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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 8, 2016	2016_226192_0023	008365-15, 003817-16	Follow up

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

DEBORA SAVILLE (192)

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): July 19 and 20, 2016.

This follow-up inspection was completed in regards to outstanding compliance order #001 from inspection 2015_228172_0006 related to lighting and compliance order #001 from inspection 2016_226192_0002 related to weekly skin and wound reassessment.

The following intakes were inspected at the same time as this Follow-up Inspection and can be found in a separate report:
026829-15 – Complaint related to staffing, dining and snack service, and Personal Support Services.
029312-15 - Complaint related to Personal Support Service, Skin and Wound Care and staffing.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care, Assistant Director of Care, Maintenance Person, Registered Practical Nurse and residents.

The inspector toured the home, reviewed lighting upgrades, measured light levels at various locations, reviewed medical records, training records and policy and procedure.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and is therefore subject to lighting requirements under the section of the lighting table titled "All other homes."

Lighting levels were measured in areas identified during the previous inspection (2015_228172_006) to be out of compliance with the lighting requirements including tub rooms, corridors, resident rooms and ensuite bathrooms. Outdoor conditions were bright and natural light sources were excluded as much as possible. All light fixtures were

turned on if not already illuminated and allowed to warm up. Using a handheld light meter, held 30 inches above and parallel to the floor the following measurements were acquired:

A) Room M-11 was observed to be equipped with a florescent tube ceiling light at the entrance to the room and centered on the ceiling over the wardrobes and tube lighting over each bed. Lighting at the entrance to the room and at the head of the bed was greater than the required 215.28 lux. Lighting at the side of the bed one (187 lux) and bed four (194 lux) where the resident would exit the bed, were below the required level of 215.28 lux.

B) Room 211 was observed to be equipped with florescent tube ceiling light at the entrance to the room and over bed tube lighting.
Light meter readings on entrance to the room were greater than the required 215.28 lux. Lighting over and around bed three in the room were unable to be tested as the light was not working on July 19, 2016 and July 20, 2016. Lighting over beds one and two in room 211 met the required 215.28 lux.

C) Corridors - lighting between the lounge and North Main corridor where two square lights with U shaped bulbs (180 lux and 99 lux) were located failed to meet the required 215.28 lux. It is noted that fixtures had been purchased by the home and were to be installed in this area within the next two weeks.

D) Resident bathrooms on the East Wing were noted to be equipped with florescent tube lighting on the wall over the bathroom fixtures. The bathroom accessed from room M02; at the toilet (190 lux) and at the vanity (270 lux). The bathroom accessed from M03; at the toilet (88 lux) and at the vanity (105 lux). The bathroom accessed through M05; at the toilet (105 lux) and at the vanity (240 lux). The bathroom accessed through M09; at the toilet (96 lux) and at the vanity (216 lux). The minimum level required was 215.28 lux.

The licensee failed to ensure that lighting levels were maintained at required minimum levels.

The severity of this area of non-compliance was identified to be minimal harm or potential for actual harm and the scope was a pattern. There was a previously issued compliance order on February 6, 2015 with a compliance date of March 31, 2015. [s. 18.]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

A) Review of the medical record identified that resident #001 sustained a fall that resulted in an area of altered skin integrity in 2016. The resident was transferred to hospital and returned to the home. The medical record failed to identify assessment of the area of altered skin integrity initially, on return from hospital or on a weekly basis until the area of altered skin integrity was healed.

On July 19, 2016, Director of Care (DOC) #100 who is the lead for the Skin and Wound program, stated that it would be the expectation that the area of altered skin integrity would be assessed on return from hospital and weekly until healed and confirmed that no

assessment of the area of altered skin integrity had been completed.

B) Review of the medical record identified that resident #001 sustained an area of altered skin integrity which was assessed. Further record review failed to identify weekly assessments of the area of altered skin integrity.

On July 19, 2016, DOC #100 stated that the area of altered skin integrity sustained by resident #001 had occurred. Review of the medical record with DOC #100 confirmed that no weekly assessment of the area of altered skin integrity had been completed for specified weeks in 2016.

C) Record review identified that resident #001 was assessed to have an area of altered skin integrity. No weekly assessments of the area of altered skin integrity were identified in the medical record.

On July 19, 2016, DOC #100 reviewed the medical record and stated that no weekly assessments of the area of altered skin integrity had been completed.

The licensee failed to ensure that weekly wound assessments were completed when resident #001 sustained areas of altered skin integrity.
[s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Review of the medical record for resident #002 identified that the resident had an area of altered skin integrity. No weekly wound assessment was evident in the medical record for specified weeks in 2016.

Review of the Compliance Plan submitted by the licensee on February 10, 2016 stated that the "Skin Care Coordinator would keep a tracking list and will ensure all active residents are identified on the list. Weekly she will run a report to ensure all assessments are completed. Any assessment not completed would then be assigned for the next day so they are completed within the week."

On July 19, 2016, DOC #100 stated that she had been auditing the weekly assessments up to May 2016 but had stopped auditing at about that time. DOC #100 stated that it

was the expectation that weekly wound assessments be completed when a resident exhibited altered skin integrity and should have been completed for resident #002 on the identified dates.

The licensee failed to ensure that weekly wound assessments were completed for resident #002 who exhibited an area of altered skin integrity. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Record review identified that resident #003 was identified to have specified areas of altered skin integrity in 2016. Assessments were completed weekly except for specified dates in 2016.

On July 19, 2016, DOC #100 stated that weekly assessments of the area of altered skin integrity should have been completed by registered staff.

The licensee failed to ensure that resident #003's areas of altered skin integrity including, skin breakdown and pressure ulcers were assessed weekly by a member of the registered nursing staff.

The severity of this area of non-compliance was identified to be minimal harm or potential for actual harm and the scope was widespread as the concern was evident for three of three residents reviewed. There was a previous compliance order issued February 6, 2016 with a compliance date of March 31, 2016. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of the plan of care identified that resident #003 had their plan of care revised and interventions related to skin and wound care removed.

Review of assessments completed related to skin and wound care identified that resident #003 exhibited altered skin integrity since the plan of care had been revised. Interventions related to skin conditions and areas of altered skin integrity were not included in the plan of care. Review of Point of Care failed to identify interventions specific to the identified areas of altered skin integrity.

On July 19, 2016, Assistant Director of Care #103 stated that the plan of care had been revised after it was identified that one area of altered skin integrity had healed and had not been updated when new areas of altered skin integrity had been identified.

The licensee failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed.

The severity of this area of non-compliance was identified to be minimal risk and the scope isolated. This area of non-compliance was previously issued as a WN during the January 5, 2016 RQI and as a VPC on October 27, 2015. [s. 6. (10) (b)]

Issued on this 24th day of August, 2016

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

Original report signed by the inspector.

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) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2016_226192_0023
Log No. / Registre no:	008365-15, 003817-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 8, 2016
Licensee / Titulaire de permis :	GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home / Foyer de SLD :	GOLDEN YEARS NURSING HOME 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea Brissette

To GOLDEN YEARS NURSING HOMES (CAMBRIDGE) 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: 2015_228172_0006, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall ensure lighting in the specified areas and all other areas of the home are maintained at the minimum required levels.

Grounds / Motifs :

1. The licensee has failed to ensure that the lighting requirements set out in the

lighting table were maintained.

The home was built prior to 2009 and is therefore subject to lighting requirements under the section of the lighting table titled "All other homes."

Lighting levels were measured in areas identified during the previous inspection (2015_228172_006) to be out of compliance with the lighting requirements including tub rooms, corridors, resident rooms and ensuite bathrooms. Outdoor conditions were bright and natural light sources were excluded as much as possible. All light fixtures were turned on if not already illuminated and allowed to warm up. Using a handheld light meter, held 30 inches above and parallel to the floor the following measurements were acquired:

A) Room M-11 was observed to be equipped with a florescent tube ceiling light at the entrance to the room and centered on the ceiling over the wardrobes and tube lighting over each bed. Lighting at the entrance to the room and at the head of the bed was greater than the required 215.28 lux. Lighting at the side of the bed one (187 lux) and bed four (194 lux) where the resident would exit the bed were below the required level of 215.28 lux.

B) Room 211 was observed to be equipped with florescent tube ceiling light at the entrance to the room and over bed tube lighting.
Light meter readings on entrance to the room were greater than the required 215.28 lux. Lighting over and around bed three in the room were unable to be tested as the light was not working on July 19, 2016 and July 20, 2016. Lighting over beds one and two in room 211 met the required 215.28 lux.

C) Corridors - lighting between the lounge and North Main corridor where two square lights with U shaped bulbs (180 lux and 99 lux) were located failed to meet the required 215.28 lux. It is noted that fixtures had been purchased and were to be installed in this area within the next two weeks.

D) Resident bathrooms on the East Wing were noted to be equipped with florescent tube lighting on the wall over the bathroom fixtures. The bathroom accessed from room M02 light meter readings; at the toilet (190 lux) and at the vanity (270 lux). The bathroom accessed from M03 light meter readings; at the toilet (88 lux) and at the vanity (105 lux). The bathroom accessed through M05 light meter reading; at the toilet (105 lux) and at the vanity (240 lux). The bathroom accessed through M09 light meter readings; at the toilet (96 lux) and

at the vanity (216 lux). The minimum level required was 215.28 lux.

The licensee failed to ensure that lighting levels were maintained at required minimum levels.

The severity of this area of non-compliance was identified to be minimal harm or potential for actual harm and the scope was a pattern. There was a previously issued compliance order on February 6, 2015 with a compliance date of March 31, 2015. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_226192_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that residents #001, #002 and #003 and all other residents of the home demonstrating altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Record review identified that resident #003 was identified to have specified areas of altered skin integrity in 2016. Assessments were completed weekly except for specified dates in 2016.

On July 19, 2016, DOC #100 stated that weekly assessments of the area of altered skin integrity should have been completed by registered staff.

The licensee failed to ensure that resident #003's areas of altered skin integrity including, skin breakdown and pressure ulcers were assessed weekly by a member of the registered nursing staff. (192)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Review of the medical record for resident #002 identified that the resident had an area of altered skin integrity. No weekly wound assessment was evident in the medical record for specified weeks in 2016.

Review of the Compliance Plan submitted by the licensee on February 10, 2016 stated that the "Skin Care Coordinator would keep a tracking list and will ensure all active residents are identified on the list. Weekly she will run a report to ensure all assessments are completed. Any assessment not completed would then be assigned for the next day so they are completed within the week."

On July 19, 2016, DOC #100 stated that she had been auditing the weekly assessments up to May 2016 but had stopped auditing at about that time. DOC #100 stated that it was the expectation that weekly wound assessments be completed when a resident exhibited altered skin integrity and should have been

completed for resident #002 on the identified dates.

The licensee failed to ensure that weekly wound assessments were completed for resident #002 who exhibited an area of altered skin integrity. (192)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

A) Review of the medical record identified that resident #001 sustained a fall that resulted in an area of altered skin integrity in 2016. The resident was transferred to hospital and returned to the home. The medical record failed to identify assessment of the area of altered skin integrity initially, on return from hospital or on a weekly basis until the area of altered skin integrity was healed.

On July 19, 2016, Director of Care (DOC) #100 who is the lead for the Skin and Wound program, stated that it would be the expectation that the area of altered skin integrity would be assessed on return from hospital and weekly until healed and confirmed that no assessment of the area of altered skin integrity had been completed.

B) Review of the medical record identified that resident #001 sustained an area of altered skin integrity which was assessed. Further record review failed to identify weekly assessments of the area of altered skin integrity.

On July 19, 2016, DOC #100 stated that the area of altered skin integrity sustained by resident #001 had occurred. Review of the medical record with DOC #100 confirmed that no weekly assessment of the area of altered skin integrity had been completed for specified weeks in 2016.

C) Record review identified that resident #001 was assessed to have an area of altered skin integrity. No weekly assessments of the area of altered skin integrity were identified in the medical record.

On July 19, 2016, DOC #100 reviewed the medical record and stated that no weekly assessments of the area of altered skin integrity had been completed.

The licensee failed to ensure that weekly wound assessments were completed when resident #001 sustained areas of altered skin integrity.

The severity of this area of non-compliance was identified to be minimal harm or potential for actual harm and the scope was widespread as the concern was evident for three of three residents reviewed. There was a previous compliance order issued February 6, 2016 with a compliance date of March 31, 2016. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2016

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
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
Inspection de soins de longue durée
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 8th day of August, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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