Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 17, 18, 20, Oct 5, 15, 16, 17, 19, 23, 24, 25, 2012	2012_021111_0026	Critical Incident

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

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

HILLSDALE TERRACES
600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), two Registered Nurses(RN), two Registered Practical Nurses (RPN), and three Personal Support Workers (PSW)

During the course of the inspection, the inspector(s) observed two residents, reviewed health care records for two current residents and one deceased resident, reviewed the homes policies on abuse prevention and management, falls prevention and management, and responsive behaviours for log # 001894, 002389 & 000138

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

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. Related to Log 000138:

Review of an identified resident's progress notes indicated there were four incidents of resident to resident physical abuse resulting in injury.

2. Review of an identified resident's progress notes indicated several residents were subjected to on-going verbal and physical aggression from the identified resident, and some of the residents repeatedly.

3. In all the incidents listed above, the interventions by nursing were limited and the actions taken by the home failed to demonstrate a preventive approach in order to protect all residents from the identified resident's on-going verbal and physical abuse and aggressive responsive behaviours.

4. The licensee failed to ensure that multiple residents were protected from physical abuse from an identified cognitively impaired resident 02[s.19(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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Related to Log 000138:

Review of the health record for an identified resident indicated two incidents of resident to resident abuse occurred and there was no documented evidence to indicate the home completed an immediate investigation,or took appropriate action in response to the incident.

The licensee failed to ensure that every alleged, suspected or witnessed incidents of the abuse of a resident by anyone that the licensee knew of or that was reported to the licensee was immediately investigated and appropriate action was taken in response to every such incident [s.23(1)(a)(i)(b)].

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Related to Log 000138:

The licensee failed to ensure that for an identified resident who demonstrates on-going emotional, verbal and physically aggressive responsive behaviours, the behavioural triggers were identified, where possible and that effective strategies were developed and implemented to respond to these behaviours, and appropriate actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented [s.53(4)(a),(b),(c)].

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Related to Log 002389:

Review of the progress notes for an identified resident indicated the resident sustained multiple falls.

The licensee failed to ensure that the resident was reassessed and the plan of care revised when the care set out in the plan was not effective related to falls [s.6(10)(c)].

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 all residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set in the plan has not been effective related to fall management, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log 000138:

Review of the progress notes for an identified resident indicated 3 incidents of resident to resident abuse occurred resulting in harm or injury and there was no documented evidence to indicate that the incidents were reported to the Director.

2. The licensee failed to ensure that when a person has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm to the resident, immediately reported the suspicion and the information upon which it is based, to the Director[s.24(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 when a person has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Related to Log 000138:

Seven critical incident reports were submitted to the Director under the type as "other" despite the description of each incident reflected as resident to resident abuse.

Four critical incident reports that were submitted to the Director for "other" and involved more than one resident, did not describe all the individuals involved in the incident.

The licensee failed to ensure that when submitting an incident report to the Director, the type of incident is accurately reflected according to the description of the incident and that a description of the individuals involved in the incident is included[s.107(4)1,2.].

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Related to Log 002389:

Interview of 1 RPN & 2 RN's indicated that residents are to be assessed using a Comprehensive Post Fall Evaluation after every fall.Review of the homes policy on Falls Prevention and Management also confirmed this procedure.

Review of the health record for an identified resident indicated the resident sustained multiple falls and the Comprehensive Post Fall Evaluation was not completed after each fall.

Interview of the DOC, 1 RPN & 3 RN's indicated the Falls Risk Assessment Tool is to be completed on each resident on admission and quarterly.Review of the homes policy on Falls Prevention and Management confirmed this procedure.

Review of the Fall Risk Assessment Tools for an identified resident at high risk for falls indicated that this procedure did not occur.

The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls [s.49(2)].

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to Log 000138:

Review of the health record for an identified resident indicated 3 incidents of resident to resident physical abuse occurred and the police were not notified.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense [s.98].

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 the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense., to be implemented voluntarily.

Issued on this 25th day of October, 2012

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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.

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 25th day of October, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Lynda Brown	**Inspector ID #**	111
Log #:	001894-11, 002389-11 and 000138-12		
Inspection Report #:	2012_021111_0026		
Type of Inspection:	Critical Incident		
Date of Inspection:	September 17, 18, 20, October 5, 15, 16, 17, 19, 23, 24 and 25, 2012		
Licensee:	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, Whitby ON L1N 6A3		
LTC Home:	HILLSDALE TERRACHES 600 Oshawa Blvd., North, Oshawa ON L1G 5T9		
Name of Administrator:	Marcey Wilson		

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

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:

LTCHA, 2007 S.O. 2007, c.8,s.19.(1) – Every license 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:

The licensee is to prepare, implement and submit a plan to ensure that all residents in the long-term care home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff including but not limited to the following:

1) The licensee must prepare, implement and submit a plan immediately to ensure that all residents are protected when resident #2 is demonstrating responsive behaviours.

While this plan is being prepared and until the planned interventions have been found to be effective, the licensee must ensure that other residents in the home are protected from the resident's responsive behaviours.

2) Staff to be re-trained on the home's policy on prevention of abuse and neglect, specifically: prevention, reporting and investigation the abuse.

3) Staff to be re-trained on the home's policy on Responsive Behaviours, specifically: procedures.

The written plan is to be submitted to: Lynda Brown, LTCH inspector-Nursing via email to: Lynda.brown2@ontario.ca by November 3, 2012.

Grounds:

1. Related to Log #000138

   Review of an identified resident's progress notes indicated there were four incidents of resident to resident physical abuse resulting in injury.

2. Review of an identified resident's progress notes indicated several residents were subjected to on-going verbal and physical aggression from the identified resident, and some of the residents repeatedly.

3. In all the incident listed above, the interventions by nursing were limited and the actions taken by the home failed to demonstrate a preventive approach in order to protect all residents from the identified resident's on-going verbal and physical abuse and aggressive responsive behaviours.

4. The licensee failed to ensure that multiple residents were protected from physical abuse from an identified cognitively impaired resident #02. [s. 19(1)]

This order must be complied with by:	November 16, 2012

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:

LTCHA, 2007 S.O. 2007, c.8, s. 23.(1) – Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witness incident of the following that that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23(1)

Order:

The licensee is to prepare, implement and submit a plan to ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated; (i)abuse of a resident by anyone; and
(b) appropriate action is taken in response to every such incident.

The written plan is to be submitted to: Lynda Brown, LTCH inspector-Nursing via email to: Lynda.brown2@ontario.ca by November 3, 2012.

Grounds:

1. Related to Log 000138:

Review of the health record for an identified resident indicated two incidents of resident to resident abuse occurred and there was no documented evidence to indicate the home completed an immediate investigation, or took appropriate action in response to the incident.

The licensee failed to ensure that every alleged, suspected or witnessed incidents of the abuse of a resident by anyone that the licensee knew of or that was reported to the licensee was immediately investigated and appropriate action was taken in response to every such incident. [s. 23(1)(a)(i)(b)]

This order must be complied with by:	November 16, 2012

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:

O. Reg 79/10, s. 53. (4) – The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg 79/10, s. 53. (4)

Order:

The licensee is to prepare, implement and submit a plan of corrective action to ensure that when resident #02 is demonstrating responsive behaviours;
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Grounds:

Related to Log 000138:

The licensee failed to ensure that for an identified resident who demonstrates on-going emotional, verbal and physically aggressive responsive behaviours, the behavioural triggers were identified, where possible and that effective strategies were developed and implemented to respond to these behaviours, and appropriate actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions were documented [s.53(4)(a),(b),(c)]

This order must be complied with by:	October 30, 2012

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 26th day of October, 2012	
Signature of Inspector:	Kathleen Enid
Name of Inspector:	Lynda Brown
Service Area Office:	Ottawa Service Area Office