Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 9, 2013	2013_230134_0010	O-000500-13	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet, LINDSAY, ON, K9V-5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

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

COLETTE ASSELIN (134)

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): July 24, 25 and 26, 2013

During the course of this complaint inspection (log # O-000500-13), a critical inspection #2013_230134_0010 was also conducted.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Education Coordinator and with several residents.

During the course of the inspection, the inspector(s) reviewed residents' health records, the Nursing checklist for Investigating alleged abuse of Resident by Family or Staff, The Oral and Dental Care and Referral, the Lift Procedures, the Abuse and Neglect of a Resident Policy #VII-G-10.00,

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, S.O. 2007, c.8 section 24 (1) 2., in that an allegation of staff to resident abuse was not reported immediately to the Director.

In late January 2013/early February 20013, staff member #S87 had reasonable grounds to suspect an allegation of abuse between staff member #S100 and Resident #1. Staff member #S87 did not report this incident to management or to the Director. Staff #87 indicated to the inspector on July 24, 2013 that he/she did not report the incident due to fear of reprisal from staff member #S100 and other staff.

On a specified date in May, 2013 the ADOC received a letter from staff member #S87 informing him/her that a few months back he/she had witnessed an incident of abuse between staff member #S100 and Resident #1 and had indicated in the letter that he/she would provide a full account of what had happened as well as other accounts of abuse he/she had seen.

On a specified date in June, 2013, a police officer delivered a letter t the home's management, which had been written by staff member #S87 providing a detailed description of an allegation of abusive approach by staff member #S100 toward Resident #1.

As such, the suspicion of staff to resident abuse, which dates back to late January/early February, 2013, was not reported to the Director immediately as per legislative requirement. [s. 24. (1)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c 8, s. 24(1) 2., in that the licensee did not immediately notify the Director as soon as it became aware of reasonable grounds to suspect sexual abuse by one resident towards another resident.

On a specified date in July, 2013, staff member #S110 witnessed an incident of a sexual nature, which was not consensual between two residents.

The licensee immediately investigated and took action in response to the incident but as soon as reasonable grounds to believe sexual abuse had occurred, the licensee did not immediately report the allegation of sexual abuse to the Director via the Critical Incident System (CIS) or by the after-hour pager. The incident occurred on a specified

1. The licensee failed to comply with the LTCHA 2007, S.O. 2007, c.8 section 24 (1) 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c.8, s. 3(1)1., in that staff member #S90 did not comply with the licensee's Abuse and Neglect policy whereby "all employees are expected to respond to residents with patience and compassion".

On a specified date in May, 2013 Resident #6 reported three incidents of staff to resident incidents of emotional and verbal abuse.

Resident #6 reported to the ADOC that on a specified day in May, 2013, he/she had gone out with his/her son and when he/she returned to the home, he/she heard staff member #S90 yell out his/her name and asking him/her "Where have you been?...You know it's your bath day". He/She also reported to the ADOC that Staff #S90 makes him/her uncomfortable.

Resident #6 also reported to the ADOC, that on specified day in May, 2013, that while he/she was making an alternate choice for the vegetables, staff member #S90 walked away and did not let him/her finish, that the staff member turned around to walk away and put his/her arm up and said "whatever".

On a specified day in May,2013, Resident #6 reported to the ADOC that staff member #S90 had been disrespectful toward him/her, after he/she had requested a towel to dry his/her hair. The staff member had responded "you're not the only resident on the floor...I have other residents to look after".

As such, staff member #S90 did not promote Resident #6's right to be treated with courtesy, respect and in a way that fully recognized his/her individuality and dignity.

The licensee failed to comply with the LTCHA, 2007 S.O. 2007, c.8, s. 3 (1)(1), when Resident #1's rights were not fully respected and promoted, in that, the clear and specific directions as identified in his/her care plan regarding his/her behaviour management interventions, were not followed.

On July 24, 2013, staff member #S87 reported to the inspector that he/she had observed staff member #S100 use physical force against Resident #1 in late January/early February 2013. Staff member #87 indicated that he/she had not reported the incident of alleged abuse to management due to fear of reprisal from staff

member #S100 and other staff and did not report the allegation of abuse to the Director immediately.

On July 24, 2013, staff member #S100 was interviewed by Inspector #134 regarding an allegation of abuse toward Resident #1, which had been made against him/her. Staff member #S100 reported that he/she recalled an incident that occurred in late January/early February 2013. He/she described the incident and his/her interventions. The approach used by Staff #S100 was not done according to the clear directions provided in Resident #1's care plan.

Resident #1's plan of care was reviewed, there is a list of interventions for staff to follow related to aggression and agitation management. These interventions are very specific as to not invade the resident's personal space and to allow him/her to do household tasks in the dining room to decrease agitation. There are other entries specifying to approach Resident #1 slowly and from the front and to allow him/her to respond to direction or requests".

On a specified date in July, 2013, staff member #111, who works closely with residents with responsive behaviours and who knows Resident #1 well, was interviewed. He/She indicated he/she was very aware of Resident #1's triggers and which interventions are to be used to diminish agitation and aggression. Staff member #111 reported that "Resident #1 understands and there is no need to touch him/her as the resident is easily directed".

On July 24, 2013, the DOC and the ADOC were interviewed and they indicated the allegation of staff to resident abuse had been reported to them on a specified date in June, 2013, by the police. The officer had received the letter of concern from staff member #S87. At the time of the inspection, on July 24, 2013, staff #S100 had not been interviewed by Management regarding the allegation of abuse toward Resident #1, dated January/early February 2013. [s. 3. (1) 1.]

2. The licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c.8, s. 3(1) 3., in that Resident #7 was not protected from neglect by staff.

The Ontario Reg.79/10, made under the Long Term Care Home Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, service or assistance required for health, safety or well-being, and includes inaction or a pattern

of inaction that jeopardizes the health, safety or well being of one or more residents

The following occurrences demonstrate inaction that jeopardized the health and well being of Resident #7, in that it failed to provide the resident with care and assistance with toileting need.

Resident #7 was found sitting on the bedpan for approximately 4 hours by a family member on a specified day in May, 2013. The resident had been placed on the bedpan by the day staff at 14:30.

The PSW, who had placed the resident on the bedpan, had reported to management that the call bell had been given to the resident and the evening staff had been told that Resident #7 was on the bedpan before leaving for the day.

Staff members, who made their rounds at the beginning of the afternoon shift did not notice that Resident #7 was on the bedpan.

The plan of care was reviewed and there is an entry that specifies the resident requires total assistance by 2 people for repositioning in bed. The resident was bedridden and was therefore not repositioned for 4 hours. Furthermore, there is a nursing diagnosis specifying that resident #7 has poor memory.

Resident #7 is using a specialized pressure reduction surface due to risk of impaired skin integrity.

As such, the fact that Resident #7 was left on the bedpan and not repositioned in bed nor for the dinner meal, for a period of approximately 4 hours, jeopardized the resident's health, safety and well being. [s. 3. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff fully respects the Residents' Rights and treat all residents with courtesy and respect in a way that fully recognizes their individuality and respects their dignity. As well to ensure all staff is aware of the definitions of abuse and neglect and the O.Reg. 79/10, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with the O. Reg 79/10 s. 34 (1) (a), in that Resident #2 did not receive mouth care to maintain the integrity of the oral tissue.

Resident #2's care plan was reviewed and there is an entry that specifies "to apply toothpaste to tooth brush and provide guidance in brushing of his/her teeth. Perform daily assessment with focus on broken teeth".

The Resident Assessment Protocol (RAP) reads as follows: "Resident has own teeth and requires assistance from staff to care for them related to cognitive impairment and physical limitations".

On July 24, 2013, the following staff members; #S102, #S85, #S103, #S84, #S103 and #S86, were interviewed by Inspector #134. Each staff member described different approaches to complete Resident #2's mouth and oral care. Several staff members indicated that the resident's condition had changed since Christmas 2012 and that now more assistance was required from staff with mouth care. According to several staff members, the resident had an electric toot brush at admission. They indicated that mouth care went well using the electric tooth brush but since the batteries had died, several months ago, staff now use a regular toothbrush when available or they will use foam swabs and mouthwash to brush his/her natural teeth. Several staff member reported that Resident #2's gums were bleeding when using the regular toothbrush and that he/she had halitosis.

The charge RN and unit RPN were interviewed and reported that the resident had not been referred to a dentist or dental hygienist in the last year.

The inspector assessed the resident's mouth on July 25, 2013 at approximately 14:30 assisted by staff #S85. The resident's teeth were covered with a thick film of opaque viscous-like substance and a heavy accumulation of matter, along the gum line, was noted.

On July 26, 2013, staff member #S84 was interviewed and reported mouth care was provided to Resident #2 in early am using several foam swabs and mouth wash; that food debris, which had pocketed in the resident's mouth the night before, was removed from the resident's mouth prior to breakfast. Inspector #134 visited Resident #2 on July 26 at approximately 11:30 and observed that a new labelled electric toothbrush had been delivered to the resident's room. Staff member #S84, who was

assigned to Resident #2, indicated that this information had not been communicated at morning report and therefore swabs soaked in mouth wash had been used to complete the resident's mouth care instead of using the new electric toothbrush. [s. 34. (1) (a)]

2. Resident #10 has his/her own teeth and there is an entry in the plan of care indicating "he/she has sore gums since Feb 2013". The care plan goal as it relates to oral hygiene, is to decrease inflammation of the gums. The intervention identified is that staff is to provide total assistance. There are no clear direction provided as to how to proceed to ensure dental care maintains integrity of his/her oral tissue.

Staff member #S84 was interviewed and reported that Resident #10's natural teeth are cleaned using foam swabs and mouth wash because the resident does not always cooperate when mouth care is done.

As such, the inconsistent approach in providing mouth care to Residents #2 and #10, who have their own teeth, is not conducive to maintaining the integrity of their oral tissue. [s. 34. (1) (a)]

3. The licensee failed to comply with the O. Reg 79/10 s. 34 (1) (c), in that Resident #2 was not offered an annual dental assessment and other preventive dental services.

Resident #2's last "dental care resident assessment protocol" was reviewed. There is an entry indicating Resident #2 has his/her own teeth and requires assistance from staff to care for them related to poor memory. The clinical assessment has not changed from the last assessment, the care plan goals and interventions were reviewed by care members and continue to be effective in preventing, improving and maintaining the RAP problem. Referrals are not needed at this time".

Staff member #S109 was interviewed and reported to the Inspector that there was no indication found in the health records that the resident was offered an annual dental assessment or other preventive services, subject to payment authorized by the substitute decision maker (SDM). [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the residents' plan of care provides clear direction to staff as to individualized mouth care interventions required for each resident more specifically for those with their own teeth and ensure that residents are offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or substitute decision maker, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
 i. what the licensee has done to resolve the complaint, or
 ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

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1. The licensee failed to comply with the O. Reg 79/10 s. 101. (1) 1, 2, 3 i, ii, in that it failed to investigate a written complaint on a specified date in May, 2013, where the complainant raised concerns related to an allegation of abuse between a staff member and a resident. The complaint was not investigated immediately and no response was provided to the informant within 10 days of delivering the letter to the ADOC.

On July 24, 2013 the inspector interviewed the Administrator, DOC and ADOC regarding the follow-up to the letter of complaint addressed to the ADOC where staff member #87 describes an incident of allegation of abusive treatment by one staff member toward Resident #1. The DOC and ADOC responded that there was no follow-up conducted to the incident of allegation of abuse because the dates provided by the informant did not coincide with staff member #S100's work schedule.

Management indicated they had been notified of the allegation of staff to resident abuse of late January/early February, 2013, on specified date in June, 2013, when a police officer had brought in the letter of complaint, after he had met with staff member #S87, who had raised concerns to him about allegation of staff to resident abuse.

Management reported they had not interviewed staff member #S100 to validate the allegations made against him/her, once they had received the written letter of concern from the police on a specified date in June, 2013.

There is an indication in a written report completed by staff member #S87, that when he/she met with the DOC, ADOC, staff member #S105 and staff member #S106, on a specified date in May, 2013, that Management had not questioned him/her regarding the incident of alleged abuse between staff member #S100 and Resident #1, which had been raised in the letter to the ADOC in May, 2013.

As such, the written concern raised in a letter dated May, 2013, was not investigated immediately and no response was provided to the informant within 10 days of delivering the letter to the ADOC. [s. 101. (1)]

Issued on this 13th day of August, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Casseli, LTCH Inspector #134

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2013_230134_0010
Log No. / Registre no:	O-000500-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 9, 2013
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KAWARTHA LAKES 26 Francis Streeet, LINDSAY, ON, K9V-5R8
LTC Home / Foyer de SLD :	VICTORIA MANOR HOME FOR THE AGED 220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gerry Bencze

To THE CORPORATION OF THE CITY OF KAWARTHA LAKES, 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 :

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

Order / Ordre :

The licensee shall ensure the Director is notified immediately of all incidents of suspected abuse of a resident by anyone, that resulted in harm or risk of harm to the resident.

Grounds / Motifs :

1. The licensee failed to comply with the LTCHA 2007, S.O. 2007, c.8 section 24 (1) 2., in that an allegation of staff to resident abuse was not reported immediately to the Director.

In late January 2013/early February 20013, staff member #S87 had reasonable grounds to suspect an allegation of abuse between staff member #S100 and Resident #1. Staff member #S87 did not report this incident to management or to the Director. Staff #87 indicated to the inspector on July 24, 2013 that he/she did not report the incident due to fear of reprisal from staff member #S100 and other staff.

On a specified date in May, 2013 the ADOC received a letter from staff member #S87 informing him/her that a few months back he/she had witnessed an incident of abuse between staff member #S100 and Resident #1 and had

indicated in the letter that he/she would provide a full account of what had happened as well as other accounts of abuse he/she had seen.

On a specified date in June, 2013, a police officer delivered a letter to the home's management, which had been written by staff member #S87 providing a detailed description of an allegation of abusive approach by staff member #S100 toward Resident #1.

As such, the suspicion of staff to resident abuse, which dates back to late January/early February, 2013, was not reported to the Director immediately as per legislative requirement. [s. 24. (1)] (134)

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c 8, s. 24(1) 2., in that the licensee did not immediately notify the Director as soon as it became aware of reasonable grounds to suspect sexual abuse by one resident towards another resident.

On a specified date in July, 2013, staff member #S110 witnessed an incident of a sexual nature, which was not consensual between two residents.

The licensee immediately investigated and took action in response to the incident but as soon as reasonable grounds to believe sexual abuse had occurred, the licensee did not immediately report the allegation of sexual abuse to the Director via the Critical Incident System (CIS) or by the after-hour pager. The incident occurred on a specified date in July, 2013 and the incident was reported two days later via CIS. [s. 24. (1)]

The risk level associated with not reporting to the Director was deemed to be minimal, however, the fact that this was issued twice in January 2012 and January 2013, provided sufficient grounds to issue this order. (134)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

Ministère 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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of August, 2013

Signature of Inspector / Signature de l'inspecteur : Colette Asselin

Name of Inspector / Nom de l'inspecteur : COLETTE ASSELIN

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