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

Hamilton Service Area Office
119 King Street West 11th Floor
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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
May 01, 2017;	2017_569508_0004 (A1)	004616-17, 004624-17	Follow up

Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST SUITE 901 TORONTO ON M3J 2V5

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

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

ROSEANNE WESTERN (508) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 1 day of May 2017 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

ROSEANNE WESTERN (508) - (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): January 10, 12, 16, 17, 18, 19, 20, 2017.

During this inspection the Inspector toured the facility, observed provision of resident care, observed meal services, reviewed video footage, reviewed resident clinical records, staff training records, medication incident reports and relevant policies and procedures. This inspection was conducted concurrently with complaint inspection report # 2017_569508_0001.

During the course of the inspection, the inspector(s) spoke with the interim Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI Co-ordinator), the Nursing Unit Clerk, the Nursing Consultant, registered staff, Personal Care Providers (PCP), agency staff, residents and family.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

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

2 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with compliance order O. Reg. 79/10, s. 36 in relation to staff training for safe transferring, inspection report #2016_250511_0011 / 019456-16, 021976-16, 024225-16, 026676-16, The compliance order directed the licensee to comply with the following by December 19, 2016:

1. Ensure staff follow the residents plans of care when assisting residents in relation to transferring, positioning, and turning techniques, according to their assessed needs and preferences;
2. Ensure all direct care staff receive retraining regarding safe transferring, positioning and turning techniques for assisting residents;
3. Ensure staff competency related to lifts and transfers be audited annually according to the home's policy, to ensure the highest level of competency by the employees;
4. Ensure staff who do not pass the competency audit be paired with an employee who has passed their audit, re-educated, and retested;
5. Ensure documentation be retained of training, staff audit results, and retraining;
6. Establish an auditing process to ensure that staff using transferring and positioning devices or techniques to assist residents are using safe techniques appropriate to the needs of the resident.

During interviews conducted on January 18, 19 and 20, 2017, with the DOC, the ADOC and the Nurse Consultant, it was confirmed that agency staff who were providing direct care to residents had not received retraining regarding safe transferring, positioning and turning techniques for assisting residents.

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

According to resident #001's RAI MDS assessments in October 2015 and January 2016, they required assistance from two staff for bed mobility and transferring.

A) Transferring:

Review of evidence on 12 identified dates revealed staff used unsafe transferring techniques for resident #001. On four specified dates in November 2015, six specified dates in December 2015, one specified date in January and one specified date in February 2016, evidence reviewed and staff interviews confirmed resident #001 was transferred unsafely and at times causing the resident to grimace and appear to be in distress.

B) Turning and Positioning:

Review of evidence on seven identified dates revealed staff used unsafe positioning techniques while roughly turning and positioning resident #001 during

care, while the resident was in bed.

During Inspector interview, the DOC confirmed that PSW staff had turned and positioned resident #001 in an unsafe and rough manner and had demonstrated unsafe transferring techniques as noted above.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order O. Reg. 79/10, s. 53(4) in relation to staff training for responsive behaviours, inspection report #2016_250511_0011 / 019456-16, 021976-16, 024225-16, 026676-16. The

compliance order directed the licensee to comply with the following by January 2, 2017:

1. Implement strategies that have been developed to respond to residents demonstrating responsive behaviours, where possible;
2. Assess and reassess residents with responsive behaviours in relation to the behaviours demonstrated;
3. Document assessments, plan of care, and strategies implemented when responding to residents demonstrating responsive behaviours;
4. Educate all staff on Responsive Behaviour Program and the care of residents with responsive behaviours;
5. Monitor that staffs implementation of strategies, to respond to residents, demonstrating responsive behaviours, is in accordance to the home's policy;
6. Implement an audit and evaluation process to ensure that the program is implemented and the needs of residents with responsive behaviours are addressed.

During interviews conducted on January 18, 19 and 20, 2017, with the DOC, the ADOC and the Nurse Consultant, it was confirmed that agency staff who were providing direct care to residents had not received training on the Responsive Behaviour Program and the care of residents with responsive behaviours.

1. The licensee has failed to ensure that b) strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible and c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

According to resident #001's health records they were cognitively impaired and demonstrated responsive behaviours

(b) Strategies not implemented.
The written plan of care, printed in August 2015, and available to staff between November 2015, and February 2016, provided staff with ten descriptive strategies to implement when providing resident care to reduce the resident's responsive behaviours.

Review of evidence between November 2015 and February 28, 2016, indicated that the resident demonstrated behaviours during approximately 40 care occasions

and that PSWs #104, #111, #112, #117, #118, #121, #124, #127, #128, and #132 had not implemented the strategies that had been developed to manage behaviours.

During interviews, PSWs #104, #112, #116, #120, #125, and #128 confirmed that the resident had responsive behaviours. They confirmed they had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours.

During interview, RPN #135 stated that resident #001 would demonstrate responsive behaviour if care was not provided as directed in the plan of care. RPN #135 also stated that they observed PSWs #104, #121, #125 and #128 providing rushed care to resident #001 and without speaking with the resident and had instructed PSWs to re-approach if the resident was not happy.

PSWs #104, #112, #118, and #128 stated that they cared for the resident in a specified manner since they thought that the approach was expected of them in the course of providing care given the resident??s responsive behaviours; they stated not knowing this was wrong. All PSWs confirmed that the resident appeared to be in distress through facial grimacing and tone of voice as they provided care while not implementing strategies identified in the plan of care to manage these behaviours.

During interview, the DOC stated that PSW staff had not followed resident #001's plan of care, or implemented strategies developed to manage responsive behaviours. They confirmed that staff not implementing the strategies contributed to the resident's distress and escalation of behaviours during their care.

(c) Actions not taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.
The home's “Responsive Behaviour Management”, policy Section 4.11.10, last reviewed June 2013, located in the Bella Senior Care Resident Services Manual, directed staff to do the following with residents that exhibited “Complex/Difficult/Responsive Behaviours":

i) Initiate behaviour documentation in the resident's record for a 7 day period,
ii) Hold interdisciplinary conference to be planned at the end of 7 day time period to review the behaviour tracking record,

iii) The Interdisciplinary team will analyze behaviours that occurred to identify triggers and consequence of the behaviour if possible,
iv) Continue to monitor behaviour and effect of interventions,
v) If behaviours continued, review with physician to obtain a consult for psychogeriatric assessment,
vi) Notify psychogeriatric team regarding the issue and provide a copy of the behaviour flow sheet, and
vii) Continue monitoring and documenting the resident's behaviours.

Review of resident #001's health record and interviews with PSWs #104, #112, #116, #118, #120, #125, and #128 revealed that the resident had cognitive impairment and demonstrated responsive behaviours. The DOC confirmed that the resident exhibited "Complex/difficult" behaviours according to the home's policy. The plan of care last revised in August 2015, directed staff to implement at least 10 different strategies for the management of their behaviours.

Review of resident #001's health record indicated that the most recent assessment by Behavioural Supports Ontario (BSO) had been in 2012. The DOC could not state when the last referral or completed assessment of resident #001's behaviours had been. During interview, RPN #135 stated that BSO had not been involved with resident #001's care for at least two years. Review of the progress notes indicated no entries regarding responsive behaviours between November 1, 2014 and February 28, 2016. The DOC and ADOC confirmed that PSW staff should have notified registered staff of resident #001's behaviours and registered staff should have documented these issues in the progress notes.

Notes written by the resident's physician between February 2015 and February 2016, indicated that the resident's behaviours had settled down and there were no new issues.
Review of the resident's health record did not reveal behaviour documentation such as the use of the Direct Observation Sheet (DOS) charting and the DOC was unable to confirm if or when it was completed last. Although the plan of care was updated in August 2015, the DOC confirmed that an interdisciplinary conference and/or behaviour team meeting were not held for management of resident #001's responsive behaviours according to the home's policy, that there was no evaluation or analysis to identify other strategies, and that staff had not documented the behaviours observed according to the home's policy.

During interview, PSWs #104, #112, #118, #125, and #128 stated that while they

had not followed the plan of care, they had reported difficulties providing care and had been told by registered staff on numerous occasions to get the care done. In evidence provided by the resident's family member between November 2015 and February 2016, PSWs were observed providing care, without implementing identified intervention for responsive behaviours. The PSWs interviewed uniformly stated that they did not think that the care provided and the approach used was improper and stated that they continued to care for residents using the approaches that were identified as improper until they were educated in 2016.

The home failed to take actions, including assessments, reassessments and interventions, as described in their Responsive Behaviour program, into the plan of care for resident #001 to ensure that their care was based on their assessed needs and that the resident's responses to interventions were documented.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

Issued on this 1 day of May 2017 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : ROSEANNE WESTERN (508) - (A1)

Inspection No. / No de l'inspection : 2017_569508_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 004616-17, 004624-17 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : May 01, 2017;(A1)

Licensee / Titulaire de permis : BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5

LTC Home / Foyer de SLD : BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Michael Bausch

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that all direct care staff, including agency staff receive retraining regarding safe transferring, positioning and turning techniques for assisting residents.

Grounds / Motifs :

1. The licensee failed to comply with compliance order O. Reg. 79/10, s. 36 in relation to staff training for safe transferring, inspection report #2016_250511_0011 / 019456-16, 021976-16, 024225-16, 026676-16, The compliance order directed the licensee to comply with the following by December 19, 2016:

1. Ensure staff follow the residents plans of care when assisting residents in relation to transferring, positioning, and turning techniques, according to their assessed needs and preferences;
2. Ensure all direct care staff receive retraining regarding safe transferring, positioning and turning techniques for assisting residents;
3. Ensure staff competency related to lifts and transfers be audited annually according to the home's policy, to ensure the highest level of competency by the employees;
4. Ensure staff who do not pass the competency audit be paired with an employee who has passed their audit, re-educated, and retested;
5. Ensure documentation be retained of training, staff audit results, and retraining;

6. Establish an auditing process to ensure that staff using transferring and positioning devices or techniques to assist residents are using safe techniques appropriate to the needs of the resident.

During interviews conducted on January 18, 19 and 20, 2017, with the DOC, the ADOC and the Nurse Consultant, it was confirmed that agency staff who were providing direct care to residents had not received retraining regarding safe transferring, positioning and turning techniques for assisting residents.

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

According to resident #001's RAI MDS assessments in October 2015 and January 2016, they required assistance from two staff for bed mobility and transferring.

A) Transferring:

Review of evidence on 12 identified dates revealed staff used unsafe transferring techniques for resident #001. On four specified dates in November 2015, six specified dates in December 2015, one specified date in January and one specified date in February 2016, evidence review and staff interview confirmed resident #001was transferred unsafely and at times causing the resident to grimace and appear to be in distress.

B) Turning and Positioning:

Review of evidence on seven identified dates revealed staff used unsafe positioning techniques while roughly turning and positioning resident #001 during care, while the resident was in bed.

During Inspector interview, the DOC confirmed that PSW staff had turned and positioned resident #001 in an unsafe and rough manner and had demonstrated unsafe transferring techniques as noted above.

(508)

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

Apr 07, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

(A1)
The licensee shall ensure that all direct care staff, including agency staff receive retraining on the home's Responsive Behaviour program.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order O. Reg. 79/10, s. 53(4) in relation to staff training for responsive behaviours, inspection report #2016_250511_0011 / 019456-16, 021976-16, 024225-16, 026676-16. The

compliance order directed the licensee to comply with the following by January 2, 2017:

1. Implement strategies that have been developed to respond to residents demonstrating responsive behaviours, where possible;
2. Assess and reassess residents with responsive behaviours in relation to the behaviours demonstrated;
3. Document assessments, plan of care, and strategies implemented when responding to residents demonstrating responsive behaviours;
4. Educate all staff on Responsive Behaviour Program and the care of residents with responsive behaviours;
5. Monitor that staffs implementation of strategies, to respond to residents, demonstrating responsive behaviours, is in accordance to the home's policy;
6. Implement an audit and evaluation process to ensure that the program is implemented and the needs of residents with responsive behaviours are addressed.

During interviews conducted on January 18, 19 and 20, 2017, with the DOC, the ADOC and the Nurse Consultant, it was confirmed that agency staff who were providing direct care to residents had not received training on the Responsive Behaviour Program and the care of residents with responsive behaviours.

1. The licensee has failed to ensure that b) strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible and c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

According to resident #001's health records they were cognitively impaired and demonstrated responsive behaviours

(b) Strategies not implemented.
The written plan of care, printed in August 2015, and available to staff between November 2015, and February 2016, provided staff with ten descriptive strategies to implement when providing resident care to reduce the resident's responsive behaviours.

Review of evidence between November 2015 and February 28, 2016, indicated that the resident demonstrated behaviours during approximately 40 care occasions and

that PSWs #104, #111, #112, #117, #118, #121, #124, #127, #128, and #132 had not implemented the strategies that had been developed to manage behaviours.

During interviews, PSWs #104, #112, #116, #120, #125, and #128 confirmed that the resident had responsive behaviours. They confirmed they had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours.

During interview, RPN #135 stated that resident #001 would demonstrate responsive behaviour if care was not provided as directed in the plan of care. RPN #135 also stated that they observed PSWs #104, #121, #125 and #128 providing rushed care to resident #001 and without speaking with the resident and had instructed PSWs to re-approach if the resident was not happy.

PSWs #104, #112, #118, and #128 stated that they cared for the resident in a specified manner since they thought that the approach was expected of them in the course of providing care given the resident??s responsive behaviours; they stated not knowing this was wrong. All PSWs confirmed that the resident appeared to be in distress through facial grimacing and tone of voice as they provided care while not implementing strategies identified in the plan of care to manage these behaviours.

During interview, the DOC stated that PSW staff had not followed resident #001's plan of care, or implemented strategies developed to manage responsive behaviours. They confirmed that staff not implementing the strategies contributed to the resident's distress and escalation of behaviours during their care.

(c) Actions not taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.
The home's “Responsive Behaviour Management”, policy Section 4.11.10, last reviewed June 2013, located in the Bella Senior Care Resident Services Manual, directed staff to do the following with residents that exhibited “Complex/Difficult/Responsive Behaviours":

i) Initiate behaviour documentation in the resident's record for a 7 day period,
ii) Hold interdisciplinary conference to be planned at the end of 7 day time period to review the behaviour tracking record,
iii) The Interdisciplinary team will analyze behaviours that occurred to identify triggers

and consequence of the behaviour if possible,
iv) Continue to monitor behaviour and effect of interventions,
v) If behaviours continued, review with physician to obtain a consult for psychogeriatric assessment,
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vii) Continue monitoring and documenting the resident's behaviours.

Review of resident #001's health record and interviews with PSWs #104, #112, #116, #118, #120, #125, and #128 revealed that the resident had cognitive impairment and demonstrated responsive behaviours. The DOC confirmed that the resident exhibited "Complex/difficult" behaviours according to the home's policy. The plan of care last revised in August 2015, directed staff to implement at least 10 different strategies for the management of their behaviours.

Review of resident #001's health record indicated that the most recent assessment by Behavioural Supports Ontario (BSO) had been in 2012. The DOC could not state when the last referral or completed assessment of resident #001's behaviours had been. During interview, RPN #135 stated that BSO had not been involved with resident #001's care for at least two years. Review of the progress notes indicated no entries regarding responsive behaviours between November 1, 2014 and February 28, 2016. The DOC and ADOC confirmed that PSW staff should have notified registered staff of resident #001's behaviours and registered staff should have documented these issues in the progress notes.

Notes written by the resident's physician between February 2015 and February 2016, indicated that the resident's behaviours had settled down and there were no new issues.
Review of the resident's health record did not reveal behaviour documentation such as the use of the Direct Observation Sheet (DOS) charting and the DOC was unable to confirm if or when it was completed last. Although the plan of care was updated in August 2015, the DOC confirmed that an interdisciplinary conference and/or behaviour team meeting were not held for management of resident #001's responsive behaviours according to the home's policy, that there was no evaluation or analysis to identify other strategies, and that staff had not documented the behaviours observed according to the home's policy.

During interview, PSWs #104, #112, #118, #125, and #128 stated that while they had

not followed the plan of care, they had reported difficulties providing care and had been told by registered staff on numerous occasions to get the care done. In evidence provided by the resident's family member between November 2015 and February 2016, PSWs were observed providing care, without implementing identified intervention for responsive behaviours. The PSWs interviewed uniformly stated that they did not think that the care provided and the approach used was improper and stated that they continued to care for residents using the approaches that were identified as improper until they were educated in 2016.

The home failed to take actions, including assessments, reassessments and interventions, as described in their Responsive Behaviour program, into the plan of care for resident #001 to ensure that their care was based on their assessed needs and that the resident’s responses to interventions were documented.

(508)

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

May 08, 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

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

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

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 1 day of May 2017 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : ROSEANNE WESTERN

Service Area Office /
Bureau régional de services : Hamilton