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
Apr 23, 2018	2018_587129_0003	011134-17	Complaint

Licensee/Titulaire de permis

Grace Villa Limited
284 Central Avenue LONDON ON N6B 2C8

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

Grace Villa Nursing Home
45 Lockton Crescent HAMILTON ON L8V 4V5

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 13, 14, 21, 23, March 1, 2, and 6, 2018

During this inspection log # 011134-17 related to a medication incident was inspected.

During the course of the inspection, the inspector(s) spoke with residents, Registered Practical Nurses and the Director of Care (DOC).
During this inspection the inspector observed medication administration, reviewed resident's clinical records, reviewed Medication Incident Reports, reviewed Professional Advisory Committee minutes and reviewed the licensee's "Medication Incident Reporting" policy and procedure.

The following Inspection Protocols were used during this inspection:
Medication

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

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

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

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) Resident #004 was not administered an identified drug in accordance with the directions for use specified by the resident's physician.
During an interview with the DOC, they reviewed the Medication Administration Record (MAR) and physician orders and confirmed that the resident was to receive a specific dose of the identified drug three times a day. The physician wrote an order on an identified date which directed the first dose of the identified drug was to increase to a specified dose. The MAR for an identified month in 2017, indicated that the physician's order had not been transcribed in accordance with the physician's directions and identified that the resident was to receive the increase dose of the identified drug at all three administration times.
The DOC, the MAR and a Medication Incident Notification (MIN) confirmed that resident #004 was not administered the identified drug, in accordance with the directions from the physician, when the resident was administered the incorrect dose of this drug 38 times over a specific review period in 2017.
There was no evidence in resident #004's clinical record that staff had documented any indication that the resident had experienced harm during the time this medication was not administered in accordance with the physician's directions.

b) Resident #006 was not administered an identified drug, in accordance with the directions for use specified by the resident's physician.
During an interview with the DOC they reviewed clinical documentation, including physician's orders and confirmed that the resident was to receive the identified drug in the specific dose twice a day. At this time the DOC also confirmed that the order for the identified drug had not been altered between the time a medication reconciliation was completed and the time this medication incident was identified. Investigative notes of this incident, maintained by the home, indicated that at the time this drug was to be reordered, registered staff noted that there was still medication available. The investigative notes indicated that this drug was not placed in the medication pouch with the resident's other medications.
The DOC, MIN and records maintained by the pharmacy service provider confirmed that resident #006 was not administered the identified drug, in accordance with the directions from their physician, when the records indicated that the resident was not provided with this medication 42 times during a specified review period.
There was no evidence in resident #006's clinical record that staff had documented any indication that the resident had experienced harm during the time this medication was not administered in accordance with the physician's directions.

c) Resident #005 was not administered an identified drug, in accordance with the directions for use specified by the resident's physician.
During an interview with the DOC they reviewed clinical documentation, including physician's orders and confirmed that the resident was to receive the identified drug at a specified dose twice a day and that this order had not been altered between the time a medication reconciliation was completed and the time this medication incident was identified. Investigative notes maintained by the home indicated that on an identified day in 2017 staff noted and reported that the second dose of the identified drug had not been administered to the resident.
The DOC, the staff person involved in the incident, the MIN and the MAR confirmed that resident #005 was not administered the identified drug, in accordance with the directions specified by their physician, when the resident did not receive the second dose of this drug on an identified date in 2017.
There was no evidence in resident #005's clinical record that staff had documented any indication that the resident had experienced harm during the time this medication was not administered in accordance with the physician's directions. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan,

policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with Ontario Regulation 114 (2), 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.

Specifically, staff did not comply with licensee's policy "Medication Incident Reporting", identified as policy 9-1 with a date of January 2014 and February 2017, which is part of the licensee's medication management system.

The Medication Incident Reporting policy with a date of February 2017, directed that staff were to "Complete the Medication Incident Report (MIR), when a medication incident or adverse drug has occurred, including near miss situations."

Staff did not comply with the above noted directions when:

a) A Medication Incident Report (MIR) was not completed when an incorrect medication, that resident #001's physician had not ordered the resident to receive was sent with the resident on an identified date in 2016. Resident #001 and documentation maintained by the home confirmed that Registered Practical Nurse (RPN) #100 provided medications for resident #001 to take that included a bottle of an identified drug that the resident's physician had not ordered them to receive. A family member of resident #001 contacted the home and alerted RPN #100 that the resident had received an incorrect medication and the resident had not taken the medication. In response RPN #100 retrieved the incorrect bottle of medication.
The Director of Care (DOC), the MIR and records maintained by the home confirmed that a MIR was not completed until after the home was contacted by the Ministry of Health and Long-Term Care, 220 days after the above noted medication incident had occurred.

b) A MIR was not completed when an incorrect medication, that resident #001's physician had not ordered the resident to receive, was sent with the resident on a second identified date in 2016. Resident #001 and documentation maintained by the home confirmed that RPN #100 provided medications to resident #001 that included an identified medication the resident's physician had not ordered the resident to receive. A family member of resident #001 contacted the home on an identified date, and alerted RPN #100 that the resident had received an incorrect medication. In response, RPN

incorrect medication and provide the medication that the resident's physician had ordered to the resident. Resident #001 confirmed that they had not taken the incorrect medication.
The Director of Care (DOC), the MIR and records maintained by the home confirmed that a MIR was not completed until after the home was contacted by the Ministry of Health and Long-Term Care, 179 days after this medication incident had occurred. [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 and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: 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).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was 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.

a) Registered staff did not report two medication incidents involving resident #001 to the DOC, the resident's physician or the pharmacy provider.

i) Resident #001 and documentation maintained by the home confirmed that Registered Practical Nurse (RPN) #100 sent medications with resident #001 to take which included a bottle of an identified medication the resident's physician had not ordered them to receive. A family member of resident #001 contacted the home on an identified date in 2016, and alerted RPN #100 that the resident had received an incorrect medication. In response RPN #100 retrieved the incorrect bottle of medication.
The Director of Care (DOC) and records maintained by the home confirmed that RPN #100 did not report this medication incident to the DOC, the resident's physician or the pharmacy service provider until after the home was contacted by the Ministry of Health and Long-Term Care, 220 days after the above noted medication incident had occurred.

i) Resident #001 and documentation maintained by the home confirmed that RPN #100 sent medications with resident #001 which included an incorrect medication that the resident's physician had not ordered them to receive. A family member of resident #001 contacted the home on an identified date in 2016, and alerted RPN #100 that the resident had received an incorrect medication. In response, RPN #100 retrieved the incorrect drug and supplied the resident with the correct medication the resident's physician had ordered the resident to receive.
The Director of Care (DOC) and records maintained by the home confirmed that RPN #100 did not report this medication incident to the DOC, the resident's physician or the pharmacy service provider until after the home was contacted by the Ministry of Health and Long-Term Care, 179 days after this medication incident had occurred.

b) Registered staff did not report a medication incident involving resident #004 to the resident or the resident's Substitute Decision Maker (SDM)

The DOC, the Medication Administration Record (MAR) and a Medication Incident Report (MIR) indicated that resident #004 was administered an incorrect dose of and identified drug 38 over an identified review period in 2017. During an interview with the DOC, they confirmed that sometimes resident #004 directs their own care and sometimes staff feel that they need to contact the resident's designated SDM about an issue. During the interview, the DOC confirmed that they were unable to provide any evidence that this medication incident was reported to either resident #004 or their SDM.

c) Registered staff did not report a medication incident involving resident #006 to the

resident's SDM.

The DOC, records maintained by the home and a MIR indicated that resident #006 was not administered an identified drug in accordance with the physician's orders.
Investigative notes maintained by the home confirmed that the resident was not provided with 42 doses of the medication over an identified review period in 2017.
During an interview with the DOC, they confirmed that resident #006 was not able to make decisions related to medication and they were unable to provide any evidence that this medication incident was reported to resident #006's SDM.

d) Registered staff did not report a medication incident involving resident #005 to the resident's SDM or the resident's physician.

The DOC, records maintained by the home and a MIR indicated that resident was not administered an identified drug twice a day in accordance with the physician's orders.
The MIR indicated that the resident did not receive the above noted drug the second time on an identified date in 2017.
During an interview with the DOC, they confirmed that resident #005 would not have been able to make decisions regarding mediation and they were unable to provide any evidence that this medication incident was reported to resident #004's SDM or their physician. [s. 135. (1) (b)]

2. The licensee failed to ensure that there was a written record kept of the review, analysis and corrective actions taken for all medication incidents and adverse drug reactions.

a) The DOC, the MIR and the MAR confirmed that resident #004 received the incorrect dose of an identified drug 38 times over a specific review period in 2017. The DOC and the MIR confirmed, there was not a written record kept of the review, analysis or corrective actions taken related to this medication incident.

b) The DOC, the MIR and the MAR confirmed that staff did not provide resident #005 with an identified drug, as directed by the resident's physician on an identified date in 2017. The DOC and the MIR confirmed there was not a written record kept of the review or analysis of this medication incident. [s. 135. (2) (c)]

3. The licensee failed to ensure that a written record was kept of the quarterly review of all medication incidents and adverse drug reactions that had occurred in the home since

the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The DOC confirmed that the quarter review of medication incidents and adverse drug reactions occurred during the Professional Advisory Committee (PAC) meetings. The DOC and a review of the minutes of the June 27, 2017, PAC meeting, confirmed that the written record of this meeting did not provide verification that there had been a review undertaken of all medication incidents and adverse drug reactions that had occurred in the three months preceding the meeting. The DOC also confirmed that they were unable to provide written verification that all medication incidents that had occurred since the PAC meeting held on June 27, 2017, had been reviewed at the following meeting held in September 2017, when they were unable to provide minutes of this PAC meeting. [s. 135. (3) (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 and ensuring that:
- every medication incident involving a resident and every adverse drug reaction was 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;
- that there was a written record was kept of the review, analysis and corrective actions taken for all medication incidents and adverse drug reactions, and
-a written record was kept of the quarterly review of all medication incidents and adverse drug reactions that had occurred in the home since the last review, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that access to the areas where drugs were stored was restricted to (i) persons who may dispense, prescribe or administer drugs in the home, and (ii) the Administrator.

On an identified date and at a specified time in 2018, the Inspector observed a staff person who was not allowed to dispense, prescribe or administer drug in the medication room located on the second floor home area with the medication room door was closed. The inspector noted that there were no persons who may dispense, prescribe, and administer drugs or the Administrator in the medication room or in the vicinity around the medication room at that time. The staff person confirmed they were an contracted service brought in to repair the medication room door. Immediately after this observation, RPN #115 was noted to enter the medication room and indicated that they were unaware that the identified worker had been left unattended in the medication room.
Registered staff failed to ensure that the medication room on the second floor home area was restricted to persons who may dispense, prescribe or administer drugs, when they allowed a contracted maintenance worker to have unrestricted and unsupervised access to an area in the home were drugs were stored. [s. 130. 2.]

Issued on this 16th day of May, 2018

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2018_587129_0003
Log No. / No de registre :	011134-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 23, 2018
Licensee / Titulaire de permis :	Grace Villa Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Grace Villa Nursing Home 45 Lockton Crescent, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet West

To Grace Villa Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131(2) of Ontario Regulation 79/10.

Specifically the licensee must:

a) Ensure residents #004, #005, #006 and any other residents, are administered drugs in accordance with the directions for use specified by the prescriber.

b) Ensure the medication incidents that involved the following residents are reviewed, analyzed, plans are put in place to reduce the risk of a recurrence and that this process is documented:
- Resident #004 – medication incident dated June 20, 2017.
- Resident #005 – medication incident dated December 16, 2017.
- Resident #006 – medication incident dated June 7, 2017.

c) Ensure the development and implementation of a system of monitoring and the administration of medications to residents. Records of auditing activities are to be maintained.

Grounds / Motifs :

1. The severity of this issue was determined to be a level 2 as there was a potential for actual harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance in a similar area that included:
~ s. 129 - written notification (WN) issued April 26, 2017 (2017_569508_0007);
~ s. 131 – voluntary plan of correction (VPC) issued April 26, 2017 (2017_569508_0007);

~ s. 135(1)- voluntary plan of correction (VPC) issued April 26, 2017 (2017_569508_0007);
~ s. 135(2) –voluntary plan of correction (VPC) issued April 26, 2017 (2017_569508_0007)
~ s. 135(3)-voluntary plan of correction (VPC) issued April 26, 2017 (2017_569508_0007)

2. Drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

a) Resident #004 was not administered an identified drug in accordance with the directions for use specified by the resident's physician.
During an interview with the DOC, they reviewed the Medication Administration Record (MAR) and physician orders and confirmed that the resident was to receive a specific dose of the identified drug three times a day. The physician wrote an order on an identified date, that directed the first dose of the identified drug was to increase to a specified dose. The MAR for an identified month in 2017, indicated that the physician's order had not been transcribed in accordance with the physician's directions and identified that the resident was to receive the increase dose of the identified drug at all three administration times. The DOC, the MAR and a Medication Incident Notification (MIN) confirmed that resident #004 was not administered the identified drug, in accordance with the directions from the physician, when the resident was administered the incorrect dose of this drug 38 times over a specified review period in 2017.
There was no evidence in resident #004's clinical record that staff had documented any indication that the resident had experienced harm during the time this medication was not administered in accordance with the physician's directions.

b) Resident #006 was not administered an identified drug, in accordance with the directions for use specified by the resident's physician.
During an interview with the DOC they reviewed clinical documentation, including physician's orders and confirmed that the resident the identified drug in the specific dose twice a day. At this time the DOC also confirmed that the order for the identified drug had not been altered between the time a medication reconciliation was completed and the time this medication incident was identified. Investigative notes of this incident, maintained by the home, indicated that at the time this drug was to be reordered, registered staff noted that there

was still medication available. The investigative notes indicated that this drug was not placed in the medication pouch with the resident's other medications.
The DOC, MIN and records maintained by the pharmacy service provider confirmed that resident #006 was not administered the identified drug, in accordance with the directions from their physician, when the records indicated that the resident was not provided with this medication 42 times during a specified review period.
There was no evidence in resident #006's clinical record that staff had documented any indication that the resident had experienced harm during the time this medication was not administered in accordance with the physician's directions.

c) Resident #005 was not administered an identified drug, in accordance with the directions for use specified by the resident's physician.
During an interview with the DOC they reviewed clinical documentation, including physician's orders and confirmed that the resident was to receive the identified drug at a specified dose twice a day and that this order had not been altered between the time a medication reconciliation was completed and the time this medication incident was identified. Investigative notes maintained by the home indicated that on an identified day in 2017 staff noted and reported that the second dose of the identified drug had not been administered to the resident.
The DOC, the staff person involved in the incident, the MIN and the MAR confirmed that resident #005 was not administered the identified drug, in accordance with the directions specified by their physician, when the resident did not receive the second dose of this drug on an identified date in 2017.
There was no evidence in resident #005's clinical record that staff had documented any indication that the resident had experienced harm during the time this medication was not administered in accordance with the physician's directions. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2018

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

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 23rd day of April, 2018

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 : PHYLLIS HILTZ-BONTJE

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