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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 10, 2018;	2018_689586_0018 (A1)	014993-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Telfer Place
245 Grand River Street North PARIS ON N3L 3V8

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

Amended by JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié
Extension of compliance due date as requested by the home.

Issued on this 10 day of August 2018 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 10, 2018;	2018_689586_0018 (A1)	014993-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Telfer Place
245 Grand River Street North PARIS ON N3L 3V8

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

Amended by JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 11, 12, 13, 16, 17, 18 and 19, 2018.

The following Critical Incident System (CIS) inspection were completed concurrently with the RQI:

014794-17 - Prevention of Abuse & Neglect;

015343-17 - Prevention of Abuse & Neglect;

007829-18 - Falls Prevention;

009604-18 - Personal Support Services;

003463-18 - Prevention of Abuse & Neglect; and,

008327-18 - Prevention of Abuse & Neglect.

The following Complaint inspections were completed concurrently with the RQI:

020898-17 - Medication Administration, Prevention of Abuse & Neglect; and,

004208-18 - Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive

Director, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, dietary staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed resident-staff interactions and care, reviewed health records, policies and procedures, training records, internal investigation notes, staff files, and Resident Council meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

5 WN(s)
3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was protected from abuse.

O.Reg. 79/10, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On an identified date in 2018, the home submitted a CIS report #2742-000004-18, which indicated that RPN #115 heard yelling coming from a resident room and went in to find that residents #008 and #007 had an altercation. Resident #007 sustained injury and was sent to the hospital for further investigation.

According to resident health records, the two residents had a similar altercation on an earlier date in 2018 and resident #007 sustained injury.

Approximately two months later, the home submitted a CIS report #2742-000008-18, which indicated that RPN #114 heard screaming coming from a resident room and went in to find that residents #008 and #007 had an altercation.

Resident #008 had a history of verbal and physical responsive behaviours toward co-residents and staff.

In an interview with registered staff #110, they confirmed that the above incidents occurred. In an interview with the DOC they also confirmed the above incidents occurred and that they met the definition of physical abuse. They acknowledged that resident #007 was not protected from abuse by resident #008 on three occasions in 2018.

This area of non-compliance was identified during a CIS inspections, log #003463-18 and 008327-18, conducted concurrently during this RQI. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) On an identified date in 2018, the home submitted a CIS report #2742-000004-18, which indicated that RPN #115 heard yelling coming from a resident room and went in to find that residents #008 and #007 had an altercation. Resident #007 sustained injury and was sent to the hospital for further investigation.

In response to the incident, the home initiated two specific interventions. Upon review of resident #007's documented plan of care, there was no indication of either of the interventions. The DOC reviewed the documented plan of care and confirmed this, acknowledging that these interventions should have been added to the plan of care.

This area of non-compliance was identified during CIS inspections, log #003463-18 and 008327-18, conducted concurrently during this RQI. (586).

B) On an identified date in 2018, the home submitted a CIS report #2742-000007-18, which identified that resident #010 had a fall that resulted in a significant change in their health status.

Resident #010 returned from hospital. The documented plan of care was reviewed and it was identified that the resident had experienced falls over a one month period.

The falls focus and interventions in the documented plan of care, which front line staff use to direct care, was reviewed and did not include new interventions were trialed over the time period of the multiple falls.

On an identified date in July 2018, resident #010's room was observed with the DOC and it was noted that the resident had three falls interventions in place. An interview was completed with PSW #116 and it was shared that front line staff had been putting these interventions in place.

The falls plan of care interventions were reviewed with the DOC. It was confirmed that the planned care staff were using to prevent falls, specially the interventions in place when the resident was observed by the LTCH Inspector, were not identified in resident #010's written plan of care. (583)

This area of non-compliance was identified during a CIS inspection, log #007829-18, conducted concurrently during this RQI. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an identified date in 2017 the home submitted a CIS report #2742-000013-17, of alleged staff-to-resident abuse towards resident #011. At the time of the inspection resident #011 and PSW staff #117 were no longer in the home.

The home's investigation notes were reviewed and it was documented that while PSW #108 and #118 where providing care in another area they heard PSW #117 yelling at resident #011. PSW #118 was interviewed. They confirmed they responded to the incident because they heard the yelling and shared the staff member sounded frustrated. PSW #118 initiated an intervention to aid in communication with the resident, and the resident was able to calm down.

The documented plan of care identified that resident #011 required the use of a specific intervention to aid in that. In an interview with PSW #118 and RN #119, it was shared that the resident and staff would use the intervention regularly with success. In an interview with the DOC, it was confirmed that staff #117 did not use the interventions as directed in the resident's plan of care at the time of the incident. (583)

This area of non-compliance was identified during a CIS inspection, log #014794-17, conducted concurrently during this RQI.

B) On an identified date in May 2018, the home submitted a CIS report #2742-000009-18, of alleged staff to resident abuse towards resident #012. Resident #012 sustained injury and was transferred to hospital.

As per a review of the homes investigation notes and during an interview with PSW #121, it was identified that PSW #120 completed identified aspects of resident #012's care.

The Minimum Data Set (MDS) assessment identified resident #012's level of assistance required for the identified care areas, and the documented plan of care was consistent with this.

In an interview with the DOC it was confirmed that resident #012's identified aspects of care were not completed by two staff during care on the identified date in 2018 when the incident occurred, as specified in the plan of care.

This area of non-compliance was identified during a CIS inspection, log #009604-18, conducted concurrently during this RQI [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #3: 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 :

1. The licensee failed to ensure that for residents with responsive behaviours, written strategies, including techniques and interventions were developed to prevent, minimize or respond to the responsive behaviours.

Resident #008 had a history of verbal and physical responsive behaviours toward co-residents and staff. The resident was physically abusive toward a specified resident on three occasions in 2018, resulting in injury. Two of the incidents occurred in the same area of the home.

According to Behaviour Support Ontario (BSO) documentation, resident #008 had a specific trigger in the home causing these behaviours. The notes also included specific interventions for staff to manage these behaviours. This information was not included in the resident's documented plan of care.

Through interviews with registered staff #107 and #110 and PSW staff #108, they each discussed responsive behaviours that resident #008 exhibited. They also indicated that there was a specific intervention that was often effective in managing these behaviours. None of the information was listed in the resident's documented plan of care, which front line staff used to direct care, nor were there interventions discussed to mitigate or manage any risk toward the resident or co-residents.

The documented plan of care did include one type of behaviour; however, no interventions to manage this were included.

In an interview with the DOC they confirmed these strategies, techniques, and interventions, and that they were not included in resident #008's documented plan of care to prevent, minimize or respond to their responsive behaviours.

This area of non-compliance was identified during a complaint inspection log #004208-18, conducted concurrently during this RQI. [s. 53. (1) 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 for residents with responsive behaviours, written strategies, including techniques and interventions are developed to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A review of the home's medication incidents for a three month period of time was completed. This review included an Incident Report from an identified date in 2018, regarding a medication error involving resident #007. Interviews with RPN #100 and RN #101 confirmed the dosages of the medications they provided to the resident. The RN reported they could have provided the incorrect dose of medication.

Interview with the DOC confirmed that the incident took place as documented above. The DOC also confirmed that during an identified period of time in 2018, resident #007 did not receive their medication in accordance with the directions for use specified by the prescriber.

B) A review of the Complaint Intake log #020898-17, identified that resident #009 missed a dose of a particular medication on an identified date in 2017.

Review of the Medication Incident Report identified that staff #103 did not provide a dose of a medication to resident #009. Confirmation of this information was identified in the progress notes when the dose of medication was noted to be in the blister pack in the medication cart.

Interview with the DOC confirmed that the provided details were accurate in relation to the incident. The DOC confirmed that resident #009 did not receive their medication in accordance with the directions for use specified by the prescriber.

Drugs were not administered to resident #007 and resident #009 in accordance with the directions for use specified by the prescriber.

This area of non-compliance was identified during a complaint inspection log #020898-17, conducted concurrently during this RQI. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

In accordance with Ontario Regulation 79/10 section 114(2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy titled 'LTC-Medication Management', last reviewed in March 2018, which was part of the licensee's medication management system.

A) The policy identified that staff were to ensure that "the resident information on

each medication dispenser (pouch/blister pack/vials, etc.) corresponds identically with the Resident's Medication Administration Record (MAR/eMAR) before administering the medication".

A review was conducted of a medication incident report which identified a dispensing error related to resident #007.

On an identified date in 2017, the resident was ordered an analgesic at an identified dosage. Interviews with RN #101 and RPN #100 confirmed that they had each signed the eMAR during the time of the error and possibly could have administered the wrong dose as dispensed by pharmacy.

The registered staff verified that the licensee's policy with administration was to check the eMAR with the information provided on the pouch prior to administering medication to the resident.

Interview with the DOC identified that the eMAR and the medication pouch were inconsistent with regards to dosage for the medication and that the error could have been identified during routine checks. The DOC confirmed that the staff at the home did not follow the licensee's policy in relation to medication administration.

Staff did not comply with the LTC-Medication Management policy.

B) The policy identified that staff were to ensure that scheduled medications would be administered according to standard medication administration times. Medication should be given within the recommended time frame, 60 minutes before and 60 minutes after the scheduled administration time.

Review of a complaint log #020898-17, identified that resident #009 did not receive their scheduled medication on an identified date in 2017.

Review of the Medication Incident Report identified that staff #103 did not provide a dose of a medication to resident #009. Confirmation of this information was identified in the progress notes when the dose of medication was noted to be in the blister pack in the medication cart on a subsequent shift.

Interview with the DOC confirmed that the provided details were accurate in relation to the incident. They reported that action was taken in regards to the incident and that resident #009 was not harmed as a result. The DOC confirmed

that staff #103 did not follow the licensee's policy with regards to administering scheduled medications.

This area of non-compliance was identified during a complaint inspection log #020898-17, conducted concurrently during this RQI.

Staff did not comply with the policy as directed. [s. 8. (1) (b)]

Issued on this 10 day of August 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l’inspecteur (No) : Amended by JESSICA PALADINO (586) - (A1)

Inspection No. / No de l’inspection : 2018_689586_0018 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 014993-18 (A1)

Type of Inspection / Genre d’inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 10, 2018;(A1)

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Telfer Place
245 Grand River Street North, PARIS, ON, N3L-3V8

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Darleen Barber

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with LTCHA s. 19 (1).

Specifically the licensee shall ensure resident #007, and all other residents, are protected from physical abuse by resident #008.

Grounds / Motifs :

1. The licensee failed to ensure that every resident was protected from abuse.

O.Reg. 79/10, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On an identified date in 2018, the home submitted a CIS report #2742-000004-18, which indicated that RPN #115 heard yelling coming from a resident room and went in to find that residents #008 and #007 had an altercation. Resident #007 sustained injury and was sent to the hospital for further investigation.

According to resident health records, the two residents had a similar altercation on an earlier date in 2018 and resident #007 sustained injury.

Approximately two months later, the home submitted a CIS report #2742-000008-18, which indicated that RPN #114 heard screaming coming from a resident room and went in to find that residents #008 and #007 had an altercation.

Resident #008 had a history of verbal and physical responsive behaviours toward co-residents and staff.

In an interview with registered staff #110, they confirmed that the above incidents occurred. In an interview with the DOC they also confirmed the above incidents occurred and that they met the definition of physical abuse. They acknowledged that resident #007 was not protected from abuse by resident #008 on three occasions in 2018.

This area of non-compliance was identified during a CIS inspections, log #003463-18 and 008327-18, conducted concurrently during this RQI.

The severity of this issue was determined to be a level 3 as there was actual harm and risk to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level of 3 history as they had related non-compliance with this section of the LTCH that included:
-Voluntary Plan of Correction (VPC) issued on February 23, 2017 (2017_556168_0005) (586)

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

Oct 19, 2018(A1)

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this   10   day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JESSICA PALADINO - (A1)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Service Area Office / Bureau régional de services : Hamilton