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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, 2017	2017_689586_0008	024691-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

DOVER CLIFFS
501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

JESSICA PALADINO (586), DIANNE BARSEVICH (581), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30, 31 and November 1 and 2, 2017.

The following Follow-up Inspection was completed concurrently with the RQI:
012600-17 - Nutrition & Hydration

The following Complaint Inspection was completed concurrently with the RQI:
022853-17 - Housekeeping; Prevention of Abuse & Neglect; Infection Prevention & Control; Dining & Snack Service; Medication Administration; Staffing

The following Critical Incident System (CIS) Inspection was conducted concurrently with the RQI:
013801-17 - Medication Administration

The following Inquiries were conducted on-site concurrently with the RQI:
007436-17 - Prevention of Abuse & Neglect
007691-17 - Falls Prevention & Management
015859-17 - Falls Prevention & Management

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Co-ordinator, Environmental Services Manager (ESM), Registered Dietitian (RD), Food Services Manager (FSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and families.

During the course of the inspection, the inspectors reviewed resident health records, medication incident investigation notes, audits, policies and procedures, and staff schedules, interviewed staff and observed resident care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 68. (2)	CO #001	2017_556168_0014	586

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule from July 1 to October 20, 2017, identified that an RN that was a member of the regular nursing staff was not on duty for 25 shifts. In an interview with the ED on November 2, 2017, they stated that agency RN staff was present on the above shifts but confirmed the home was unable to staff those shifts with an RN who was an employee of the home. [s. 8. (3)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A. Resident #015 fell on an identified date in 2017 which resulted in a significant injury. A specific intervention was to be applied for an allotted amount of time during healing. Review of the written plan of care did not identify the application of the intervention. Interview with RN #100 and review of the plan of care confirmed that the intervention was planned care for the resident and was not documented in the written plan of care. (581).

B. Resident #016 had an Minimum Data Set (MDS) assessment completed which identified the level of pain the resident experienced. The MDS assessment completed at the following quarterly review indicated an increase in pain.

A review of the resident's plan of care did not include a focus statement related to pain until two months later, which was confirmed by the ADOC, following a review of the clinical record. The ADOC confirmed that the plan of care should have included a focus statement, goals and interventions related to pain prior to the date it was added, as it was a part of the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #012 had a MDS assessment completed in 2016, which noted that they had a fall in the past 30 days. A review of the MDS assessment completed in March 2017, identified that the resident had "none of the above" in reference to accidents including no mention that the resident had a fall in the past 31 to 180 days.

Review of the assessments in the clinical record identified that the resident had a fall on an identified date in 2017, within 31-180 days since the time of the assessment.

Interview with the ADOC confirmed that the assessments were not consistent with each other, following a review of the clinical record. [s. 6. (4) (a)]

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

Resident #022 was observed when they received their medications on an identified date during the RQI. RPN #103 was observed, following a meal, to administer the medications and take then complete another clinical nursing duty with the resident as identified on the eMAR.

On review of the physician's order from the week prior identified that the resident was to have this clinical nursing duty completed before meals and no longer after the meal. RPN #103 was identified to be "nurse #2 signature", was the staff member who processed the order, as identified by the DOC. The resident had the clinical nursing duty completed following the noon meal, which was not consistent with the order. Care was

not provided according to the physician's orders. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

During the RQI, resident #011 was observed in bed with specific falls and transfer interventions in place. Review of the logo posted above the bed identified something different than what was observed. Review of the plan of care identified that resident #011 required the same interventions as listed on the logo. Interview with PSW #102 stated the resident no longer required those interventions, rather required something else. Interview and observation of the resident's bed system with RPN #103 confirmed the plan of care was not reviewed and revised when the resident's care needs changed related to falls and transfer interventions. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: 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. Where the Act or this Regulation required 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 failed to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

O. Reg 79/10 s. 68(2)(a) requires the licensee to ensure that the programs include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

The home's newly instituted hydration protocol directed night PSW staff to circle the daily total fluid intake of a resident each day when they were below their daily goal, and if circled for three consecutive days, to alert the night RN. The night RN would then update the Dashboard and 24 hour shift report to alert the day RN that they need to assess for signs and symptoms of dehydration for that resident. If the resident did not display any signs and symptoms of dehydration, a progress note of the assessment was to be completed; and if they did appear dehydrated, a referral to the RD was also to be made.

Review of the Resident Daily Hydration Tracking Logs, identified that residents #020, #021, #022 and #023 were below their fluid targets for three consecutive days during a month in 2017.

Review of the shift reports for the corresponding dates did not identify that residents #020, #021 and #022 were below their fluid targets by the PSW's.

Review of the resident health records for residents #020, #021, #022 and #023 did not identify any progress notes of the assessments completed by the RN's. Review of the Dashboard did not identify any information about the targets not being met.

In an interview with the ED on November 1, 2017, they confirmed that the shift reports and progress notes by were not completed as per policy, and acknowledged that no indication of hydration assessments could be located. They confirmed that the home's hydration protocol was not complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

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

The home's procedure "Processing Physician's Orders" (policy number 3:4), identified to "process all new, changed or discontinued orders as per home policies and procedures" and "all new orders will be checked by two different nurses, by comparing the original order to the eMAR. The Administration Record Report under the clinical tab can be utilized to facilitate this eMAR verification process".

A review was conducted of the October 2017, eMAR and the current physician's orders for resident #022. This reviewed identified that not all written orders received were captured, as required, in the eMAR.

i) An order about a specific clinical nursing duty to be provided for a resident was not included on the eMAR, which was confirmed during a review of the clinical record by the DOC.
ii) Directions to prevent complications of a specific medical condition were not included on the eMAR, which was confirmed during a review of the clinical record by the DOC.
iii) Orders for direction on not to give the resident a specific type of fluid, was not included on the eMAR, which was confirmed during a review of the clinical record by the DOC.

Interview with the DOC identified that they had since reviewed the resident's orders and eMAR with the pharmacy and planed to have all orders reviewed and rewritten for clarity for staff. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

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

The home had a procedure "Routine Practices and Additional precautions - Contact Precautions" (IPC2-O10.06, effective date March 31, 2017), which identified the procedure for residents with contact precautions was to have "contact precautions signage visible on entry to room".

i) Carts containing personal protective equipment (PPE) were identified outside of various resident rooms during the RQI. Carts were stored outside of identified rooms; however, there was no signage in place on the doors to suggest that additional precautions were required. Interview with the Executive Director confirmed that residents #023 and #044 were both on contact precautions and that signage should have been posted on their doors, visible on entry to the room.

ii) During the RQI, signage was posted on an identified resident room door which identified that specific precautions were in place. Interview with the ED identified that the the home did not have any residents on that type of precaution and that resident #041 was on a different type of precaution and that the signage was not accurate. [s. 229. (4)]

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was kept clean and sanitary.

On October 30 and 31, 2017, the front entrance to the home, specifically the foyer between the two doors, was noted not to be clean. On observation there were cobwebs on the upper corners of the side light window, over the fire safety kit, over the electric door opener, around the lighting, ceiling corners and around posted signage. There were small dark discoloured and raised areas noted randomly on the walls.

Interview with housekeeping staff #105 verified that the flooring in this area was cleaned daily and a wipe down was completed on a weekly basis. Interview with the ESM confirmed that the area had cobwebs and discoloured areas when observed and verbalized the expectation for cleaning. The ESM provided clarification for the first floor housekeeping staff in the form of a memo for the area to be cleaned and the desired frequency and indicated that the home would implement an Exterior Audit of the home which would review both the maintenance and the cleaning of the area. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD).

The licensee did not comply with the conditions to which the licensee was subject in relation to the completion of the RAP assessment summary for non-triggered clinical conditions.

A. Resident #016 was coded in their Admission MDS Assessment with an identified level of pain. They were coded in their subsequent Quarterly MDS assessment with a different level of pain. A review of the clinical record did not include any RAPs for the non-triggered condition of pain, which was confirmed during an interview with the ADOC, who held responsibilities for RAI-MDS assessments in the home.

B. Resident #012 was coded in their Quarterly MDS assessment with no pain. They were coded in their two subsequent Quarterly MDS assessments with different levels of pain. A review of the clinical record did not include any RAPs for the non-triggered condition of pain, which was confirmed during an interview with the ADOC, who held responsibilities for RAI-MDS assessments in the home.

Interview with the ADOC identified their recent awareness of their need to complete non-triggered RAPs and that they had just begun this process for non-triggered clinical conditions including pain. [s. 101. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Resident #043 was involved in a medication incident on an identified date in 2017. The incident was identified and reported several days later. A review of the incident reports, progress notes and Critical Incident Report were inconsistent as to the nature of the incident. Interview with the ADOC and ED, who investigated the incident, were not able to clearly describe the actual incident, following a review of the documents available. The medication incident, which involved a resident was not documented, as confirmed during an interview with the ED. [s. 135. (1)]

Issued on this 9th day of November, 2017

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586), DIANNE BARSEVICH (581), LISA VINK (168)
Inspection No. / No de l'inspection :	2017_689586_0008
Log No. / No de registre :	024691-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 3, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	DOVER CLIFFS 501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pauline Robinson

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that a Registered Nurse (RN), who is an employee of the home, is scheduled to work in the home and on duty and present at all times except as provided for in the regulations.

To achieve this requirement the licensee shall develop written strategies to recruit, hire and retain RNs, who will hold the position of an employee of the licensee and a member of the regular nursing staff, and implement the strategies to an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the risk of harm toward the residents, the scope of a pattern of incidences, and the Licensee's history of non-compliance (VPC) on the May 24, 2017, Complaint Inspection with the s. 8 related to 24-hour nursing.

The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule from July 1 to October 20, 2017, identified that an RN that was a member of the regular nursing staff was not on duty for 25 shifts. In an interview with the ED on November 2, 2017, they stated that agency RN staff was present on the above shifts but confirmed the home was unable to staff those shifts with an RN who was an employee of the home. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 23, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 3rd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Jessica Paladino

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