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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 08, 2017;	2016_199626_0032 (A1)	027722-16, 027730-16, 027734-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

DENISE BROWN (626) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On February 7, 2017 the home's Administrator requested a change in compliance date for order #001. A new compliance date was granted for March 31, 2017.

Issued on this 8 day of February 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

DENISE BROWN (626) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 14, 15, 16, 19, 20, 21, 22, 23 and 28, 2016

Follow-up Intake Logs:

Intake Log #027722-16: CO #001 related to plan of care

Intake Log #027730-16: CO #002 related to medication administration

Intake Log #027734-16: CO #003 related to medication administration

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Resident Care Area Managers (RCAM), Register Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Clinical Consultant Pharmacist, Physiotherapy Assistants, Educator and residents.

During the inspection the inspector toured the resident home areas, observed staff to resident provision of care and medication administration. The inspector reviewed residents' health records and applicable policies.

The following policies were reviewed:

Falls Management, Medication Management, Medication Incident and Reporting, High Alert Medications and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

Medication

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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. 131. (1)	CO #002	2016_327570_0014	626
LTCHA, 2007 s. 6.	WN	2016_327570_0014	626
LTCHA, 2007 s. 6.	CO #001	2016_327570_0014	626

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

On December 14, 2016, an inspection was conducted in follow-up inspection to determine compliance to Compliance Orders (CO) #001, CO #002 and CO #003. These three orders were related to a previous inspection in 2016 and had a specified date for re-inspection. The current inspection revealed, that the home was compliant in meeting the requirements of CO #001, CO #002 and was compliant with some of the requirements of CO #003 which is indicated as follows:

- Conducting Electronic Medication Record (eMar) daily audit for 15 consecutive days involving 10 percent of the six Resident Home Areas (RHA) to assess accuracy;

- Ensure that the eMar audit process includes a visual verification of all key elements of the medication administration process, including but not limited to ensuring that the right resident is receiving the right medications, at the right dose, using the right route at the specified time.

- Review the current medication administration routines to ensure appropriate support systems are in place when employing new or casual nurses or when the usual RN/RPN deployment pattern is altered.

In the same inspection, related to CO #003, it was determined that the home was non-compliant with the following stipulation of the order:

- Take effective corrective actions when registered nursing staff are not administering medications in line with legislative requirements, established practice standards, policies or procedures.

Compliance Order #003 required that the home take effective corrective actions when registered nursing staff are not administering medication in line with legislative
requirements, established practice standards, policies or procedures and to achieve compliance by a specified date in 2016. A review of the documentation after the specified compliance date, indicated that this was not consistently performed.

A review of two separate documentations pertaining to resident #005, indicated that the first incident occurred on two separate specified dates and found that a specified medication was omitted for a period of three days. Based on the records reviewed, there was no evidence of corrective actions.

During an interview, the DOC could not recall discussing this incident with the registered staff members involved in the incidents.

A review of the documentation pertaining to resident #011, who was admitted on a specified date in 2016, indicated that the resident did not receive medications until the following day. The resident did not receive four medications as information was not properly entered into Point Click Care and was required to confirm the medications which were pending in the system. There was documentation by the Pharmacist pertaining to the cause of the incident and suggestions for nursing but there was no evidence that this was communicated to the registered staff.

In an interview, the DOC could not recall discussing this incident with the registered staff members involved in the incident.

A review of the documentation involving resident #005 and resident #011 on two separate dates, found no corrective action following the incidents. In an interview with the inspector on December 20, 2016, the DOC did not recall speaking to the registered staff regarding a corrective action following the incidents. There was no indication that the residents experienced any adverse reactions as a result of the medication incidents.

During separate interviews on December 20, 2016, RPN #100, #107 and #108 who were not involved in these medication incidents and were not aware of corrective actions related to any incidents, all indicated that they were aware of the process. Registered Practical Nurses #100, #107 and #108 in their separate interviews on a specified date indicated, that following staff involvement in a medication incident, the incident would be reported to the DOC and staff disciplined or retrained.

Pharmacy Consultant #106 in an interview on December 20, 2016, indicated that the incident report form was revised and the new forms did not contain a response time. Subsequently, pharmacy had not responded to the home in a timely manner with corrective actions for medication incidents in order for the DOC to act on. This problem was discovered in the monthly meeting and was corrected. In the same interview the Pharmacy Consultant #106, indicated that medication incidents and corrective actions are documented on the Incident Report Summary and reviewed in the Medication Management Meetings held at the home on a monthly basis.

In another interview on December 28, 2016, the Administrator indicated that it was

the understanding that the DOC had followed-up with corrective actions when there were medication incidents. In the same interview, the Administrator indicated that it is the expectation in the home that corrective action be taken when there is a medication incident and that this information should be communicated to the staff involved and documented.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber and corrective actions were not taken when registered staff did not administer medications as prescribed. [s. 131. (2)]

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

Review of the licensee`s Medication Management policy RC-06-05-07, updated June 2016, outlines the practice requirements under the following sections:

Required Documents
b. MAR/eMAR-Paper or electronic format to be used to document all medications given to a resident.

Policy
The medication administration process will comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

Procedures
5. Scheduled medications will be administered according to standard medication administration times.
Medication should be given with in the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time.
10. Medications will be administered following the 8 rights of medication administration: Right resident; Right drug; Right dose; Right time; Right route (including need for medication to be crushed); Right reason; Right response; Right documentation.

The Medication Administration Audit Report was generated the eMAR indicate, the medication scheduled administration time, the actual time that the medication was administered and the time that it was documented by the nurse.

Related to resident #008

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #008's three scheduled medications were administered in the morning. The three medications were administered greater than one hour of the scheduled medication administration time on six separate days. One of the three medications was schedule to be administered more than once a day and was administered again at noon on each of these six days, at intervals of fifty minutes to two hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

3. Related to resident #005

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #005's nine scheduled medications were administered in the morning. The nine medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the nine medications was schedule to be administered more than once a day and was administered again at noon on each of these four days at intervals of one to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

4. Related to resident #007

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #007's six scheduled medications were administered in the morning. The six medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the six medications was schedule to be administered more than once a day and was administered again at noon on each of these four days at intervals of two to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 8 day of February 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : DENISE BROWN (626) - (A1)

Inspection No. / No de l'inspection : 2016_199626_0032 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 027722-16, 027730-16, 027734-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 08, 2017;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 Administrator / Nom de l'administratrice ou de l'administrateur : Angela Rodrigues

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2016_327570_0014, CO #003;

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 :

1. Immediately upon being served with this Compliance Order and for 15 consecutive days after that to conduct a 15 day audit of at least 10 percent of the electronic medication records (E-Mar) currently in use in each of the six Resident Home Areas (RHA) to review the E-MAR and assess the practice of medication administration at the time specified and,

2. Develop and implement a plan to ensure that medications are administered at the specified time and,

3. Educate all registered nursing staff and agency registered nursing staff about the licensee Policy #RC-06-05-07 Medication Management in a formal education session, and evaluate staff knowledge of the policy following the session, which should include understanding of the policy's requirement to administer medication within 60 minutes of the scheduled time of the medication.

4. Take immediate effective corrective actions as it pertains to medication incidents, when registered nursing staff are not administering medication in line with legislative requirements, established practice standards, policies or procedures.

5. Extendicare Assist must immediately provide nursing leadership and play an active role in supporting the home in implementing effective response in the analysis of the medication audits, staff education related to medication administration, corrective action as pertains to medication administration practices, including and not limited to medication incidents.

Grounds / Motifs :

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

On December 14, 2016, an inspection was conducted in follow-up inspection to determine compliance to Compliance Orders (CO) #001, CO #002 and CO #003. These three orders were related to a previous inspection in 2016 and had a specified date for re-inspection. The current inspection revealed, that the home was compliant in meeting the requirements of CO #001, CO #002 and was compliant with some of the requirements of CO #003 which is indicated as follows:

- Conducting Electronic Medication Record (eMar) daily audit for 15 consecutive days involving 10 percent of the six Resident Home Areas (RHA) to assess accuracy;

- Ensure that the eMar audit process includes a visual verification of all key elements of the medication administration process, including but not limited to ensuring that the right resident is receiving the right medications, at the right dose, using the right route at the specified time.

- Review the current medication administration routines to ensure appropriate support systems are in place when employing new or casual nurses or when the usual RN/RPN deployment pattern is altered.

In the same inspection, related to CO #003, it was determined that the home was non-compliant with the following stipulation of the order:

- Take effective corrective actions when registered nursing staff are not administering medications in line with legislative requirements, established practice standards, policies or procedures.

Compliance Order #003 required that the home take effective corrective actions when registered nursing staff are not administering medication in line with legislative requirements, established practice standards, policies or procedures and to achieve compliance by a specified date in 2016. A review of the documentation after the specified compliance date, indicated that this was not consistently performed.

A review of two separate documentations pertaining to resident #005, indicated that the first incident occurred on two separate specified dates and found that a specified medication was omitted for a period of three days. Based on the records reviewed, there was no evidence of corrective actions.

During an interview the DOC could not recall discussing this incident with the registered staff members involved in the incidents.

A review of the documentation pertaining to resident #011, who was admitted on a specified date in 2016, indicated that the resident did not receive medications until the following day. The resident did not receive four medications as information was

not properly entered into Point Click Care and was required to confirm the medications which were pending in the system. There was documentation by the pharmacist pertaining to the cause of the incident and suggestions for nursing but there was no evidence that this was communicated to the registered staff.

In an interview, the DOC could not recall discussing this incident with the registered staff members involved in the incident.

A review of the documentation involving resident #005 and resident #011 on two separate dates, found no corrective action following the incidents. In an interview with the inspector on December 20, 2016, the DOC did not recall speaking to the registered staff regarding a corrective action following the incidents. There was no indication that the residents experienced any adverse reactions as a result of the medication incidents.

During separate interviews on December 20, 2016, RPN #100, #107 and #108 who were not involved in these medication incidents and were not aware of corrective actions related to any incidents, all indicated that they were aware of the process. Registered Practical Nurses #100, #107 and #108 in their separate interviews on a specified date indicated, that following staff involvement in a medication incident, the incident would be reported to the DOC and staff disciplined or retrained.

Pharmacy Consultant #106 in an interview on December 20, 2016, indicated that the incident report form was revised and the new forms did not contain a response time. Subsequently, pharmacy had not responded to the home in a timely manner with corrective actions for medication incidents in order for the DOC to act on. This problem was discovered in the monthly meeting and was corrected. In the same interview the Pharmacy Consultant #106 indicated that medication incidents and corrective actions are documented on the Incident Report Summary and reviewed in the Medication Management Meetings held at the home on a monthly basis.

In another interview on December 20, 2016, the Administrator indicated that it was the understanding that the DOC had followed-up with corrective actions when there were medication incidents. In the same interview, the Administrator indicated that it is the expectation in the home that corrective action be taken when there is a medication incident and that this information should be communicated to the staff involved and documented.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber and corrective actions were not taken when registered staff did not administer medications as prescribed. [s. 131. (2)] (626)

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

Review of the licensee`s Medication Management policy RC-06-05-07, updated June 2016, outlines the practice requirements under the following sections:

Required Documents
b. MAR/eMAR-Paper or electronic format to be used to document all medications given to a resident.

Policy
The medication administration process will comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

Procedures
5. Scheduled medications will be administered according to standard medication administration times.
Medication should be given with in the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time.
10. Medications will be administered following the 8 rights of medication administration: Right resident; Right drug; Right dose; Right time; Right route (including need for medication to be crushed); Right reason; Right response; Right documentation.

The Medication Administration Audit Report was generated the eMAR indicate, the medication scheduled administration time, the actual time that the medication was administered and the time that it was documented by the nurse.

Related to resident #008

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #008's three scheduled medications were administered in the morning. The three medications were administered greater than one hour of the scheduled medication administration time on six separate days. One of the three medications was schedule to be administered more than once a day and was administered again at noon on each of these six days at intervals of fifty minutes to two hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)] (626)

3. Related to resident #005

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #005's nine scheduled medications were administered in the morning. The nine medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the nine medications was schedule to be administered more than once a day and was administered again at noon on each of these four days, at intervals of one to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)] (626)

4. Related to resident #007

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #007's six scheduled medications were administered in the morning. The six medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the six medications was schedule to be administered more than once a day and was administered again at noon on each of these four days at intervals of two to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

This order is being reissued for the fourth time under s. 131 (2) because the licensee was previously ordered to develop and implement a monitoring process to ensure that all medications were administered to all residents in accordance to the direction for use , and as specified by the prescriber. Compliance Order #003 was issued under LTCHA 2017, s.131 (2) Administration of Drugs during inspection #2015_365194_0028 with compliance date of February 29, 2016 and was reissued during inspection #2016_360111_0009 with compliance date of May 26, 2016. This Compliance Order was reissued during inspection #2016_327570_0014 with compliance date of October 31, 2016, which also requires corrective action when registered nursing staff are not administering medications in line with legislative requirements, established practice standards, policies or procedures. This history of repeated non-compliance, along with the scope and risk associated with the noted medication administration practices in the home were considered when the decision to issue this order was made. This non-compliance is also being referred to the Director for further action by the Director. (626)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Mar 31, 2017(A1)

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

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

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

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 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

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

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

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 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

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 8 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DENISE BROWN

Service Area Office /
Bureau régional de services : Ottawa