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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2016	2016_389601_0008	010568-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

HILLSDALE ESTATES
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

KARYN WOOD (601), BAIYE OROCK (624), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), DENISE BROWN (626), JULIET MANDERSON-GRAY (607)

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): April 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, and May 2, 2016.

The following logs were inspected during the Resident Quality Inspection (RQI):

Critical incident numbers M539-000026-16, M539-000027-16 (log #009735-16), M539-000009-16, M539-000013-16 (log#003884-16), M539-000024-16 (log #008793-16),

M539-000038-16 (log #012880-16) submitted by the home regarding resident to resident altercations.

Critical incident numbers M539-000011-16 (log #004524-16), M539-000033-16 (log #011892-16), M539-000034-16 (log# 011970-16) submitted by the home regarding allegations of abuse to a resident.

Complaint log(s) #032179-15, #011833-15, #022518-15, #011794-15 regarding communication in the home and concerns regarding resident care.

Complaint log #027436-15 regarding staffing levels.

Follow up log #001393-16 regarding mandatory reporting of a critical incident.

Follow up log #001440-16 regarding medication incidents and adverse drug reactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Resident Care Coordinators (RCC), Administrative Assistant, Environmental Manager, RAI Coordinator, Occupational Therapist, Physio Therapist Assistant, Registered Dietitian, Infection Control Nurse, Scheduling Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), members of the Behavioural Support Team (BSO), Food and Service Worker, President of the Resident Council and Family Council, family members and residents.

The inspectors also toured the home, observed interactions between staff and residents during the provision of care, dining and snack services, administration of medication, reviewed clinical health records and the licensee's applicable policies, family and resident council minutes.

The following Inspection Protocols were used during this inspection:

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

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)**

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. 107. (3)	CO #001	2015_360111_0020	601
O.Reg 79/10 s. 135. (2)	CO #002	2015_360111_0020	601

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #060 and resident #061 by not implementing the identified interventions.

Related to log #008793-16:

On an identified date, time and place resident #060 exhibiting a specific responsive behaviour approached resident #061 and a potential harmful interaction occurred between the two residents.

Review of resident #060's care plan indicted that resident #060 had episodes of responsive behaviours. The interventions included to monitor and document behaviour and attempt to determine underlying causes; consider location, time of day, persons involved; observe mood patterns and document signs and symptoms of the identified responsive behaviour; ongoing assessment to determine if problems relate to change in condition; evaluation and recommendations by the PIECES team and begin a DOS to assess behaviour and patterns.

Review of resident #060's Behaviour Assessment Tool completed by PSW #158 approximately seven months prior to the incident identified that resident #060 responsive behaviours included the identified responsive behaviour. Resident #060's triggers were identified as noise, commotion, yelling or other residents entering the residents room. Interventions included directing resident #060 to programs or away from noisy areas.

Review of resident #060's progress notes identified that ten days prior to the incident the Social Worker had documented on resident #060's progress notes that a referral had been emailed to the BSO staff for possible interventions due to resident #060 having an escalation of the responsive behaviour.

RPN #109 documented in resident #060's progress notes that it had been reported and observed that resident #060 had been exhibiting the identified responsive behaviours and becoming more difficult to manage prior to the incident.

Review of resident #060's clinical records identified that a Dementia Observation System (DOS) had been completed for five days following the incident of resident #060 exhibiting the responsive behaviour towards resident #061. During this time resident #060 was being monitored by staff and was noted to have exhibited the responsive behaviour on one occasion.

Related to log #008793-16:

On an identified date and time, resident #061's Substitute Decision Maker (SDM) reported to the Director of Nursing that resident #060 had approached the SDM and resident #061 while they were having a conversation. Resident #061's SDM indicated that resident #060 came from an area close by and approached them with a potentially harmful responsive behaviour.

During an interview, resident #061 indicated being fearful of resident #060 and believed that resident #060 was upset with the resident because resident #061 had been complaining to the nurses about a specific issue involving resident #060.

Review of resident #060 and #061's care plan at the time of the incident did not identify the steps required to minimize the risk of altercations and potentially harmful interactions between resident #060 and resident #061 by identifying but not implementing interventions related to resident #060 specific issue that was upsetting resident #061.

Review of resident #061's progress notes for a three month period identified that resident #061 had discussed concerns with the nursing staff regarding a specific issue related to resident #060 that occurred on seven occasions.

Review of resident #061's progress notes for approximately a two months period prior to the incident identified that resident #061's SDM had discussed with the nursing staff concerns about the specific issue between resident #061 and #060.

Review of resident #060's progress notes for a three month period identified that resident #060's specific issue had been documented as occurring on four occasions.

Review of the Annual Medical completed by the Physician twenty-three days prior to the incident indicated that resident #060 had identified responsive behaviours. The Physician identified that the behaviour was not improving and ordered the Mini-Mental State Exam (MMSE) at this time.

During an interview, BSO #158 and BSO #159 indicated being aware of resident #060's specific issue and interventions were in place. BSO #158 and BSO #159 also indicated the MMSE recently ordered by the Physician had not been completed prior to the incident.

Therefore, the planned interventions for resident #060 were not implemented successfully on the day of the identified incident and steps were not taken to minimize the risk for resident #061 resulting in a second potentially harmful altercation between resident #060 and #061. [s. 54. (b)]

2. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #044 and resident #045 by not identifying and implementing interventions following an altercation.

Related to log #009735-16:

Review of critical incident report and clinical records indicated that on an identified date and time, HCA #165 witnessed resident #044 exhibiting harmful identified responsive behaviours towards resident #045. The residents were separated by HCA #165 and RPN #166. Following the altercation it was identified that resident #045 was upset and and minor injuries were noted.

Review of critical incident indicated the immediate action following the incident was to separate resident #044 and #045 and monitoring of both residents.

Two days following the first incident, HCA #167 observed resident #044 exhibiting a second harmful responsive behaviour towards resident #045. Following the altercation it was identified that resident #045 was emotionally upset but did settle.

Review of the critical incident indicated the immediate action was to separate the residents and staff monitoring was initiated for resident #044. The DOS was also initiated following the second incident.

Review of resident #044's plan of care at the time of both incidents identified that resident #044 had specific responsive behaviours.

Review of resident #044's Behaviour Support Ontario (BSO) tip sheet in place at the time of the incident identified that resident #044 had a history of responsive behaviours. The BSO tip sheet indicated that resident #044's trigger for the responsive behaviour was other residents wandering into the resident's room. The interventions included to try to keep other residents from entering resident #044's room.

Therefore, on an identified date there was an altercation and potentially harmful interaction between resident #044 and #045 and the monitoring of both residents that was put in place at the time of the incident was not effective to prevent a second altercation from occurring two days following the first incident. [s. 54. (b)]

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to bed mobility.

Related to Log # 004524-16:

A critical incident report (CIR) was received for improper/incompetent treatment of a resident that resulted in risk of harm to the resident. The CIR indicated that on an identified date, it was reported to RPN #153 by PSW #154 that resident #046 sustained a minor injury following the resident being transferred from bed to another location.

Review of resident #046's plan of care in place at the time of the incident indicated the resident requires extensive assistance by two staff with transferring and bed mobility.

A review of the investigation notes and interview with PSW #111 confirmed that the PSW had been transferring the resident in bed independently, and the staff indicated not following interventions identified in the residents care plan relating to bed mobility. [s. 6. (7)]

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 resident #046's plan of care is provided to the resident as specified in the plan related to bed mobility, to be implemented voluntarily.

WN #3: 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 has failed to ensure that resident #059's drugs were administered to the resident in accordance with the directions for use as specified by the prescriber on an identified date.

Related to log #001440-16:

Review of resident #059's Physician orders included an order for resident #059 to receive an identified medication at 0800, 1200 and 1600 hours daily.

Record review of resident #059's Medication Administration Record and Combined Monitored Medication Record with Shift Count Sheet for the identified date and time identified that RPN #157 had documented that resident #059's identified medication had been administered on the identified date and time.

Record review of resident #059's Medication Incident Report identified that resident #059 did not receive the scheduled dose of the identified medication on the identified date and time.

During an interview, RPN #157 indicated that on the identified date and time the documentation for resident #059's identified medication was completed on resident #059's medication record and narcotic count sheet prior to the administration of the medication. The RPN also indicated being distracted by a family member at this time and forgetting to administer resident #059's identified medication on the identified date and time as prescribed by the Physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents drugs are administered to the residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there was monitoring and documentation of resident #050's response and the effectiveness of identified drugs being taken for a twenty-five day period.

During the RQI it was identified that resident #050 had a change in condition according to the most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS) related to an identified medical condition.

Review of resident #050's RAI-MDS on an identified date during a twenty-five day period indicated that resident #050 had a medical condition at the time of the assessment.

Review of resident #050's Physician orders for the identified month indicated that the Physician had prescribed a medication by mouth twice daily for a ten day period and when the medication was completed a different medication was prescribed for another thirteen days.

Six days following the initial medication being initiated, RN #160 documented in resident #050's progress notes that resident #050 was experiencing an ongoing medical symptom.

Review of resident #050's Medication Administration Record from the identified month indicated that resident #050's Physician had prescribed a medication by mouth for the medical symptoms as required. Resident #050's as required medication for medical symptoms was documented as administered on twenty-six occasions and the progress notes identified that the resident had medical symptoms on thirty-one occasions during an identified thirty-one day period.

Review of resident #050's progress notes for the identified thirty-one day period identified that there was no documentation of the monitoring of the medical condition or the ongoing medical symptoms or the effectiveness of the prescribed medication on twenty-seven identified dates.

During an interview, the Director of Nursing and RN #101 indicated the monitoring of resident #050's health status and the effectiveness of the medication should have been documented in resident #050's health record.

Therefore, there was no evidence that there was monitoring and documentation of resident #50's response and the effectiveness of the medication being taken on twenty-seven shifts within a thirty-one day period. [s. 134. (a)]

Issued on this 11th day of May, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KARYN WOOD (601), BAIYE OROCK (624), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), DENISE BROWN (626), JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2016_389601_0008
Log No. / Registre no:	010568-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 11, 2016
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	HILLSDALE ESTATES 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Peragine

To REGIONAL MUNICIPALITY OF DURHAM, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee is ordered to prepare, submit, and implement a corrective action plan that identifies the person responsible for ensuring measures are in place, the steps to be taken to minimize the risk of altercations and potentially harmful interactions between the identified residents to include the following:

The licensee shall ensure:

1. a review and update of resident #060, #061, #044 and #045 care plans is completed to ensure that responsive behaviours are identified for individual residents exhibiting behaviours, that triggers to the behaviours are identified, and that for each behaviour identified there are strategies in place to assist staff in managing the responsive behaviours;

2. a monitoring process is developed to evaluate the effectiveness and timelines of the residents planned interventions aimed at protecting residents from altercations and responsive behaviours, triggers if any identified, actions taken by staff, and the resident's response to the planned intervention;

3. ensure that all registered nursing staff receive education specific to their responsibilities to monitor, evaluate, document and communicate within the multidisciplinary team on residents who have responsive behaviours and to ensure that those residents with escalating behaviours are referred to the BSO lead for further assessment in a timely manner.

This corrective action plan is be submitted by May 26, 2016 to Karyn Wood, LTCI via email to OttawaSAO.MOH@ontario.ca.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #060 and resident #061 by not implementing the identified interventions.

Related to log #008793-16:

On an identified date, time and place resident #060 exhibiting a specific responsive behaviour approached resident #061 and a potential harmful interaction occurred between the two residents.

Review of resident #060's care plan indicted that resident #060 had episodes of

responsive behaviours. The interventions included to monitor and document behaviour and attempt to determine underlying causes; consider location, time of day, persons involved; observe mood patterns and document signs and symptoms of the identified responsive behaviour; ongoing assessment to determine if problems relate to change in condition; evaluation and recommendations by the PIECES team and begin a DOS to assess behaviour and patterns.

Review of resident #060's Behaviour Assessment Tool completed by PSW #158 approximately seven months prior to the incident identified that resident #060 responsive behaviours included the identified responsive behaviour. Resident #060's triggers were identified as noise, commotion, yelling or other residents entering the residents room. Interventions included directing resident #060 to programs or away from noisy areas.

Review of resident #060's progress notes identified that ten days prior to the incident the Social Worker had documented on resident #060's progress notes that a referral had been emailed to the BSO staff for possible interventions due to resident #060 having an escalation of the responsive behaviour.

RPN #109 documented in resident #060's progress notes that it had been reported and observed that resident #060 had been exhibiting the identified responsive behaviours and becoming more difficult to manage prior to the incident.

Review of resident #060's clinical records identified that a Dementia Observation System (DOS) had been completed for five days following the incident of resident #060 exhibiting the responsive behaviour towards resident #061. During this time resident #060 was being monitored by staff and was noted to have exhibited the responsive behaviour on one occasion.

Related to log #008793-16:

On an identified date and time, resident #061's Substitute Decision Maker (SDM) reported to the Director of Nursing that resident #060 had approached the SDM and resident #061 while they were having a conversation. Resident #061's SDM indicated that resident #060 came from an area close by and approached them with a potentially harmful responsive behaviour.

During an interview, resident #061 indicated being fearful of resident #060 and believed that resident #060 was upset with the resident because resident #061 had been complaining to the nurses about a specific issue involving resident #060.

Review of resident #060 and #061's care plan at the time of the incident did not identify the steps required to minimize the risk of altercations and potentially harmful interactions between resident #060 and resident #061 by identifying but not implementing interventions related to resident #060 specific issue that was upsetting resident #061.

Review of resident #061's progress notes for a three month period identified that resident #061 had discussed concerns with the nursing staff regarding a specific issue related to resident #060 that occurred on seven occasions.

Review of resident #061's progress notes for approximately a two months period prior to the incident identified that resident #061's SDM had discussed with the nursing staff concerns about the specific issue between resident #061 and #060.

Review of resident #060's progress notes for a three month period identified that resident #060's specific issue had been documented as occurring on four occasions.

Review of the Annual Medical completed by the Physician twenty-three days prior to the incident indicated that resident #060 had identified responsive behaviours. The Physician identified that the behaviour was not improving and ordered the Mini-Mental State Exam (MMSE) at this time.

During an interview, BSO #158 and BSO #159 indicated being aware of resident #060's specific issue and interventions were in place. BSO #158 and BSO #159 also indicated the MMSE recently ordered by the Physician had not been completed prior to the incident.

Therefore, the planned interventions for resident #060 were not implemented successfully on the day of the identified incident and steps were not taken to minimize the risk for resident #061 resulting in a second potentially harmful altercation between resident #060 and #061. [s. 54. (b)]

2. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #044 and resident #045 by not identifying and implementing interventions following an altercation.

Related to log #009735-16:

Review of critical incident report and clinical records indicated that on an identified date and time, HCA #165 witnessed resident #044 exhibiting harmful identified responsive behaviours towards resident #045. The residents were separated by HCA #165 and RPN #166. Following the altercation it was identified that resident #045 was upset and and minor injuries were noted.

Review of critical incident indicated the immediate action following the incident was to separate resident #044 and #045 and monitoring of both residents.

Two days following the first incident, HCA #167 observed resident #044 exhibiting a second harmful responsive behaviour towards resident #045. Following the altercation it was identified that resident #045 was emotionally upset but did settle.

Review of the critical incident indicated the immediate action was to separate the residents and staff monitoring was initiated for resident #044. The DOS was also initiated following the second incident.

Review of resident #044's plan of care at the time of both incidents identified that resident #044 had specific responsive behaviours.

Review of resident #044's Behaviour Support Ontario (BSO) tip sheet in place at the time of the incident identified that resident #044 had a history of responsive behaviours. The BSO tip sheet indicated that resident #044's trigger for the responsive behaviour was other residents wandering into the resident's room. The interventions included to try to keep other residents from entering resident #044's room.

Therefore, on an identified date there was an altercation and potentially harmful interaction between resident #044 and #045 and the monitoring of both residents that was put in place at the time of the incident was not effective to

prevent a second altercation from occurring two days following the first incident. [s. 54. (b)]

The non-compliance with O. Reg. 79/10, s. 54(b) order was ordered based on the fact that there was a second altercation between resident #060 and #061 within a six week period and there was a second altercation between resident #044 and #045 within a two day period. There was no evidence that that steps were taken to minimize the risk of altercations and potentially harmful interactions between the identified residents or that the identified interventions were implemented at the time of the second incidents.

In addition, the compliance history of the licensee included an order on August 15, 2015 and January 22, 2015 in a similar area. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

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
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 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 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 11th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

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