSCN acknowledged to the inspector that the seven-day menus were not posted for residents. [s. 73. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the communication of the seven-day dining and snack service menus to residents, to be implemented voluntarily.

WN #5: 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 missing or unaccounted for controlled substance.

In a complaint received by the Director, it was stated that resident #002 had been administered the incorrect dose of a controlled substance resulting in a fall in 2014. The medication was being administered to manage the resident's behaviours.

The inspector requested the daily count sheets for controlled substances for a month in 2014, prior to the fall. The DOPCSN provided the inspector with narcotic daily counts for the month in 2014 and benzodiazepines daily counts initiated after the fall in 2014.

In an interview with the inspector, the DOPCSN and S #105 stated that prior to when the fall occurred in 2014, benzodiazepines were not treated as a locked narcotic and no daily counts were being completed. During that same interview, the DOPCSN stated that during a meeting with S #101, they alluded to other staff not documenting the administration of a control substance. The DOPCSN stated that they conducted a review of the administration of a controlled substance specific to resident #002, and were unable to account for sixteen tablets. They also stated that they did not notify the Director of the unaccounted for controlled substance and were unaware that they were required to do so. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed no later than one business day after the occurrence of a missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double – locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

In a complaint received by the Director, it was stated resident #002 had been administered the incorrect dose of a medication resulting in a fall in 2014 and being administered a medication to manage behaviours.

The inspector requested the daily count sheets for controlled substances for a month in 2014, prior to the fall. The DOPCSN provided the inspector with narcotic daily counts for the month in 2014 and benzodiazepines daily counts initiated after the fall in 2014. In an interview with the inspector the DOPCSN and S #105 stated that prior to the fall, benzodiazepines were not treated as a locked narcotic; the benzodiazepines would sit on an open shelf in the locked medication room. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. During a tour of the home, the inspector observed the Licensee copy of the Resident Quality Inspection Report 2014_339579_0013 posted on a board outside of the dining area.

Upon review of the report, the inspector identified personal health information of a resident.

Given that the licensee copy of the inspection report, which contained personal health information of a resident making them identifiable was posted in a public area, the licensee failed to ensure confidentiality in accordance with the Personal Health Information Protection Act, 2004. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and situations what may lead to abuse and neglect and how to avoid such situations.

The licensee reviewed the home's Zero Tolerance of Abuse and Neglect policy #VII-41 reviewed date of July 19, 2012, which stated staff training and education will include:
Policy and procedures for Zero tolerance of Abuse and Neglect
Policy and procedures on reporting and whistle-blowing protection against retaliation
Policy and procedures for managing complaints
Policy and procedures for minimizing restraining and use of PASDs
Elder Abuse Prevention Strategies and Educational Tools

The policy failed to identify training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and situations what may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including that a monthly audit be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies were discovered.

The inspector requested the daily count sheets for controlled substances for a month in 2014. The DOPCSN provided the inspector with narcotic daily counts for the month in 2014 and benzodiazepines daily counts initiated on July 20, 2014.

In an interview with the inspector, the DOPCSN and S #105 stated that prior to when the fall occurred in 2014, benzodiazepines were not treated as a locked narcotic and no daily counts were being completed. During that same interview, the DOPCSN stated that during a meeting with S #101, they alluded to other staff not documenting the administration of a control substance. The DOPCSN stated that they conducted a review of the administration of a controlled substance specific to resident #002, and were unable to account for sixteen tablets. [s. 130. 3.]

Issued on this 28th day of October, 2015

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

Original report signed by the inspector.

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) :	MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2015_376594_0015
Log No. / Registre no:	S-000445-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 6, 2015
Licensee / Titulaire de permis :	LADY DUNN HEALTH CENTRE 17 Government Road, Box 179, Wawa, ON, P0S-1K0
LTC Home / Foyer de SLD :	LADY DUNN HEALTH CENTRE 17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SALLY GARLAND

To LADY DUNN HEALTH CENTRE, 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. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for resident #002 and for every other resident, that sets out clear medication administration directions to staff and others who provide direct care to the resident

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident when administering a medication.

In a complaint received by the Director, it was stated resident #002 had been administered the incorrect dose of a medication resulting in a fall in 2014, when being administered a medication to manage behaviours.

In an interview with the inspector, S #101 stated they administered a medication to resident #002 in 2014 to manage the resident's responsive behaviours.

The inspector reviewed resident #002's 2014 Medication Administration Records (MARs) and identified a medication order. The inspector observed two other Medication Reviews for resident #002, and identified the medication order documented different dosages.

The inspector interviewed the DOPCSN who stated that upon review, it was observed that in one month in 2014 the order was transcribed on the MAR, however it was not transcribed in the following month's MAR. The DOPCSN further stated to the inspector that the expectation was that the night shift nurse double check orders between the Medication Review and the MAR. The DOPCSN stated the correction had been missed over several months on a daily basis. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 16, 2015

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.

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

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 6th day of October, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Monika Gray

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