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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2015	2015_289550_0005	O-001493-15, O-001491-15	Follow up

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

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

This inspection was conducted on the following date(s): March 11, 12 and 13 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Physiotherapist, the Physiotherapist Assistant, the RAI Coordinator, several Personal Support Workers and several Residents. The Inspector also reviewed resident's health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Minimizing of Restraining
Personal Support Services
Responsive Behaviours

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (9)	CO #006	2014_289550_0025	550

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The Licensee has failed to ensure that there is a written plan of care Resident #006 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.

Inspector reviewed the most recent MDS data dated a specific dated in January 2015 for Resident #006. Section E, Mood and Behaviour patterns revealed that Resident #006 had wandering behaviour daily and was not easily altered, verbally abusive behaviour 4-6 days a week but less than daily and was not easily altered, socially inappropriate or disruptive behaviour daily and was not easily altered and resisting care behaviour 1-3 days in the last 7 days and was not easily altered.

Inspector revised the progress notes from a specific date in December 2014 to a specific date in March 2015 for Resident #006 and observed the following:
On a specific day in December 2014: some agitation early am.
On a specific day in February 2015: agitated and yelling at everyone.
On a specific day in February 2015: resident is rude to the other residents who were sitting at her table with her for supper.
On a specific day in February 2015: Some agitation in am but settled down after breakfast. At 15:45 agitated, shouting at everyone.
On a specific day in February 2015: 6:15 resident is up in w/c, very loud, agitated and in a foul mood.

Interviewed PSW staff #S101 who is also the BSO staff for the home. She indicated to Inspector #550 Resident #006 is verbally abusive, yells often, is loud and disruptive. She indicated to inspector these behaviours are triggered if people are in this resident's way, if this resident is not served first in the dining room and if this resident does not want to get up. She indicated the behaviours occur almost on a daily basis. As BSO staff she does one on one activities with this resident but does no other interventions as the resident is being followed by the psychogeriatric team.

Inspector #550 revised Resident #006's actual plan of care dated a specific day in October 2014. The plan of care identifies wandering and verbally abusive behaviours. Goals and triggers are identified for the wandering behaviours but there are no interventions identified. Goals and interventions are identified for the verbally abusive behaviour but the triggers are not identified.

Inspector revised Resident #006's plan of care with the RAI Coordinator and observed the plan of care does not identify all the responsive behaviours that are identified in the latest MDS assessment. The RAI Coordinator indicated to Inspector #550 Resident #006 still has behaviours of wandering, verbally abusive, socially inappropriate or disruptive and resisting care. She further indicated these behaviours are triggered if the resident is not served 1st in the dining room, if someone is in the resident's way and the resident wants to go by and sometimes just because this resident is in a bad mood. She indicated there was a recent upgrade made to the Medicare System and that behaviours that are identified in the MDS assessment are no longer automatically identified in the care plan. She indicated she would have to speak to someone from Medicare System to make sure all identified behaviours in the MDS assessments are identified in the plan of care.

The DOC indicated to Inspector #550 all behaviours are documented in the progress notes on a daily basis by registered staff. She indicated it is her expectation that all behaviours, triggers and interventions are documented the resident's respective plan of care.

Inspector #550 reviewed the most recent MDS assessment for Resident #006 dated a specific date in January 2015. Section H: continence in the last 14 days indicated the resident is continent of bowels and incontinent of bladder with multiple daily episodes. Inspector reviewed the activity of daily living flow record for the assessment period of a specific week in January 2015. It was documented Resident #006 was incontinent of bladder most/all shift as follows: this resident was incontinent on 16/21 shift, not incontinent on 2/21 shifts and no documentation for 3/21 shifts. It further indicated the

resident had not been incontinent of bowels during this assessment period. Inspector reviewed Resident #006's daily flow sheets for the months of January, February and March (1-11) 2015 and observed the resident to be incontinent of bladder on a daily basis.

During an interview, PSW staff #S101 indicated to Inspector #550 Resident is incontinent of bladder on a daily basis. She indicated Resident #006 is capable of ringing the call bell but by the time staff get to the resident, the resident was incontinent. She indicated staff toilet the resident on a regular routine, the resident voids in the toilet but is also always incontinent in between.

Inspector reviewed Resident #006's most recent care plan dated a specific day in October 2015 and observed it indicated the resident is occasionally incontinent of bladder 2 times per week but not daily. It also indicated the resident is continent and had complete control of bowels.

During an interview, the RAI Coordinator indicated to Inspector #550 she uses the Activities of Daily Living Flow Record form that is filled out by PSWs during the assessment period to document her assessment in MDS. She indicated to Inspector the care plan of Resident #006 does not reflect the resident's most recent assessment that was done on a specific day in January 2015.

This inspection was a follow-up inspection for Compliance Order #003 for LTCHA, 2007, s. 6. (1) that was issued on November 7, 2014 as part of inspection #2014_289550_0025 and had a compliance date of December 14, 2014. [s. 6. (1)]

2. The Licensee has failed to ensure that Resident #007's plan of care includes the restraint by a physical device used with the resident.

On March 13, 2015 Inspector #550 observed Resident #007 sitting in his/her wheelchair in the front lounge after breakfast. The resident had a front closure lapt belt that was applied and a padded mitt to his/her right hand. The padded mitt is hand made; it consists of 2 pieces of 2 inch foam attached together at the top end and is approximately 7 inches long. The resident's hand is inserted between the two foams and the foams are inserted between two pieces of material that are sewed together leaving and open area to insert the resident's hand. It is attached at the wrist by the white strap. Inspector observed that the foam inside the padded mitt was worn and folded in a way that kept the resident's fingers in a closed fist. One part of the white strap was attached to the

resident's right wrist and the other part was tied in a loop but was not attached to anything. Staff #S104 indicated to inspector staff attach one part of the white strap to the resident's wheelchair during care while the other part is attached to the resident's wrist to prevent him/her from striking out. The resident was unable to grab anything with his/her right hand because of the thickness of the foam.

Inspector reviewed Resident #007's health records and observed on the most recent Three Month Review form dated a specific day in January 2015, a physician order for:
-posey limb holder to right arm during care
-lap belt, front fastening to w/chair for safety
-2 bedside rails up for safety
No order was noted for the padded mitt restraint in the Three Month Review form or in the physicians orders.

Inspector reviewed Resident #007's actual written care plan dated a specific day in October 2014 and observed the following:
Limb restraint: Posey limb restraint to RT wrist, to be used during care only and removed afterward.
Full bed rails on all open sides of bed
Front fastening belt to w/c to prevent falls and optimal positioning.
There was no provision for the padded mitt.

During an interview, PSWs staff #S102 and #S103 indicated to Inspector #550 Resident #007 has a wrist restraint to be applied only when they provide care in his/her w/c or feed the resident and it is to be removed immediately after, the resident has a front closure seat belt applied when he/she is in his w/c, a padded mitt to be applied at all times except when he/she is in bed and two full bed rails when he/she is in bed. Staff #S102 and #S103 indicated the wrist restraint is used on a daily basis when they feed the resident and when they provide care to the resident in his/her w/c as the resident will hit staff. Both PSWs indicated to Inspector #550 they document the restraints on the Restrictive Devices: Monitoring / Repositioning Record form and the resident is unable to remove these restraints on his/her own.

During an interview, the Director of Care indicated to Inspector #550 she did not consider the padded mitt as a restraint because the resident is able to move his/her hand and fingers inside the mitt and this is the reason there is no physician order, no consent or documentation on the padded mitt. She indicated all restraints have to be identified in a resident's care plan to provide clear direction to staff. [s. 6. (1)]

3. The Licensee has failed to ensure that the care plan for Resident #004 includes physiotherapy services provided to the resident.

Inspector #550 reviewed Resident #004's health records. Inspector observed the Physiotherapist documented on the most recent physiotherapy assessment form dated a specific day in December 2015 this resident is to receive physiotherapy services 2-3x/week.

Inspector reviewed Resident #004's actual care plan dated a specific day in August 2014 and observed there is no provision for physiotherapy services.

During an interviewed the Physiotherapist for the home indicated to Inspector #550 he updated Resident #004's care plan in the Medicare system but he did not print a new copy of the care plan. He indicated it is the responsibility of the RAI coordinator to print the care plans.

The RAI Coordinator indicated to Inspector she prints new copies of residents care plans when she does their quarterly assessments. She indicated it is the responsibility of the Physiotherapist to print the resident's care plan when he makes changes to the plan of care or he has to hand write the corrections on the paper copy of the care plan as this is the only care plan staffs have access to. The staff do not have access to the Medicare System.

During an interview, the Assistant DOC indicated to Inspector #550 staff do not have access to Medicare System, they access the paper copies of the resident's care plan. [s. 6. (1)]

4. The licensee has failed to ensure that Resident #002's written plan of care provides clear directions to staff regarding physiotherapy services.

Inspector #550 revised Resident #002's health records. It was documented by the Physiotherapist on the "Formulaire de Révision - Physiothérapie" form dated a specific day in January 2015 Resident #002 was to received physiotherapy services 3 times per week.

Inspector reviewed Resident #002's most recent plan of care dated a specific day in October 2015 and observed it was documented the resident was to receive physical

therapy 30 minutes total in 2 days per week. A note in the progress notes by the Physiotherapist assistant dated a specific day in February 2015 indicated the resident received therapy services 2-3 times per week.

During an interview, the Physiotherapist indicated to Inspector #550 Resident #002 is to receive physiotherapy services 2-3x/week depending on the time they have available and the plan of care should indicate the same. [s. 6. (1) (c)]

5. The licensee has failed to ensure that staff and others who provide direct care to Resident #001 are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Inspector #550 reviewed Resident #001's actual care plan dated a specific day in December 2014 which is the care plan in place according to the ADOC. It was documented in the care plan in French under the therapy section, deconditioning secondary to increased dementia, the goal is to maintain functional abilities for the next 2 quarters. Walking program, 4ww sup, 100m; Nu step as per protocol and balance Exercises, 3x5 (min-squat, ext/abd hip, marching and walking).

Inspector reviewed the progress notes and observed it was documented by the Physiotherapist on a specific day in February 2015 "D/C from physio, refuse".

Inspector reviewed the Physio flow sheet in the resident's health record for the months of January to March 2015. It was documented on a specific day in February 2015 "D/C" and a handwritten note at the top of the form indicated the resident always refuses, does not want activities or physio exercises.

Inspector reviewed Resident #003's actual care plan dated a specific day in November 2014. It was documented:
Therapies: Resident will maintain mobility of extremities and will exercise and prevent contractures.
Physical therapy, Resident had active exercises to upper extremities for 3 days in a week (45 minutes)
Take Resident to the program that has been established.

Inspector reviewed the resident's flow sheet for physiotherapy services for the months of July, August and September 2014 for Resident #003 and observed a note from the Physiotherapist indicated the physio services were discontinued on a specific day in

August 2014.

During an interview the Physiotherapist for the home indicated to Inspector #550 he updated Resident #001 and 003's electronic care plan in the Medicare system when he discontinued the therapy services but he did not know why a new care plan for the resident was not printed. He indicated the RAI Coordinator is the person responsible for printing the care plans once they are updated.

During an interview, the RAI Coordinator indicated to inspector she prints the resident's care plans when she does the resident's assessment quarterly. She indicated to Inspector the physiotherapist does not inform her when he makes changes to the electronic copies of the care plans therefore she does not know which care plans to print. She indicated when the Physiotherapist makes changes to a resident's electronic copy of the care plan; he should print a new care plan or make the changes to the paper copy of the care plan. She further indicated staffs do not have access to the electronic copies of the care plans in Medicare system; they only have access to the printed paper copies to guide them in the provision of care to the residents.

The ADOC indicated to Inspector #550 the paper copy of the resident's care plan is the only copy the staffs have access to. They do not have access to the electronic copies in Medicare System. [s. 6. (8)]

Additional Required Actions:

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

Issued on this 15th day of May, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2015_289550_0005
Log No. / Registre no:	O-001493-15, O-001491-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 20, 2015
Licensee / Titulaire de permis :	GENESIS GARDENS INC 438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5
LTC Home / Foyer de SLD :	FOYER ST-VIATEUR NURSING HOME 1003 Limoges Road South, Limoges, ON, K0A-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To GENESIS GARDENS 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)

Linked to Existing Order / Lien vers ordre existant: 2014_289550_0025, CO #003;

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 shall ensure that:

In addition to what was specified in the previous Order #003 issued on november 7, 2015, the residents written plan of care are revised to include changes in the resident's condition such as:

-Resident #006 shall have changes to behaviours and incontinence care identified in the plan of care
-Resident #007 shall have changes to restraining devices identified in the plan of care to include all physical devices used

To set out the planned care for the resident, the goals that is intended to achieve and clear directions to staff.

Audits and reviews of care plans of all residents who had a change in their condition in the last three months between February 17 to April 17, 2015, are conducted to ensure they include the resident's change in condition.

A progress report is to be submitted by June 18, 2015 via e-mail to joanne.henrie@ontario.ca

Grounds / Motifs :

1. The Licensee has failed to ensure that Resident #007's plan of care includes the restraint by a physical device used with the resident.

On March 13, 2015 Inspector #550 observed Resident #007 sitting in his/her wheelchair in the front lounge after breakfast. The resident had a front closure lapt belt that was applied and a padded mitt to his/her right hand. The padded mitt is hand made; it consists of 2 pieces of 2 inch foam attached together at the top end and is approximately 7 inches long. The resident's hand is inserted between the two foams and the foams are inserted between two pieces of material that are sewed together leaving and open area to insert the resident's hand. It is attached at the wrist by the white strap. Inspector observed that the foam inside the padded mitt was worn and folded in a way that kept the resident's fingers in a closed fist. One part of the white strap was attached to the resident's right wrist and the other part was tied in a loop but was not attached to anything. Staff #S104 indicated to inspector staff attach one part of the white strap to the resident's wheelchair during care while the other part is attached to the resident's wrist to prevent him/her from striking out. The resident was unable to grab anything with his/her right hand because of the thickness of the foam.

Inspector reviewed Resident #007's health records and observed on the most recent Three Month Review form dated a specific day in January 2015, a physician order for:
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his/her w/c or feed the resident and it is to be removed immediately after, the resident has a front closure seat belt applied when he/she is in his w/c, a padded mitt to be applied at all times except when he/she is in bed and two full bed rails when he/she is in bed. Staff #S102 and #S103 indicated the wrist restraint is used on a daily basis when they feed the resident and when they provide care to the resident in his/her w/c as the resident will hit staff. Both PSWs indicated to Inspector #550 they document the restraints on the Restrictive Devices: Monitoring / Repositioning Record form and the resident is unable to remove these restraints on his/her own.

During an interview, the Director of Care indicated to Inspector #550 she did not consider the padded mitt as a restraint because the resident is able to move his/her hand and fingers inside the mitt and this is the reason there is no physician order, no consent or documentation on the padded mitt. She indicated all restraints have to be identified in a resident's care plan to provide clear direction to staff. (550)

2. The Licensee has failed to ensure that there is a written plan of care Resident #006 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.

Inspector reviewed the most recent MDS data dated January 1, 2015 for Resident #006. Section E, Mood and Behaviour patterns revealed that Resident #006 had wandering behaviour daily and was not easily altered, verbally abusive behaviour 4-6 days a week but less than daily and was not easily altered, socially inappropriate or disruptive behaviour daily and was not easily altered and resisting care behaviour 1-3 days in the last 7 days and was not easily altered.

Inspector revised the progress notes from a specific day in December 2014 to a specific day in March 2015 for Resident #006 and observed the following:
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agitated and in a foul mood.

Interviewed PSW staff #S101 who is also the BSO staff for the home. She indicated to Inspector #550 Resident #006 is verbally abusive, yells often, is loud and disruptive. She indicated to inspector these behaviours are triggered if people are in this resident's way, if this resident is not served first in the dining room and if this resident does not want to get up. She indicated the behaviours occur almost on a daily basis. As BSO staff she does one on one activities with this resident but does no other interventions as the resident is being followed by the psychogeriatric team.

Inspector #550 revised Resident #006's actual plan of care dated a specific day in October 2014. The plan of care identifies wandering and verbally abusive behaviours. Goals and triggers are identified for the wandering behaviours but there are no interventions identified. Goals and interventions are identified for the verbally abusive behaviour but the triggers are not identified.

Inspector revised Resident #006's plan of care with the RAI Coordinator and observed the plan of care does not identify all the responsive behaviours that are identified in the latest MDS assessment. The RAI Coordinator indicated to Inspector #550 Resident #006 still has behaviours of wandering, verbally abusive, socially inappropriate or disruptive and resisting care. She further indicated these behaviours are triggered if the resident is not served 1st in the dining room, if someone is in the resident's way and the resident wants to go by and sometimes just because this resident is in a bad mood. She indicated there was a recent upgrade made to the Medicare System and that behaviours that are identified in the MDS assessment are no longer automatically identified in the care plan. She indicated she would have to speak to someone from Medicare System to make sure all identified behaviours in the MDS assessments are identified in the plan of care.

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Inspector #550 reviewed the most recent MDS assessment for Resident #006 dated a specific date in January 2015. Section H: continence in the last 14 days indicated the resident is continent of bowels and incontinent of bladder with

multiple daily episodes. Inspector reviewed the activity of daily living flow record for the assessment period of a specific week in January 2015. It was documented Resident #006 was incontinent of bladder most/all shift as follows: this resident was incontinent on 16/21 shift, not incontinent on 2/21 shifts and no documentation for 3/21 shifts. It further indicated the resident had not been incontinent of bowels during this assessment period. Inspector reviewed Resident #006's daily flow sheets for the months of January, February and March (1-11) 2015 and observed the resident to be incontinent of bladder on a daily basis.

During an interview, PSW staff #S101 indicated to Inspector #550 Resident is incontinent of bladder on a daily basis. She indicated Resident #006 is capable of ringing the call bell but by the time staff get to the resident, the resident was incontinent. She indicated staff toilet the resident on a regular routine, the resident voids in the toilet but is also always incontinent in between.

Inspector reviewed Resident #006's most recent care plan dated a specific day in October 2015 and observed it indicated the resident is occasionally incontinent of bladder 2 times per week but not daily. It also indicated the resident is continent and had complete control of bowels.

During an interview, the RAI Coordinator indicated to Inspector #550 she uses the Activities of Daily Living Flow Record form that is filled out by PSWs during the assessment period to document her assessment in MDS. She indicated to Inspector the care plan of Resident #006 does not reflect the resident's most recent assessment that was done on a specific day in January 2015.

This inspection was a follow-up inspection for Compliance Order #003 for LTCHA, 2007, s. 6. (1) that was issued on November 7, 2014 as part of inspection #2014_289550_0025 and had a compliance date of December 14, 2014. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 20th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

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