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
Jun 22, 2015	2015_190159_0014	H-002678-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE OAKVILLE ON L6H 7A2

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 10, 11, 12, 2015

During the course of this inspection, the inspector observed meal service in one home area, reviewed relevant resident clinical records, interviewed staff and residents.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Registered staff, Registered Dietitian, Corporate Registered Dietitian, Personal Support Workers (PSWs)and residents.

The following Inspection Protocols were used during this inspection:
Dining Observation
Nutrition and Hydration

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

4 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the rights of residents including resident #001 were

respected and promoted when resident #001 was not cared for in a manner consistent with their needs.

The clinical record indicated that on a specified date in March 2015, the Nurse Practitioner assessed the resident and wrote an order for resident to be sent to the hospital [redacted]. The hospital notes indicated the attending physician in the hospital was to arrange for a swallowing assessment by Speech and Language Pathologist (SLP). The resident remained in hospital until specified date in March 2015, when resident was re-admitted to the home.

In March, 2015, on a specified date the resident returned from the hospital with an order for SLP swallowing assessment. The hospital SLP had suggested that the resident was discharged home before the SLP was able to assess resident for swallowing difficulties. The SLP had suggested that the Community Care Access Centre (CCAC) SLP to assess resident for swallowing.

March 2015, the interdisciplinary progress notes documented indicated that the resident was seen by the Nurse Practitioner (NP). The documented notes had stated that in hospital the SLP had suggested swallowing assessment upon discharge home, dietitian to see the resident.

March 2015, the progress notes and the Director of Care interview confirmed a dietary referral was sent to Registered Dietitian for the resident to be assessed for swallowing. However, no documentation was found that the resident was assessed by RD or SLP.

On a specified date in March 2015, the attending physician wrote an order for the resident to have SLP swallowing assessment as per hospital SLP order. Clinical record and the staff interview confirmed there was no referral made to CCAC for SLP swallowing assessment.

April, 2015, the progress notes documented identified the Registered Nurse had asked the RD regarding resident's re-assessment before SLP referral. Another referral was done for the RD to conduct swallowing assessment. The progress notes indicated the resident was experiencing difficulty swallowing minced texture food. The clinical record indicated that the resident had on going swallowing problem. However, there was no documentation to support that swallowing assessment was conducted, interventions to address the issue, including nutrition assessment by RD was done.
It was confirmed by the DOC that the resident's care needs changed during this identified

period, however, the resident was not provided the care consistent to their needs.

April 2015, the nutrition care notes documented by RD stated " follow-up swallowing assessment from SLP hospital in March 2015 and SLP recommendations; SLP assessment not required at this time." The directions were given to provide resident a regular diet, minced texture and nectar consistency thickened fluids, continue with current interventions.

During the interview the RD admitted that she did over-ride doctors' and hospital SLP orders and did not review the hospital discharged notes. The clinical record and the hospital discharged notes confirmed that the resident did not have swallowing assessment by SLP during the hospitalization in March 2015.

The progress documented June 2015, identified resident was provided supper meal in their room and fed by a Personal Support Worker (PSW). The PSW noted resident gurgling after finishing feeding the meal. The resident was suctioned, compression was applied and 911 were called. The paramedics came and followed [redacted] instructions. [redacted]

PHI to [illegible] 15.1.5

On June 12, 2015, interview with the RD and the DOC confirmed that the referral for SLP ordered by the attending physician and the hospital SLP was not made to CCAC SLP. It was further confirmed that the resident did not receive the care and the identified swallowing assessment was not conducted for the resident. [s. 3. (1) 4.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the residents' care set out in the plan of care , including resident #001's and #002's was provided to the residents as specified in the plan.

(A) Resident #001's written plan of care had identified the resident was experiencing swallowing difficulty, increased coughing, spluttering and throat cleaning and required SLP swallowing assessment.

On a specified date in March 2015, resident returned from the hospital with an order for SLP swallowing assessment. On a specified date in March 2015, the Nurse Practitioner assessed the resident and wrote an order for swallowing assessment by SLP and the resident to be seen by RD. The RN made another referral to RD for assessment.

On a specified date in March 2015, the attending physician wrote an order for swallowing assessment by SLP. Review of clinical record indicated physicians and the hospital SLP order for swallowing assessment were not followed; and the referral was not made to CCAC for SLP swallowing assessment.
Resident did not have swallowing assessment by SLP as specified in the written plan of care.

PHI removed

It was confirmed by the Director of Care and the RD that the physicians' orders for swallowing assessment were not followed and the resident did not have swallowing assessment by SLP.

(B) The written plan of care for resident #002, developed by Registered Dietitian in November 2013, indicated the resident to be positioned at 90 degree angle when eating, tuck a pillow on their back if needed to ensure upright position. Staff to adjust tilt chair so chin is level/slightly tucked to ensure upright position. The care plan had identified resident had chewing and swallowing difficulty due to impaired cognition.

On June 10, 2015, at the lunch meal resident #002 was observed being fed by a care giver. Resident in tilt chair was observed to be not safely positioned, had their head tilted back with their chin pointed towards the ceiling while being fed, creating a risk for choking. Registered staff confirmed the resident was not safely positioned during the meal and the resident was repositioned after the MOH inspector intervened.

It was confirmed by the DOC that the care giver did not provide care to the resident as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a Registered Dietitian (RD) who is a member of the staff of the home assessed resident #002 hydration status and any risk related to hydration.

The progress notes documented in March 2015, indicated a dietary referral was made to the registered dietitian. The documented reason for the referral was "resident has not met their daily recommended fluid requirement for a specified period in March 2015."

On April 4, 2015, the registered dietitian documented in progress notes quarterly Nutrition/Hydration assessment was completed. The RD notes stated no change had been made to diet type, texture or fluid consistency and would be follow-up by RD/Nutrition Manager as needed. Resident's nutrition status at that time was at high Nutritional/Hydration Risk. However, the RD did not assess hydration status of the resident and did not address the hydration issue identified in the referral.

Clinical record (including Minimum Data Set (MDS) quarterly assessments, progress notes, care plan) and staff interviews confirmed the RD did not assess resident's hydration status. Review of electronic food and fluid intake record (Point of Care) confirmed resident did not meet the recommended daily fluid requirement on several consecutive days in April, 2015 and May 2015. The progress notes documented confirmed six dietary referrals were made to the RD for re-assessment of resident's hydration status. Examples: Referrals were made on April 15, 2015, April 22, 2015, May 3, 2015, May 6, 2015, May 17, 2015 and May 21, 2015.
The Director of Care and the RD validated that the resident did not have an interdisciplinary hydration assessment and interventions/strategies were not initiate to address resident's hydration concerns. [s. 26. (4) (a),s. 26. (4) (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 ensuring that a registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4)., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that all food and fluids prepared, stored, and served using methods which prevent adulteration, contamination and food borne illness.
On June 10, 2015, lunch meal service was observed in the Sumner House dining room. It was observed a care giver feeding resident #002 was blowing over resident's food (to cool) and feeding the same food, thus creating risk for food contamination and food borne illness. The MOH Inspector intervened and spoke with staff and the registered nurse. [s. 72. (3) (b)]

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

Issued on this 22nd day of June, 2015

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

Original report signed by the inspector.

report revised for the purpose of publication [illegible] July 15/15

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) :	ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2015_190159_0014
Log No. / Registre no:	H-002678-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 22, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	NORTHRIDGE 496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Harris

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare and implement a plan to ensure that the rights of residents are fully respected and promoted. To ensure every resident is properly sheltered, fed, clothed, groomed and care for in a manner consistent with his or her needs.

Grounds / Motifs :

1. The licensee did not ensure that the rights of residents including resident #001 were respected and promoted when resident #001 was not cared for in a manner consistent with their needs.

The clinical record indicated that on a specified date in March 2015, the Nurse Practitioner assessed the resident and wrote an order for resident to be sent to the hospital [redacted]

March 2015, the hospital notes indicated the attending physician in the hospital was to arrange for a swallowing assessment by Speech and Language Pathologist (SLP). The resident remained in hospital for a specified period and the resident was re-admitted to the home.

On a specified date in March 2015, the resident returned from the hospital with an order for SLP swallowing assessment. The hospital SLP had suggested that the resident was discharged home before the SLP was able to assess resident for swallowing difficulties. The SLP had suggested that the Community Care Access Centre (CCAC) SLP to assess resident for swallowing.

March 2015, the interdisciplinary progress notes documented indicated that the resident was seen by the Nurse Practitioner (NP). The documented notes had stated that in hospital the SLP had suggested swallowing assessment upon discharge home, dietitian to see the resident.

March 2015, the progress notes and the Director of Care interview confirmed a dietary referral was sent to Registered Dietitian for the resident to be assessed for swallowing. . However, no documentation was found that the resident was assessed by RD or SLP.

In March 2015, the attending physician wrote an order for the resident to have SLP swallowing assessment as per hospital SLP order. Clinical record and the staff interview confirmed there was no referral made to CCAC for SLP swallowing assessment.

April 2015, the progress notes documented identified the Registered Nurse had asked the RD regarding resident's re-assessment before SLP referral. Another referral was done for the RD to conduct swallowing assessment. The progress notes indicated the resident was experiencing difficulty swallowing minced texture food. The clinical record indicated that the resident had on going swallowing problem. However, there was no documentation to support that swallowing assessment was conducted, interventions to address the issue, including nutrition assessment by RD was done.
It was confirmed by the DOC that the resident's care needs changed during this identified period, however, the resident was not provided the care consistent to their needs.

April 2015, the nutrition care notes documented by RD stated " follow-up swallowing assessment from SLP hospital in March 2015 and SLP recommendations; SLP assessment not required at this time." The directions were given to provide resident a regular diet, minced texture and nectar consistency thickened fluids, continue with current interventions.

On June 12, 2015, during the interview the RD admitted that she did over-ride doctors' and hospital SLP orders and did not review the hospital discharged notes. The clinical record and the hospital discharged notes confirmed that the resident did not have swallowing assessment by SLP during the hospitalization in March 2015.

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

The progress documented by RN identified resident was provided supper meal in their room and fed by a Personal Support Worker (PSW). The PSW noted resident gurgling after finishing feeding the meal. The resident was suctioned, compression was applied and 911 were called. The paramedics came and followed instructions.

PHI removed [illegible] 157:5

On June 12, 2015, interview with the RD and the DOC confirmed that the referral for SLP ordered by the attending physician and the hospital SLP was not made to CCAC SLP. It was further confirmed that the resident did not receive the care and the identified swallowing assessment was not conducted for the resident. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall implement a plan to ensure that the care set out in the plan of care is provided to all residents including Resident #002 and ensure all residents receive care as specified in the plan of care.

Previously non compliance was issued as VPC January 19, 2015

Grounds / Motifs :

1. The licensee did not ensure that the residents' care set out in the plan of care , including resident #001's and #002's was provided to the residents as specified in the plan.

(A) Resident #001's written plan of care had identified the resident was experiencing swallowing difficulty, increased coughing, spluttering and throat cleaning and required SLP swallowing assessment.

On a specified date in March, 2015, resident returned from the hospital with an order for SLP swallowing assessment.
On a specified date in March 2015, the Nurse Practitioner assessed the resident and wrote an order for swallowing assessment by SLP and the resident to be seen by RD. The RN made another referral to RD for assessment.

In March 2015, the attending physician wrote an order for swallowing assessment by SLP.
Review of clinical record indicated physicians and the hospital SLP order for swallowing assessment were not followed; and the referral was not made to CCAC for SLP swallowing assessment.

Resident did not have swallowing assessment by SLP as specified in the written plan of care.

PHI removed to Query15711

It was confirmed by the Director of Care and the RD that the physicians' orders for swallowing assessment were not followed and the resident did not have swallowing assessment by SLP.

(B) The written plan of care for resident #002, developed by Registered Dietitian in November 2013 indicated the resident to be positioned at 90 degree angle when eating, tuck a pillow on their back if needed to ensure upright position. Staff to adjust tilt chair so chin is level/slightly tucked to ensure upright position. The care plan had identified resident had chewing and swallowing difficulty due to impaired cognition.

On June 10, 2015, at the lunch meal resident #002 was observed being fed by a care giver. Resident in tilt chair was observed to be not safely positioned, had their head tilted back with their chin pointed towards the ceiling while being fed, creating a risk for choking. Registered staff confirmed the resident was not safely positioned during the meal and the resident was repositioned after the MOH inspector intervened.
It was confirmed by the DOC that the care giver staff did not provide care to the resident as specified in the plan of care.
(159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 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 22nd day of June, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : ASHA SEHGAL

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

report revised for the purpose of publication
July 15/15