Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2018	2018_616542_0015	007116-18, 007129-18, 007133-18, 007135-18, 007137-18, 007140-18, 007144-18, 007146-18, 007774-18	Follow up

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

JENNIFER LAURICELLA (542), AMY GEAUVREAU (642), LAUREN TENHUNEN (196), SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 13 - 17, 2018

A Complaint Inspection #2018_616542_0016 and a Critical Incident (CI) Report Inspection #2018_616542_0017 were conducted concurrently with this inspection. See these reports for further non-compliances issued.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, Dietary Aides, Personal Support Workers (PSWs), residents and family members.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies and compliance plans, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #006	2018_703625_0001	642
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2018_703625_0001	692
O.Reg 79/10 s. 50. (2)	CO #005	2018_703625_0001	642
O.Reg 79/10 s. 54.	CO #007	2018_703625_0001	642
O.Reg 79/10 s. 71. (3)	CO #008	2018_703625_0001	542
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #002	2018_703625_0001	196
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #003	2018_703625_0001	196

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

On April 13, 2018, Compliance Order #001 from Critical Incident System (CIS) Inspection #2018_703625_0006 was served to the licensee, with a compliance due date of May 31, 2018. The compliance order read:

"The licensee must be compliant with s. 6 (1) (c) of the Long-Term Care Homes Act (LTCHA), 2007.

The licensee shall ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

The licensee was ordered to specifically:
- Conduct a review of resident #001's plan of care with a focus on nutrition and dietary interventions. Ensure the plan of care is clear with respect to the diet orders, feeding assistance required and related dietary interventions;

- Identify the residents in the home who are at risk of choking and require related nutrition and dietary interventions. Ensure the plans of care for those residents are clear with respect to the diet orders, feeding assistance and related dietary interventions the residents require; and

- Maintain written records of the plans of care reviewed, the findings, and the actions taken to address any inconsistencies, or lack of clarity, in the plans."

During the follow up to compliance orders, Inspector #196 conducted an interview with the Administrator. It was determined that the first part of the order, specific to resident #001, was completed. However, the Administrator reported that the remainder of the compliance order had not been done as it had been missed.

The Administrator confirmed to the Inspector, that the other residents in the home who were at risk of choking and required related nutrition and dietary interventions had not been identified. In addition, since the residents that were at risk of choking had not been identified, their plans of care had not been reviewed for clear directions.

During an interview with the Registered Dietitian (RD), they reported to the Inspector that they had started working at the home on May 7, 2018, and had not been made aware of this compliance order that had been issued to the home. [s. 6. (1) (c)]

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

Inspector #542 completed a review of resident #020's current care plan. It was documented that they were to receive a nutritional supplement three times a day at nourishment passes.

Inspector #542 observed the 1000 hours (hrs) nourishment pass on the home area where resident #020 resided. The nourishment cart contained a variety of juices and water. Inspector #542 did not observe any labelled nourishments on the cart for resident #020.

Inspector #542 interviewed PSW #118, who was providing the nourishments to the residents. PSW #118 indicated that they were often responsible for providing the nourishments as they worked the four-hour shift. Inspector #542 asked PSW #118 if they had everything that they needed on the cart. PSW #118 indicated that they only

provided juice and water at the 1000 hour pass and nothing further. PSW #118 stated that supplements were not provided during the 1000 hour pass.

Inspector #542 observed resident #020 in the dining room at lunch. It was observed that they had their lunch in front of them, along with two cups of a labeled nutritional supplement in front of them.

Inspector #542 interviewed Dietary Aide #115, who indicated that they were the staff that prepared the nutritional supplement and that resident #020 missed the one at breakfast; therefore, they provided them with the breakfast and lunch supplement at this meal.

Inspector #542 asked Dietary Aide #115 if it was a regular occurrence for the resident to receive the nutritional supplement during meals. Dietary Aide #115 indicated that resident #020 always received them during their meals.

Inspector #542 interviewed the Registered Dietitian (RD) regarding resident #020. The RD verified that the nutritional supplement was ordered to be provided during the nourishment passes and not at meals. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #542 conducted a Follow Up inspection to Compliance Order (CO) #001 served to the licensee on May 18, 2018, under inspection report 2018_703625_0001. The CO required the home to do the following by June 30, 2018;

The licensee shall ensure that the provision of the care set out in the plan of care is documented.

The licensee shall specifically:

- Conduct an audit of resident #027, #029, #035 and #038's health care records to identify the records on which staff had failed to document the care provided;

- Identify the causes of the failure to document the care provided and address them;

- Establish and implement a routine auditing schedule of the documentation of the provision of care to residents including auditing of Treatment Administration Records

(TARs), weekly wound assessments, Wound Assessment Tools, Flowsheets, Bathing Reports, Dietary Reports and all components of residents' plans of care in which documentation of the provision of care is required; and

- Maintain written records of the audits conducted, the findings and the actions taken to address any deficiencies in the documentation.

While the licensee complied with completing an audit of the above mentioned residents and some of the documentation related to the provision of care, non-compliance continued to be identified with Dietary Reports and the Treatment Administration Records (TARS).

Inspector #542 completed a review of the resident #016, #020 and #033's dietary reports, both electronic and paper documentation, from July 1, 2018 to August 15, 2018. The following was identified for each resident:

Resident #016 had the following missing documentation;

July 4, 6, 7, and 9, PM snack section,
July 14, dinner and the HS snack and,
August 1, dinner was not documented.

Resident #020 had the following missing;

July 1, 2, 13, 17 and 29, their AM snack,
July 7, 14,16 and 27, no PM snack,
July 8, supper,
July 16, lunch and the PM snack,
July 18, breakfast and lunch,
August 4 and 11, no PM snack and,
August 12, no AM snack was documented.

Resident #033 had the following missing documentation;

July 12, breakfast, AM snack and lunch,
July 13 and 14, supper and HS snack,
July 20 and 22, breakfast, AM snack, lunch and PM snack,
August 1, breakfast, AM snack and lunch and,

August 2, lunch.

Inspector #692 completed a review of the resident #026's health care record. A physician's order was obtained for a specific treatment cream to be applied twice a day. A review of the Treatment Administration Records (TARS) for resident #026 for the month of July, 2018, revealed the following missing documentation;

July 2, 6, 9, 10, 11, 13, 15, 16, 17, 19, 21, 22, 23, 24 and 31 (fifteen missing signatures).

Inspector #692 reviewed resident #027's physician's orders and noted that staff were to apply a specific intervention to an area of altered skin integrity. A review of the TARS revealed the following missing documentation;

July 18, 19, 27, 28, and 29 (5 missing signatures)
August, 2, 3, 4, 5, 6, 9, 11, 12, 13, and 14 (eleven missing signatures).

Inspector #692 reviewed resident #028's physician's orders and noted that staff were to apply a medicated cream to an area of altered skin integrity, twice a day for 2 weeks. A review of the TARS revealed the following missing documentation;

August 4, 5, 6, 11, 12 and 15.

Inspector #692 reviewed resident #020's physician's orders and noted that staff were to apply a medicated cream to areas of altered skin integrity. The TARS revealed the following missing documentation;

July 2, 13, 16, 17, 19, 22 and 23.

Inspector #692 reviewed resident #029's physician's orders and noted that staff were to apply a medicated cream to an area of altered skin integrity. The TARS revealed the following missing documentation;

July 2, 13, 14, 15, 16, 17, 19, 22, 31 and
August 2, 4, 5, 6, 7, 10, 11, 13 and 14.

Inspector #692 interviewed RPN #119 who indicated that the registered staff were responsible for ensuring that the resident's received their prescribed medicated creams

and ointments. RPN #119 indicated that if the TARS had missing signatures then it would mean that the medicated creams/ointments were not provided to the resident.

Inspector #692 interviewed the Administrator who also verified that the registered staff were to document on the TAR once the treatment had been provided to the resident. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 9th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542), AMY GEAUVREAU (642), LAUREN TENHUNEN (196), SHANNON RUSSELL (692)
Inspection No. / No de l'inspection :	2018_616542_0015
Log No. / No de registre :	007116-18, 007129-18, 007133-18, 007135-18, 007137-18, 007140-18, 007144-18, 007146-18, 007774-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 24, 2018
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Bethammi Nursing Home 63 Carrie Street, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janine Black

To St. Joseph's Care Group, 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: 2018_703625_0001, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with s. 6. (9) (1) of the LTCHA.

Specifically, the licensee must ensure that the following is completed and implemented;

a) a review of the home's current documentation regarding Dietary Intake Reports and the Treatment Administration Records (TARs) to ensure that all staff are documenting the provision of care consistently and accurately,

b) an effective auditting process of the Dietary Intake Reports and the TARs to ensure compliance.

Grounds / Motifs :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #542 conducted a Follow Up inspection to Compliance Order (CO) #001 served to the licensee on May 18, 2018, under inspection report 2018_703625_0001. The CO required the home to do the following by June 30, 2018;

The licensee shall ensure that the provision of the care set out in the plan of

care is documented.

The licensee shall specifically:

- Conduct an audit of resident #027, #029, #035 and #038's health care records to identify the records on which staff had failed to document the care provided;

- Identify the causes of the failure to document the care provided and address them;

- Establish and implement a routine auditing schedule of the documentation of the provision of care to residents including auditing of Treatment Administration Records (TARs), weekly wound assessments, Wound Assessment Tools, Flowsheets, Bathing Reports, Dietary Reports and all components of residents' plans of care in which documentation of the provision of care is required; and

- Maintain written records of the audits conducted, the findings and the actions taken to address any deficiencies in the documentation.

While the licensee complied with completing an audit of the above mentioned residents and some of the documentation related to the provision of care, non-compliance continued to be identified with Dietary Reports and the Treatment Administration Records (TARS).

Inspector #542 completed a review of the resident #016, #020 and #033's dietary reports, both electronic and paper documentation, from July 1, 2018 to August 15, 2018. The following was identified for each resident:

Resident #016 had the following missing documentation;

July 4, 6, 7, and 9, PM snack section,
July 14, dinner and the HS snack and,
August 1, dinner was not documented.

Resident #020 had the following missing;

July 1, 2, 13, 17 and 29, their AM snack,
July 7, 14,16 and 27, no PM snack,
July 8, supper,

July 16, lunch and the PM snack,
July 18, breakfast and lunch,
August 4 and 11, no PM snack and,
August 12, no AM snack was documented.

Resident #033 had the following missing documentation;

July 12, breakfast, AM snack and lunch,
July 13 and 14, supper and HS snack,
July 20 and 22, breakfast, AM snack, lunch and PM snack,
August 1, breakfast, AM snack and lunch and,
August 2, lunch.

Inspector #692 completed a review of the resident #026's health care record. A physician's order was obtained for a specific treatment cream to be applied twice a day. A review of the Treatment Administration Records (TARS) for resident #026 for the month of July, 2018, revealed the following missing documentation;

July 2, 6, 9, 10, 11, 13, 15, 16, 17, 19, 21, 22, 23, 24 and 31 (fifteen missing signatures).

Inspector #692 reviewed resident #027's physician's orders and noted that staff were to apply a specific intervention to an area of altered skin integrity. A review of the TARS revealed the following missing documentation;

July 18, 19, 27, 28, and 29 (5 missing signatures)
August, 2, 3, 4, 5, 6, 9, 11, 12, 13, and 14 (eleven missing signatures).

Inspector #692 reviewed resident #028's physician's orders and noted that staff were to apply a medicated cream to an area of altered skin integrity, twice a day for 2 weeks. A review of the TARS revealed the following missing documentation;

August 4, 5, 6, 11, 12 and 15.

Inspector #692 reviewed resident #020's physician's orders and noted that staff were to apply a medicated cream to areas of altered skin integrity. The TARS revealed the following missing documentation;

July 2, 13, 16, 17, 19, 22 and 23.

Inspector #692 reviewed resident #029's physician's orders and noted that staff were to apply a medicated cream to an area of altered skin integrity. The TARS revealed the following missing documentation;

July 2, 13, 14, 15, 16, 17, 19, 22, 31 and
August 2, 4, 5, 6, 7, 10, 11, 13 and 14.

Inspector #692 interviewed RPN #119 who indicated that the registered staff were responsible for ensuring that the resident's received their prescribed medicated creams and ointments. RPN #119 indicated that if the TARS had missing signatures then it would mean that the medicated creams/ointments were not provided to the resident.

Inspector #692 interviewed the Administrator who also verified that the registered staff were to document on the TAR once the treatment had been provided to the resident. [s. 6. (9) 1.]

The decision to re-issue this Compliance Order (CO) was based on the home's compliance history. A previous Voluntary Plan of Correction (VPC) was issued during inspection #2017_463616_0007 on August 2, 2017 and a CO was issued during inspection #2018_703625_0001 on May 18, 2018. The severity was determined to have the potential for actual harm to occur, and the scope was identified as a pattern of residents affected. (542)

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_703625_0006, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) (c) of the Long-Term Care Homes (LTCHA), 2007.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provided direct care to the resident.

On April 13, 2018, Compliance Order #001 from Critical Incident System (CIS) Inspection #2018_703625_0006 was served to the licensee, with a compliance due date of May 31, 2018. The compliance order read:

"The licensee must be compliant with s. 6 (1) (c) of the Long-Term Care Homes Act (LTCHA), 2007.

The licensee shall ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

The licensee was ordered to specifically:
- Conduct a review of resident #001's plan of care with a focus on nutrition and dietary interventions. Ensure the plan of care is clear with respect to the diet orders, feeding assistance required and related dietary interventions;

- Identify the residents in the home who are at risk of choking and require related nutrition and dietary interventions. Ensure the plans of care for those residents are clear with respect to the diet orders, feeding assistance and related dietary interventions the residents require; and

- Maintain written records of the plans of care reviewed, the findings, and the actions taken to address any inconsistencies, or lack of clarity, in the plans."

During the follow up to compliance orders, Inspector #196 conducted an interview with the Administrator. It was determined that the first part of the order, specific to resident #001, was completed. However, the Administrator reported that the remainder of the compliance order had not been done as it had been missed.

The Administrator confirmed to the Inspector, that the other residents in the home who were at risk of choking and required related nutrition and dietary interventions had not been identified. In addition, since the residents that were at risk of choking had not been identified, their plans of care had not been reviewed for clear directions.

During an interview with the Registered Dietitian (RD), they reported to the Inspector that they had started working at the home on May 7, 2018, and had not been made aware of this compliance order that had been issued to the home.

The decision to re-issue this Compliance Order (CO) was based on the home's compliance history. A Voluntary Plan of Correction (VPC) was issued during inspection #2018_703625_0001 on January 28, 2018 and a CO was issued during inspection #2018_703625_0006 on April 13, 2018. The severity of harm was determined to have the potential of harm to the residents and the scope was identified as being a pattern. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Jennifer Lauricella

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