Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2013	2013_168202_0020	T-2193-12, T -181-13	Complaint

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

OAK TERRACE
291 MISSISSAGA STREET WEST, ORILLIA, ON, L3V-3B9

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

VALERIE JOHNSTON (202)

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): April 11, 12, 15, 16, 2013 and May 02, 03, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Regional Manager of Education and Resident Services, Registered Nursing Staff, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed educational records related to behaviour management

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

The licensee failed to ensure that written approaches to care are developed to meet the needs of residents with responsive behaviours. [s.53. (1) 1].

Resident #004's plan of care identifies this resident as exhibiting verbal and physical aggression toward residents and staff. A review of resident #004's progress notes revealed 40 documented incidents of physical aggression toward residents and staff in an identified period of time.
Registered staff interviews revealed that written approaches to care, including assessment, reassessment and the identification of behavioural triggers have not been developed to meet the needs of resident #004's responsive behaviours. Staff indicate that resident #004 is unpredictable and the responsive behaviour triggers for resident #004 have not been identified. Resident #004's clinical records indicate that resident #004 was referred to the Behavioural Supports Ontario (BSO) on an identified date in 2013, two months after the onset of identified responsive behaviours, with no documented record of assessment. An interview with the Executive Director revealed that the (BSO) did not receive the referral sent on the identified date in 2013. The home resent the referral, upon inspector noting that there was no follow up to previous referral that had been sent on the identified date in 2013.

Resident #001's plan of care identifies this resident with responsive behaviours which include resistance to care or medications, verbally and physically aggressive. A review of the progress notes for resident #001 for an identified time period revealed 8 documented incidents of physical and verbal aggression toward other residents and staff.
A review of the clinical records for resident #001 revealed that on an identified date in 2013 the Mobile Behavioural Support Team (BSO) assessed resident #001, documented potential triggers and suggested potential interventions for staff to try. The (BSO) held a follow up meeting at the home with 4 direct care staff to discuss the effectiveness of interventions previously suggested. The (BSO) 'Huddle Notes' on an identified date in 2013, revealed documented verbal statements from the 4 staff indicating that resident #001 "is fine" and therefore will be discharged from the program. A review of the progress notes revealed that resident #001 had been physically and verbally aggressive on 3 more occasions while under review of the (BSO). A review of the clinical records revealed no written assessments, reassessments, or effectiveness of suggested interventions for resident #001, which may have prompted further support by the (BSO) while under the program.

Registered staff interviews revealed that they have been directed to document any incident of responsive behaviours within the progress notes. Registered staff indicate that they will use a Behavioural tracking tool to document resident behaviours, however there is no further assessment conducted or other behavioural assessment tools available for use in the home. Direct care staff interviews indicated that staff will respond to any resident to resident, resident to staff altercations by instinct.
An interview with the Director of Care confirmed that the home does not have a responsive behaviour program and will refer residents exhibiting behaviours outside the home. The (DOC) confirmed that registered staff have been directed to refer residents that exhibit responsive behaviours to the Behavioural Supports Ontario, a Mobile Team (BSO). Staff are encouraged to reengage the resident exhibiting responsive behaviours into an activity, document the incident in anecdotal progress notes. Staff may use the mini mental test to determine cognitive functioning of the resident; or document behaviours in a DOS tracking.

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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

Resident #004's plan of care identifies this resident as exhibiting verbal and physical aggression toward residents and staff. A review of resident #004's progress notes for an identified period of time revealed 40 documented incidents of physical aggression toward residents and staff.

Staff indicate that resident #004 is unpredictable and the responsive behaviour triggers for resident #004 have not been identified. Resident #004's clinical records indicated that resident #004 was referred to the Behavioural Supports Ontario (BSO) on an identified date, two months after the onset of identified responsive behaviours, with no record of assessment. Staff interviews revealed that they are to only document responsive behaviour incidents, do hourly checks and be aware of other resident's that upset resident #004. On an identified date in 2013 resident #004 was witnessed hitting resident #005 in the hallway and on a subsequent date, resident #004 was found with co-resident's head in his/her hands and dropped co-resident's head down in a violent manner. Staff interviews and clinical records indicate that there are no further interventions or strategies to minimize risk of altercations or potentially harmful interactions between resident #004, other residents and staff. Staff indicated that they fear what resident #004 will do to other residents and have great concern for resident #004's roommates who are frail and would not be able to defend themselves. Staff revealed that resident's have verbalized their fears of being hurt by resident #004 and have been seen to cower and stop in the hall as resident #004 passes by.

Resident #001's plan of care identifies this resident with responsive behaviours which include resistance to care or medications, verbally and physically aggressive. A review of the progress notes for resident #001 for an identified time period revealed 11 documented incidents of physical and verbal aggression toward other residents and staff.
Direct care staff interviews indicate that they will respond to any resident to resident, resident to staff altercations by instinct. Direct care staff revealed that they have not been provided training in behaviour management, or dealing with aggressive situations. Staff indicated that they will 'wing it' and hope for the best. An interview

with an identified staff member confirmed that he/she attended a one day crisis intervention training in 2013 and indicated that the training would be ineffective in preventing aggression in residents, however he/she felt it was designed to teach staff on 'blocking punches'. Registered staff interviews revealed that with any aggressive incident they are to document the episode, call the physician and/or refer to the Mobile Behavioural Support Unit (BSO).
The Director of Care confirmed in an interview that the home will be embarking on a nonviolent intervention to address responsive behaviours. The DOC indicated that 5 staff have received crisis intervention training and those staff will train other staff in the home. Currently the home will provide on the spot training and registered staff have been directed to reengage the resident exhibiting responsive behaviours into an activity, document the incident or altercations should one occur and document events in anecdotal progress notes.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff are provided annual training in mental health issues, including caring for persons with dementia and behaviour management pursuant to section O.Reg 79/10 s. 221 (2).

Direct care staff interviews revealed that there has been no training on mental health issues or behaviour management. An interview with the Regional Manager of Education and Resident Services (RMERS) revealed that behaviour management training and training in mental health issues is provided to staff within the licensee's 'Person-Centered Care' training program and confirmed that only 46% of staff in the home received this training in 2012. [s. 76. (7) 2.]

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 direct care staff are provided with training in mental health issues, including caring for persons with dementia and behaviour management annually, to be implemented voluntarily.

WN #4: 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 failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

Resident #001's plan of care identifies this resident as having responsive behaviours which include resistance to care or medications, verbally or physically aggressive. A clinical record review for resident #001 revealed that on an identified date in 2013 the Mobile Behavioural Support Team (BSO) assessed and documented interventions to respond to resident #001's responsive behaviours. A review of the written plan of care for resident #001 does not include the suggested interventions and only directs staff to document behaviours when resident #001 becomes angry or agitated. A review of the progress notes for resident #001 revealed 11 documented episodes of responsive behaviours with no documentation to indicate that the interventions suggested by the (BSO) were effective or incorporated into the plan of care. [s. 6. (1) (c)]

WN #5: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of resident #004. [s.26. (3) 5]

Resident #004's plan of care identifies this resident as verbally and physically abusive and will wander. Resident #004's plan of care is not based on an assessment, staff only monitor and document resident #004's responsive behaviours. [s. 26. (3) 5.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there is monitoring and documentation of the resident's response, and effectiveness of the drugs appropriate to the risk level of the drugs. [s.134. (a)]

Resident #004's written plan of care directs registered staff to administer an identified medication by mouth 1 hour prior to care. Clinical record review revealed that resident #004 received the identified medication on four occasions in 2013 with no documentation of resident's response. [s. 134. (a)]

Issued on this 13th day of May, 2013

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2013_168202_0020
Log No. / Registre no:	T-2193-12, T-181-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 7, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	OAK TERRACE 291 MISSISSAGA STREET WEST, ORILLIA, ON, L3V-3B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JUDY PETERSON~~ Roxane Hoyle

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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.
O. Reg. 79/10, s. 53 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
Please submit plan to valerie.johnston@ontario.ca by May 31, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that written approaches to care are developed to meet the needs of residents with responsive behaviours. [s.53. (1) 1].

Resident #004's plan of care identifies this resident as exhibiting verbal and physical aggression toward residents and staff. A review of resident #004's

progress notes revealed 40 documented incidents of physical aggression toward residents and staff in an identified period of time.
Registered staff interviews revealed that written approaches to care, including assessment, reassessment and the identification of behavioural triggers have not been developed to meet the needs of resident #004's responsive behaviours. Staff indicate that resident #004 is unpredictable and the responsive behaviour triggers for resident #004 have not been identified. Resident #004's clinical records indicate that resident #004 was referred to the Behavioural Supports Ontario (BSO) on an identified date in 2013, two months after the onset of identified responsive behaviours, with no documented record of assessment. An interview with the Executive Director revealed that the (BSO) did not receive the referral sent on the identified date in 2013. The home resent the referral, upon inspector noting that there was no follow up to previous referral that had been sent on the identified date in 2013.

Resident #001's plan of care identifies this resident with responsive behaviours which include resistance to care or medications, verbally and physically aggressive. A review of the progress notes for resident #001 for an identified time period revealed 8 documented incidents of physical and verbal aggression toward other residents and staff.
A review of the clinical records for resident #001 revealed that on an identified date in 2013 the Mobile Behavioural Support Team (BSO) assessed resident #001, documented potential triggers and suggested potential interventions for staff to try. The (BSO) held a follow up meeting at the home with 4 direct care staff to discuss the effectiveness of interventions previously suggested. The (BSO) 'Huddle Notes' on an identified date in 2013, revealed documented verbal statements from the 4 staff indicating that resident #001 "is fine" and therefore will be discharged from the program. A review of the progress notes revealed that resident #001 had been physically and verbally aggressive on 3 more occasions while under review of the (BSO). A review of the clinical records revealed no written assessments, reassessments, or effectiveness of suggested interventions for resident #001, which may have prompted further support by the (BSO) while under the program.

Registered staff interviews revealed that they have been directed to document any incident of responsive behaviours within the progress notes. Registered staff indicate that they will use a Behavioural tracking tool to document resident behaviours, however there is no further assessment conducted or other

behavioural assessment tools available for use in the home. Direct care staff interviews indicated that staff will respond to any resident to resident, resident to staff altercations by instinct.
An interview with the Director of Care confirmed that the home does not have a responsive behaviour program and will refer residents exhibiting behaviours outside the home. The (DOC) confirmed that registered staff have been directed to refer residents that exhibit responsive behaviours to the Behavioural Supports Ontario, a Mobile Team (BSO). Staff are encouraged to reengage the resident exhibiting responsive behaviours into an activity, document the incident in anecdotal progress notes. Staff may use the mini mental test to determine cognitive functioning of the resident; or document behaviours in a DOS tracking. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that procedures are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. Please submit plan to valerie.johnston@ontario.ca by May 31, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

Resident #004's plan of care identifies this resident as exhibiting verbal and physical aggression toward residents and staff. A review of resident #004's progress notes for an identified period of time revealed 40 documented incidents of physical aggression toward residents and staff.

Staff indicate that resident #004 is unpredictable and the responsive behaviour triggers for resident #004 have not been identified. Resident #004's clinical records indicated that resident #004 was referred to the Behavioural Supports Ontario (BSO) on an identified date, two months after the onset of identified responsive behaviours, with no record of assessment. Staff interviews revealed that they are to only document responsive behaviour incidents, do hourly checks and be aware of other resident's that upset resident #004. On an identified date in 2013 resident #004 was witnessed hitting resident #005 in the hallway and on a subsequent date, resident #004 was found with co-resident's head in his/her hands and dropped co-resident's head down in a violent manner. Staff interviews and clinical records indicate that there are no further interventions or strategies to minimize risk of altercations or potentially harmful interactions between resident #004, other residents and staff. Staff indicated that they fear what resident #004 will do to other residents and have great concern for resident #004's roommates who are frail and would not be able to defend themselves. Staff revealed that resident's have verbalized their fears of being hurt by resident #004 and have been seen to cower and stop in the hall as resident #004 passes by.

Resident #001's plan of care identifies this resident with responsive behaviours which include resistance to care or medications, verbally and physically aggressive. A review of the progress notes for resident #001 for an identified time period revealed 11 documented incidents of physical and verbal aggression toward other residents and staff.
Direct care staff interviews indicate that they will respond to any resident to resident, resident to staff altercations by instinct. Direct care staff revealed that they have not been provided training in behaviour management, or dealing with aggressive situations. Staff indicated that they will 'wing it' and hope for the best. An interview with an identified staff member confirmed that he/she attended a one day crisis intervention training in 2013 and indicated that the training would be ineffective in preventing aggression in residents, however he/she felt it was designed to teach staff on 'blocking punches'. Registered staff interviews revealed that with any aggressive incident they are to document the episode, call the physician and/or refer to the Mobile Behavioural Support Unit (BSO). The Director of Care confirmed in an interview that the home will be embarking on a nonviolent intervention to address responsive behaviours. The DOC indicated that 5 staff have received crisis intervention training and those staff will train other staff in the home. Currently the home will provide on the spot training

and registered staff have been directed to reengage the resident exhibiting responsive behaviours into an activity, document the incident or altercations should one occur and document events in anecdotal progress notes. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2013

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.

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

Ministère 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 7th day of May, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

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