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 prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Bureau régional de services de Hamilton
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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
Sep 15, 2015;	2015_205129_0017 (A1)	H-003055-15	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Grounds for Order #002- 8(1)b, have been edited.

Issued on this 15 day of September 2015 (A1)

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

Original report signed by the inspector.

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

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CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 11, 12 and 13, 2015

During the course of the inspection, the inspector(s) spoke with registered nursing staff, the resident's Physician, the home's consulting Pharmacist, the Coroner, the Manager of Resident Care, the Director of Resident Care and the Administrator. The inspector also reviewed clinical documentation, investigative notes compiled by the home and the policies and procedures included in the home's Medication Management System.

The following Inspection Protocols were used during this inspection:

Medication

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident. [131(1)]
Resident #001 received one medication over a 46 days period without this medication being prescribed for the resident. Resident #001 was admitted to the home on an identified date in 2015 and staff completed the "Best Possible Medication History Reconciliation/Admission Order (BPMH)", which documented the admission medical orders for the resident; however, the dosage for one of the medications listed had been transcribed incorrectly. Staff and clinical documentation confirmed this document had not been signed by a physician and as a result the physician had not prescribed the medication that had been inaccurately transcribed onto this document. Staff and Medication Administration Records (MAR) confirmed that the resident received the medications documented on the BPMH form for 46 days.
Staff and clinical documentation confirmed that one of the medications identified on the BPMH form administered to resident #001 had been transcribed incorrectly, when the BPMH was created on admission to the home. Prednisone had been documented at strength 147 milligrams (mg.) higher than what appeared on the preadmission information that the resident's physician signed as representing their admission medical orders for the resident. At the time of this inspection the physician confirmed they had reviewed the medications the resident was receiving prior to admission and those documents indicated the resident had been taking three, 1mg. tablets of prednisone daily in the morning which was the dosage the physician expected the resident had been receiving in the home. The resident's physician became aware of the administration of the high dose of prednisone on an identified date, when a consulting physician assessed the resident and raised a concern related to the administration of this high dose of prednisone. The administration of this inaccurate dose of prednisone contributed to a change in the resident's condition.
Resident #001 deceased on an identified date, at which time the resident's physician requested the coroner review the case. [s. 131. (1)]

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. 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 Medication Management policies, procedures, protocols and systems required in accordance with O.Reg. 79/10, s. 114(2) were complied with, in relation to the following: [8(1) b)
1. Staff did not comply with directions for completion of the "Best Possible Medication History Reconciliation/Admission Order" (BPMH) form that was included in the procedure for identifying admission medical orders, including medications. The form identified a number of signatures that were required for completion of the document. The Director of Resident Care confirmed the required signature of the physician and the date the signature was made served to verify the admission orders. The BPMH written on the date of admission for resident #001 did not contain the signature of the physician, at the time of this inspection.
2. Staff did not comply with directions identified in the home's procedure, "Transcribing Physician Orders", identified as #06-03-53 and dated September 11, 2014.
-This procedure directed that "registered staff on the unit performs the second check, sign and dates the order ensuring all processes were completed". Staff confirmed they did not comply with this direction when the registered staff who signed that they had checked the physician orders did not ensure the process of transcribing physician orders onto the BPMH had been completed accurately and resident #001 received an inaccurately transcribed dose of Prednisone over a 46 day period of time.
-This procedure also directed that "the pharmacist will double check for any discrepancies, concerns will be communicated to the nurse and/or the physician and the nurse is to follow through on concerns/discrepancies reported". Staff confirmed that this direction was not complied with when the pharmacist contacted registered staff by telephone on the date the resident was admitted to the home and forwarded a "Pharmacy/Nursing Communication Sheet" which requested staff to "please confirm

dose for prednisone 150mg daily – on ongoing or short term". These concerns were not accurately communicated to the resident #001's physician. Staff confirmed that when the resident's physician was contacted the physician was not alerted to the 150mg dose of prednisone that the pharmacist had noted on the communication sheet. The pharmacist contacted staff again 32 days later and raised concerns regarding the 150mg dose of prednisone. Staff confirmed that when the physician was contacted about the pharmacists concerns on this date, the 150mg dose was not communicated to the resident's physician. Resident #001 received an inaccurate dose of Prednisone 150mg daily over a 46 day period of time.

3. Staff did not comply with directions contained in the home's "Medication Reconciliation" policy, identified as # 7-2 and dated January 2014. This policy directed that "the nurse creates the BPMH when the resident is admitted to the home and records a complete and accurate list of the resident's current and preadmission medications including name, dosage, frequency and route". Staff and clinical documentation confirmed that this direction was not complied with, when the registered staff transcribing admission medical orders onto the BPMH order form for resident #001 did not transcribe accurate information related to the strength of the drug prednisone. Documentation provided to staff when the resident was admitted to the home indicated the resident received three, 1mg. tablets of prednisone daily in the morning. This order was inaccurately transcribed as three, 50mg tablets of prednisone daily in the morning. Resident #001 received this inaccurately transcribed dose of prednisone daily over a 46 day period of time.

4. Staff did not comply with the expectations for completing information required on the "Physician Communication Record". The Director of Resident Care confirmed that staff were expected to complete the form, that included the date a comment was made on the record, the signature of the nurse making the entry and a signature/initial of the physician indicating the physician has seen the entry. Documentation confirmed that staff did not comply with the procedure for completing this record, when a review of the Physician Communication Record indicated:
-For the week of May 20, 2015 the Physician Communication Record indicated that nursing had made 17 entries related to resident care/concerns they wanted to communicate to the resident's physicians. Thirteen of the care/concerns entries documented for this period of time did not contain the date those entries were written into the communication record, 14 of those entries did not contain the signature of the nurse who made the entry and 17 of those entries did not contain the physician's signature/initials indicating that the physician had seen the entry.
-For the week of June 1, 2015 the Physician Communication Record indicated that

nursing had made eight entries related to resident care/concerns they wanted to communicate to resident's physicians. Four of the care/concerns entries documented for this period of time did not contain the date those entries were written into the communication record, six of those entries did not contain the signature of the nurse who made the entry and eight of those entries did not contain the physician's signature/initials indicating that the physician had seen the entry.
-For the week of June 23, 2015 the Physician Communication Record indicated that nursing had made eight entries related to resident care/concerns they wanted to communicate to resident's physicians. Six of the care/concerns entries documented for this period of time did not contain the date those entries were written into the communication record, six of those entries did not contain the signature of the nurse who made the entry and eight of those entries did not contain the physician's signature/initials indicating that the physician had seen the entry.

As a result of staff not complying with Medication Management policies, procedures, protocols and systems resident #001 received an incorrect dose of prednisone over a 46 days period of time. [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the Director was immediately informed, in as much detail as possible of the unexpected death of resident #001. [107(1)2]
Resident #001 was admitted to the home on an identified date and was found with vital signs absent 56 days later. Staff and clinical documentation confirmed that while transcribing the resident's admission information a transcription error was made that resulted in the resident receiving 150mg. of prednisone daily over a 45 day period of time, instead of the 3mg. of prednisone the resident's physician had ordered. The resident's physician was notified of the administration of this large dose of prednisone when, on an identified date a consulting physician expressed concerns to staff related the large dose of prednisone being administered to the resident. The resident was found with vital signs absent 16 days after the discovery that the resident had received an inaccurate dose of medication and the home did not report the sudden death of the resident to the Director. [s. 107. (1) 2.]

Issued on this 15 day of September 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A1)

Inspection No. / No de l'inspection : 2015_205129_0017 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-003055-15 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 15, 2015;(A1)

Licensee / Titulaire de permis : THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

LTC Home / Foyer de SLD : CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patti Coates

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To THE REGIONAL MUNICIPALITY OF HALTON, 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 :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee is to ensure that all drugs administered to a resident have been prescribe for the resident.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. Resident #001 received one medication over a 46 day period, without this medication being prescribed for the resident. Resident #001 was admitted to the home on an identified date and staff completed the "Best Possible Medication History Reconciliation/Admission Order (BPMH)", which documented the admission medical orders for the resident; however, the dosage for one of the medications listed had been transcribed incorrectly. Staff and clinical documentation confirmed this document had not been signed by a physician and as a result the physician had not prescribed the medication that had been inaccurately transcribed onto this document. Staff and Medication Administration Records (MAR) confirmed that the resident received the medications documented on the BPMH form for 46 days.
Staff and clinical documentation confirmed that one of the medications identified on the BPMH form administered to resident #001 had been transcribed incorrectly, when the BPMH was created on admission to the home. Prednisone had been documented at strength 147 milligrams (mg.) higher than what appeared on the readmission information that the resident's physician signed as representing their admission medical orders for the resident. At the time of this inspection the physician confirmed they had reviewed the medications the resident was receiving prior to admission and those documents indicated the resident had been taking three, 1mg. tablets of prednisone daily in the morning which was the dosage the physician expected the resident had been receiving in the home. The resident's physician became aware of the administration of the high dose of prednisone on an identified date, when a consulting physician assessed the resident and raised a concern related to the administration of this high dose of prednisone. The administration of this inaccurate dose of prednisone contributed to a change in the resident's condition.
Resident #001 deceased on an identified date, at which time the resident's physician requested the coroner review the case.

(129)

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

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

Sep 30, 2015

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. 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 develop, implement and submit a plan to ensure that all medications administered to residents in the home are administered safely. The plan is to include, but is not limited to the following:

1. The development of a mechanism to ensure that all staff involved in any aspect of medication management are aware of the drugs usually administered in Long Term Care Homes including the usual doses of those medications.
2. The development and implement a plan to review, update and clarify the policies, procedures, protocols and systems that are a part of the home's Medication Management System.
3. The provision of direction that all transcribed orders must be double checked by two registered staff for accuracy until the time that policies are clarified and education provided to staff.
4. The development and implement of a training and education program for all staff involved in the ordering, transcription and administration of medications related to the policies, procedures, protocols and systems included in the Medication Management System.
5. The development and implement an ongoing program to monitor staff's performance in relation to medication management and administration.

The plan is to be submitted to Phyllis Hiltz-Bontje on or before September 30, 2015 at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

(A1)
1. Staff inaccurately transcribed and administered 150 milligrams of predisone daily to resident #001 over a 46 day period.

2. Staff did not comply with the following policies, procedures, protocols and systems identified in the home s Medication Management System:
a. Staff did not comply with directions for completion of the "Best Possible Medication History Reconciliation Admission Order" (BPMH) form that was included in the procedure for identifying admission medical orders, including medications. The form identified a number of signatures that were required for completion of the document. The Director of Resident Care confirmed the required signature of the physician and the date the signature was made served to verify the admission orders. The BPMH written on May 22, 2015 for resident #001 did not contain the signature of the

physician at the time of this inspection.
b) Staff did not comply with directions identified in the home's procedure, "Transcribing Physician Orders", identified as #06-03-53 and dated September 11, 2014.
-This procedure directed that "registered staff on the unit performs the second check, sign and dates the order ensuring all processes were completed". Staff confirmed they did not comply with this direction when the registered staff who signed that they had checked the physician orders did not ensure the process of transcribing physician orders onto the BPMH had been completed accurately and resident #001 received an inaccurately transcribed dose of Prednisone from May 23, 2015 to July 7, 2015.
- This procedure also directed that "the pharmacist will double check for any discrepancies, concerns will be communicated to the nurse and or the physician and the nurse is to follow through on concerns discrepancies reported". Staff confirmed that this direction was not complied with when the pharmacist contacted registered staff by telephone on May 22, 2015 and forwarded a "Pharmacy Nursing Communication Sheet" which requested staff to "please confirm dose for prednisone 150mg daily – on ongoing or short term" and these concerns were not accurately communicated to the resident #001's physician. Staff confirmed that when the resident's physician was contacted the physician was not alerted to the 150mg dose of prednisone that the pharmacist had noted on the communication sheet. The pharmacist contacted staff again on June 23, 2015 raising concerns regarding the 150mg dose of prednisone. Staff confirmed that when the physician was contacted about the pharmacists concerns on this date, the 150mg dose was not communicated to the resident's physician. Resident #001 received an inaccurate dose of Prednisone 150mg daily from May 23, 2015 to July 7, 2015.
c) Staff did not comply with directions contained in the home's "Medication Reconciliation" policy, identified as # 7-2 and dated January 2014. This policy directed that "the nurse creates the BPMH when the resident is admitted to the home and records a complete and accurate list of the resident's current and preadmission medications including name, dosage, frequency and route". Staff and clinical documentation confirmed that this direction was not complied with, when the registered staff transcribing admission medical orders onto the BPMH order form for resident #001 did not transcribe accurate information related to the strength of the drug prednisone. Documentation provided to staff when the resident was admitted to the home on May 22, 2015 indicated the resident received three, 1mg. tablets of prednisone daily in the morning. This order was inaccurately transcribed as three, 50mg tablets of prednisone daily in the morning. Resident #001 received this

inaccurately transcribed dose of prednisone daily from May 23, 2015 to July 7, 2015.
d) Staff did not comply with the expectations for completing information required on the "Physician Communication Record". The Director of Resident Care confirmed that staff were expected to complete the form, that included the date a comment was made on the record, the signature of the nurse making the entry and a signature initial of the physician indicating the physician has seen the entry. Documentation confirmed that staff did not comply with the procedure for completing this record, when a review of the Physician Communication Record indicated:
-For the week of May 20, 2015 the Physician Communication Record indicated that nursing had made 17 entries related to resident care concerns they wanted to communicate to the resident's physicians. Thirteen of the care concerns entries documented for this period of time did not contain the date those entries were written into the communication record, 14 of those entries did not contain the signature of the nurse who made the entry and 17 of those entries did not contain the physician s signature initials indicating that the physician had seen the entry.
-For the week of June 1, 2015 the Physician Communication Record indicated that nursing had made eight entries related to resident care concerns they wanted to communicate to resident's physicians. Four of the care concerns entries documented for this period of time did not contain the date those entries were written into the communication record, six of those entries did not contain the signature of the nurse who made the entry and eight of those entries did not contain the physician s signature initials indicating that the physician had seen the entry.
-For the week of June 23, 2015 the Physician Communication Record indicated that nursing had made eight entries related to resident care concerns they wanted to communicate to resident's physicians. Six of the care concerns entries documented for this period of time did not contain the date those entries were written into the communication record, six of those entries did not contain the signature of the nurse who made the entry and eight of those entries did not contain the physician s signature initials indicating that the physician had seen the entry. (129)

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

Oct 30, 2015

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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.

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
Toronto ON M5S 2B1
Télécopieur : 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 15 day of September 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office /
Bureau régional de services : Hamilton