Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2014	2014_256517_0036	L-000686-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BLENHEIM COMMUNITY VILLAGE
10 MARY AVENUE, P.O. BOX 220, BLENHEIM, ON, N0P-1A0

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

PATRICIA VENTURA (517), ALI NASSER (523), ALICIA MARLATT (590), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 21, 22, 23, 24, 28, 29, 30, 31 and August 1, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Environmental Manager, Activation Manager, Dietary Manager, Office Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Health Care Aides, Dietary Aides, Maintenance staff, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, dining room and resident common areas and confirmed posting of required information. Observed medication storage areas, resident-resident and resident-staff interactions, dining services and recreational activities. The inspectors also reviewed resident health records, home policies, procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident as evidenced by:

The inspectors observed and a manager verified bed rails were in use in multiple resident beds at the home. The Maintenance Manager reported that none of the residents at the home had received a resident specific assessment for risk of entrapment on their bed. The manager further reported all the beds at the home were previously assessed for entrapment and since that date none of the beds purchased and in use by residents were assessed for entrapment zones.

Two managers verified the expectation was that all residents using bed rails at the home received a resident specific assessment for risk of entrapment on their bed and had their bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide assistance as evidenced by:

During the lunch meal the inspector observed four residents sitting at their respective tables with their lunch meal served and without someone available to provide assistance with eating and drinking. Health record review of the four residents involved revealed the residents required assistance with eating and drinking for all meals.

Interview with staff revealed the expectation was that food was not placed in front of a resident that required assistance with eating or drinking unless a staff member was present to feed the resident.

Two managers verified the expectation was that food was not placed in front of a resident that required assistance with eating or drinking unless a staff member was present to feed the resident. [s. 73. (2) (b)]

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 residents' requiring assistance with eating and drinking are only served a meal when someone is available to provide assistance with eating and drinking, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Interview with staff revealed that one staff member was not aware of which infection control precautions to use when in a resident room.

The staff member also did not follow infection control precautions for resident care in a resident room requiring infection control precautions.

One manager explained the process of identification for residents who required infection control precautions and indicated that the staff members of the home were educated on the topic in 2013 and in 2014.

Two managers verified it was the expectation of the home that all staff could identify and implement infection control practice requirements for all residents. [s. 229. (4)]

2. The licensee has failed to ensure that residents were offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Clinical record review of two residents indicated these residents were not offered tetanus and diptheria immunizations.
Clinical record review of one resident indicated this resident was not offered diptheria immunization.

A staff member indicated the home did not have a program in place to ensure that all residents were offered immunization against tetanus and diptheria, and that a program was being developed.

One manager verified the expectation was that all residents were offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website. Another manager further verified that the home did not have a program in place to ensure that all residents were offered immunization against tetanus and diptheria. [s. 229. (10) 3.]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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:
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).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every resident had the right to 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, as evidenced by:

One electronic medication administration records (eMAR) terminal was observed to be left open and the medication cart unattended in the hallway. Personal health information(PHI)was readily accessible.

A staff member verified the eMAR terminal was not locked and PHI was accessible and confirmed the expectation that resident's PHI were to be kept confidential and not accessible. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure the temperature in the home was maintained at a minimum of 22 degrees Celsius as evidenced by:

One manager took two air temperatures of a room and they were 20.9 degrees Celsius and 19.8 degrees Celsius.

The manager also took air temperatures of other resident rooms and resident common areas. The temperatures were found to be below 22 degrees Celsius in four rooms and in one resident common area.

The manager verified the air temperature was to be maintained at a minimum of 22 degrees Celsius in all resident areas and immediately initiated corrective action to restore the temperature in the identified resident areas to a minimum of 22 degrees Celsius.

The inspector reviewed the home's document: "Random Air Temperatures". The document indicated the minimum air temperature was to be maintained at 22 degrees Celsius in all resident areas. The document also directed staff to report temperatures below 22 degrees Celsius to the manager.

One manager confirmed the expectation was the air temperature was maintained at a minimum of 22 degrees Celsius in all resident areas. [s. 21.]

WN #6: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report suspicion of Abuse of a resident by anyone that resulted in harm or risk of harm to a resident when they had reasonable grounds to suspect it occurred as evidenced by:

One resident reported to an inspector she had been a victim of physical abuse by staff members at the home. The resident did not report the incidents to management.

The home did not report the alleged physical abuse to the Director until five business days after acquiring knowledge of the incident.

The home's Resident Non-Abuse-Ontario policy stated:
"The LTCHA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care (the "Ministry"):
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident".

One manager verified that the expectation was any alleged staff-resident physical abuse causing harm or potential for harm to a resident was to be immediately reported to the Director of the Ministry. The Administrator further confirmed the alleged staff-resident abuse of this resident was not reported to the Director until five business days after acquiring knowledge of the incident. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that each resident of the home was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment was required as evidenced by:

Clinical record review for one resident indicated that the resident's substitute decision maker had requested that the resident be offered an annual dental assessment. The resident did not receive a dental assessment.

One manager verified the expectation was that the home would contact the dental service provider when a request was made by family for dental services and that this was not completed for this resident. [s. 34. (1) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure planned menu items were offered and available to residents at each meal and snack as evidenced by:

The lunch menu posted outside the dining room indicated dessert choices for the day. During lunch service the inspector observed that seven residents were not offered dessert according to the posted menu.

Interviews with staff revealed the kitchen ran out of the planed dessert choices during the lunch meal before it could be offered to all the residents. The staff also reported the seven residents involved were not offered either of the two choices of dessert listed on the lunch menu.

Two managers verified the expectation was that all residents were offered dessert as posted on the lunch menu. [s. 71. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times as evidenced by:

An inspector was able to access the products used to clean and maintain the fish aquarium in a resident common area. A staff member confirmed the aquarium chemicals were accessible to residents at the time and reported the expectation was that all chemicals be locked away and inaccessible to residents at all times.

An inspector also observed a bottle of disinfectant sitting on top of a paper towel rack in a resident washroom. A staff member confirmed the bottle of disinfectant was accessible to residents at the time and reported the expectation was that all chemicals be locked and inaccessible to residents at all times.

One manager verified the expectation was that all hazardous substances at the home were kept inaccessible to residents at all times. [s. 91.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint as evidenced by:

Health record review of one resident revealed that the resident reported a concern to a staff member.

The policy Management of Concerns/Complaints/Compliments(CSR)indicated the following:

3. The individual who was first aware of a concern/complaint initiated the Concern form.
7. If the concern/complaint alleged harm or risk to one or more Residents, an investigation begun immediately.

One manager verified that an investigation of this resident's verbal complaint was not initiated and the complaint was not resolved. [s. 101. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The Licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable, as evidenced by:

Review of the Medication Disposal Policy revealed that:
-With the exception of controlled substances, medications designated for disposal are destroyed at the home by a team of individuals compromised of two staff members, both of whom are appointed by the Director of Care.

The inspector observed discontinued medications in the medication room to be in their original state, not altered or denatured to such an extent that its consumption is rendered impossible or improbable.

This was confirmed by one manager. [s. 136. (6)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2014_255516_0016	517
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2014_255516_0016	517

Issued on this 2nd day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA VENTURA (517), ALI NASSER (523), ALICIA MARLATT (590), NANCY SINCLAIR (537)
Inspection No. / No de l'inspection :	2014_256517_0036
Log No. / Registre no:	L-000686-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 18, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BLENHEIM COMMUNITY VILLAGE 10 MARY AVENUE, P.O. BOX 220, BLENHEIM, ON, N0P-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA MAYNARD

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The plan must include a description of:

- Who will conduct the resident specific assessments while the residents are in bed.

- Short term and long term interventions available to the direct care staff when a resident is deemed unsafe for their bed.

- Where the assessment and interventions will be documented.

- How the facility will track which beds are used by which residents (e.g. track bed serial numbers).

- Who is responsible to monitor this on an ongoing basis both in the short term and the long term.

Please submit the plan by e-mail to Patricia.Ventura@ontario.ca by October 10, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident as evidenced by:

The inspectors observed and a manager verified bed rails were in use in multiple resident beds at the home. The manager reported that none of the residents at the home had received a resident specific assessment for risk of entrapment on their bed. The Maintenance Manager further reported all the beds at the home were assessed for entrapment previously and since that date none of the beds purchased and in use by residents were assessed for entrapment zones.

The Administrator and Environmental Manager verified the expectation was that all residents using bed rails at the home received a resident specific assessment for risk of entrapment on their bed and had their bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.
(517)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

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.

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 18th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Ventura

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