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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2013	2013_189120_0001	H-002278-12	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1

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

BERNADETTE SUSNIK (120)

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): December 28, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, non-registered staff and a resident.

During the course of the inspection, the inspector(s) reviewed staff interview statements, the resident's plan of care and assessments, the resident's documented activities of daily living, the home's policies and procedures with respect to documentation, resident leave of absence, missing persons, elevator breakdown, use of agency personnel and staff training.

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

Training and Orientation

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 :

[O. Reg. 79/10 s. 8(1)(b)] 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, is complied with. The licensee did not comply with their leave of absence policy.

An identified resident went missing after being returned to the home by a family member on an evening in 2012. The resident entered one of three elevators (elevator #1) which failed en route to their designated floor. The resident became trapped in the elevator for an extended period of time.

(I) The home has a "Casual/Vacation Leave of Absence" policy (LTC9-05-10.07) which refers to a form called the "Release of Responsibility for Leave of Absence". The form is to be signed by the resident or their designate as well as by registered staff when residents are leaving and arriving back onto the premises. On a specified afternoon in 2012, a family member signed the resident out and documented that the resident was going for dinner and would be returning at 9:00 p.m. on the same day. The registered staff member who was present saw the family member completing the form and provided the family member with the resident's medications for that evening, did not question the family member or review the form at the time. The form was therefore not signed by a registered staff member as required by the home's policy. In reviewing the binder for resident absences over the last 9 months, many forms were inadequately completed and none contained registered staff signatures. According to the family member, the sign out log was signed when the resident was returned to the home, however the family member and the resident entered the building at separate times. The family member did not see or encounter any staff members to inform them of the resident's return. When the resident entered the building alone, no one saw the resident enter the elevator.

The home's policy LTC9-05.10.07 further requires a casual absence (absence of less than 48 hours) to be recorded in the resident's progress note. A registered staff member documented in the resident's progress note that they went out for dinner with a family member but had not returned at the time of the entry which was made after 9 p.m. No further notations were made and according to the staff member, no further action was taken to consult the sign out log or to verify the whereabouts and expected return of the resident. The registered staff member reported to the Director of Care that they knew the resident was entitled to 48 hours of leave and therefore assumed

they were out on a casual leave of absence for 48 hours.

According to the Director of Care, two out of the three registered staff who worked during the time period the resident was missing were hired via an agency. The two agency staff reported that they informed the resident's routine personal support workers with information that the resident was on a leave of absence. The information was passed along from employee to employee. It was not until many hours after the resident became trapped in the elevator that the home's full time registered staff member began to research the whereabouts of the resident. The family was contacted and it was confirmed that the resident was returned to the home. An immediate search was initiated and when unsuccessful, the police and fire department were called in to assist. The resident was found in one of the elevators that had been placed out of service by an elevator technician/inspector. As the resident was not considered missing at this point in time, the inspector did not check the elevator before placing it out of service.

Interview with the resident confirms that upon return to the home, they used one of three elevators (elevator #1) which failed shortly after entering it. The resident did not realize that an emergency button was located on the elevator panel to sound an alarm. Some time later, the resident found a button which connected them to the home's phone system. Unfortunately at that time of day, the phones are not answered consistently and messages are sent to a voice mail system. The resident's numerous messages for assistance were left on voice mail which were not checked by any of the 3 staff members who worked over the time period the resident was missing.

(II) The home's documentation policy LTC9-05.11.06 dated February 18, 2011 has been established for registered staff and personal support workers "to ensure recording of care given and resident's response to care". Staff currently use an electronic documentation system which has been developed to capture what care has been provided to residents such as toileting, transferring, eating, bed mobility etc. Personal support workers all received training and orientation with respect to proper documentation during one of several sessions that occurred in October 2012. The home's policy and the training materials which were reviewed specifically direct staff to document accurately and as soon as possible after care delivery. However, during the absence of an identified resident on a specified day in 2012, 2 personal support workers continued to document that the resident received assistance with daily living activities.

(III) The home's policy LTC1-06.06 dated June 6, 2011 titled "Safe Smoking Practices" requires that residents be assessed for their ability to smoke independently; on admission, quarterly and when there is a change in health status and/or dexterity. An identified resident was assessed related to this policy, upon admission in 2009 and had not had any further assessments in 2010, 2011 and 2012. [s. 8. (1) (b)]

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. 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:
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. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
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).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in

accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c.8, s.3(1)3.] Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

3. Every resident has the right not to be neglected by the licensee or staff.

According to Ontario Regulation 79/10 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

An identified resident's safety was jeopardized due to the inaction of various staff members with respect to ensuring the resident's safety.

A resident went missing after being returned to the home by a family member on an evening in 2012. The resident entered one of three elevators (elevator #1) which failed while en route to their designated floor. The resident became trapped in the elevator for an extended period of time.

A series of events and practices took place while the resident was unaccounted for which contributed to the incident and which ultimately placed the resident in jeopardy. The following events and practices were identified during the inspection;

1. Two registered staff, who were hired temporarily via an agency, and who worked during the time the resident was missing did not consult the sign out log to verify the resident's whereabouts and expected return to the home. The home's leave of absence form was completed by the resident's family member indicating that the resident would be returning the same evening at 9:00 p.m. A registered staff member who was present and saw the family member signing the log, provided the family member with the resident's medications for that evening. When that staff member's shift ended, communication to the oncoming agency staff member #1 regarding the resident's whereabouts and expected return time was not clearly communicated. When agency staff member #2 began their shift the information that was passed along from staff member #1 was that the resident was on a leave of absence. The information was shared with the resident's care givers and other employees.
2. The elevator, once it failed, could not be checked by anyone other than a certified elevator technician or inspector. When the technician arrived at the home, no one recognized the resident was missing and the elevator cab was assumed to be empty

and then placed out of service by an elevator inspector/technician.
3. The elevator's emergency phone did not connect to a live operator when it was used by the resident.
4. The messages that were left by the resident were not monitored or picked up by any of the 3 staff members who worked during the time period the resident was missing.

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 every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

[O. Reg. 79/10, s. 76(2)10]. The licensee has not ensured that all staff have received training related to the Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities before performing their responsibilities.

Two registered staff members who were hired through a third party agency to work during the time period that the resident was missing did not appear to have received any training or orientation related to the home's leave of absence policy. The home's orientation checklist for the two staff members was not completed. Registered agency staff are occasionally hired when the home is not able to fulfill a shift with their own staff. When agency staff are hired, they arrive at the home typically one to several hours prior to their scheduled shift for a brief orientation. The home's regularly employed registered staff member who was present at the time the resident was signed out and who initiated the search, received training with respect to the leave of absence policy, and according to an interview held between the Director of Care and the employee, the employee had knowledge of the policy and associated forms. The Director of Care reported that new staff become aware of the leave of absence policy and forms when they are oriented, during shift changes, team meetings and formal training sessions. The home's orientation checklist for agency staff does not specifically identify that the leave of absence policy be reviewed and the home's "Agency Personnel - General Duty" policy (LTC9-03.05.01 dated May 9, 2011) does not address the home's leave of absence policy specifically.

Issued on this 16th day of January, 2013

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

B. Susnik

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0001
Log No. / Registre no:	H-002278-12
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 9, 2013
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	MALTON VILLAGE LONG TERM CARE CENTRE 7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~WENDY BEATTIE~~ Ranjit Calay

To THE REGIONAL MUNICIPALITY OF PEEL, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall;

1. Evaluate and update the current leave of absence policies and procedures and associated forms.

2. Develop and submit a plan which summarizes the time lines by which all of the staff will have received training and orientation around the updated leave of absence policies and procedures and associated forms. The plan should also include how and when individuals will be oriented or trained who work at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party regarding the leave of absence policies.

The written plan shall be submitted to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON L8P 4Y7.

Grounds / Motifs :

1. [O. Reg. 79/10 s. 8(1)(b)] 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, is

complied with. The licensee did not comply with their leave of absence policy.

An identified resident went missing after being returned to the home by a family member on an evening in 2012. The resident entered one of three elevators (elevator #1) which failed en route to their designated floor. The resident became trapped in the elevator for an extended period of time.

The home has a "Casual/Vacation Leave of Absence" policy (LTC9-05-10.07) which refers to a form called the "Release of Responsibility for Leave of Absence". The form is to be signed by the resident or their designate as well as by registered staff when residents are leaving and arriving back onto the premises. On a specified afternoon in 2012, a family member signed the resident out and documented that the resident was going for dinner and would be returning at 9:00 p.m. on the same day. The registered staff member who was present saw the family member completing the form and provided the family member with the resident's medications for that evening, did not question the family member or review the form at the time. The form was therefore not signed by a registered staff member as required by the home's policy. In reviewing the binder for resident absences over the last 9 months, many forms were inadequately completed and none contained registered staff signatures. According to the family member, the sign out log was signed when the resident was returned to the home, however the family member and the resident entered the building at separate times. The family member did not see or encounter any staff members to inform them of the resident's return. When the resident entered the building alone, no one saw the resident enter the elevator.

The home's policy LTC9-05.10.07 further requires a casual absence (absence of less than 48 hours) to be recorded in the resident's progress note. A registered staff member documented in the resident's progress note that they went out for dinner with a family member but had not returned at the time of the entry which was made after 9 p.m. No further notations were made and according to the staff member, no further action was taken to consult the sign out log or to verify the whereabouts and expected return of the resident. The registered staff member reported to the Director of Care that they knew the resident was entitled to 48 hours of leave and therefore assumed they were out on a casual leave of absence for 48 hours.

According to the Director of Care, two out of the three registered staff who

worked during the time period the resident was missing were hired via an agency. The two agency staff reported that they informed the resident's routine personal support workers with information that the resident was on a leave of absence. The information was passed along from employee to employee. It was not until many hours after the resident became trapped in the elevator that the home's full time registered staff member began to research the whereabouts of the resident. The family was contacted and it was confirmed that the resident was returned to the home. An immediate search was initiated and when unsuccessful, the police and fire department were called in to assist. The resident was found in one of the elevators that had been placed out of service by an elevator technician/inspector. As the resident was not considered missing at this point in time, the inspector did not check the elevator before placing it out of service.

Interview with the resident confirms that upon return to the home, they used one of three elevators (elevator #1) which failed shortly after entering it. The resident did not realize that an emergency button was located on the elevator panel to sound an alarm. Some time later, the resident found a button which connected them to the home's phone system. Unfortunately at that time of day, the phones are not answered consistently and messages are sent to a voice mail system. The resident's numerous messages for assistance were left on voice mail which were not checked by any of the 3 staff members who worked over the time period the resident was missing. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 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

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 9th day of January, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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