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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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
Jan 11, 2016	2015_246196_0017	030822-15	Follow up

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

NORTHWOOD LODGE
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

LAUREN TENHUNEN (196)

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): December 7, 8, 9, 10, 11, 2015

During the course of the inspection, the inspector(s) spoke with the Site Administrator, Director of Care (DOC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Team Lead of Food and Nutrition, Dietary Aides and Residents.

During the inspection, a walk through of all resident care areas was conducted, staff to resident interactions were observed, the health care records of several residents were reviewed, the home's policy on minimizing the restraining of residents and education records were reviewed and the kitchen and dietary rosters were reviewed. In addition, a breakfast, two lunch and one dinner service were observed, the provision of morning beverage pass, the afternoon nourishment pass and an evening nourishment pass were observed.

The following Inspection Protocols were used during this inspection:
Dining Observation
Minimizing of Restraining
Nutrition and Hydration
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 11. (2)	CO #003	2015_380593_0023	196
O.Reg 79/10 s. 110. (2)	CO #001	2015_282543_0024	196
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_380593_0023	196
O.Reg 79/10 s. 71. (3)	CO #004	2015_380593_0023	196
O.Reg 79/10 s. 73. (1)	CO #005	2015_380593_0023	196

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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).

Findings/Faits saillants :

1. 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.

During the inspection, RPN #104 was observed to provide resident #002 with a beverage with a specific type of fluid consistency, after which the resident coughed.

A review of the plan of care for resident #002 identified that a different type of fluid consistency was to be provided and the kitchen roster identified this same type of fluid consistency for beverages.

During discussion, the DOC confirmed that the type of fluid consistency, provided by RPN #104 was incorrect and the resident should have been provided with a different fluid consistency. [s. 6. (7)]

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.

Resident #001 was observed on a day during the inspection, tilted back in a wheelchair with their feet off the floor.

A review of the plan of care for resident #001 identified that the resident was not to be tilted back in the wheelchair because of a medical condition.

PSW #107 confirmed to the inspector that the resident was tilted back in the wheelchair and RPN #104 reported that they had tilted the resident back in their chair.

An interview was conducted with the Administrator and they indicated that staff were to

review the care plan change binder before their shift for information about changes to a resident's plan of care. They also confirmed that resident #001's wheelchair use was noted in this binder. [s. 6. (7)]

3. 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.

The provision of HS (evening) nourishment and snacks was observed on a particular date.

PSW #107 was observed to obtain a beverage with a specific type of fluid consistency from the nourishment cart and then proceed to assist resident #001 with it. The PSW reported to the inspector that the juice may have been too thin but that the resident needed to have a drink. PSW #107 was not observed to review the nourishment round sheet prior to providing this consistency of juice. Inspector then observed Dietary Aide #109 remove the juice, and provided the correct consistency of juice instead.

A review of the plan of care identified that resident #001 required a different fluid consistency type than PSW #107 provided and the nourishment round sheet identified this same type of fluid consistency.

An interview was conducted with the Administrator and they confirmed that staff are to refer to the nourishment round sheet when providing food and fluids to residents to ensure that the correct diets and fluid consistency are given. [s. 6. (7)]

4. 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.

Resident #011 was observed sitting upright in a specialized wheel chair, with a seat belt in place. An interview was conducted with the DOC and they confirmed that a seat belt was in use on resident #011.

The plan of care was reviewed and included an order from the MD for the use of a specific safety device and specialized wheel chair and consent for these same devices from the SDM (Substitute Decision Maker). The care plan identified the use of a specific safety device and a specialized wheel chair and did not identify the use of a seat belt. [s. 6. (7)]

5. 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.

The provision of HS nourishment and snacks was observed on a particular evening.

PSW #107 assisted resident #005 with apple juice that was a specific type of consistency. PSW #107 was not observed to review the nourishment round sheet prior to providing this consistency of juice.

The nourishment round sheet was reviewed and identified a different type of fluid consistency for this resident then PSW #107 provided. The current plan of care identified the resident required a different type of fluid consistency than what was provided.

An interview was conducted with the Administrator and they confirmed that staff are to refer to the nourishment round sheet when providing food and fluids to residents to ensure that the correct diets and consistency are given. [s. 6. (7)]

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

Resident #001 was observed sitting upright in a specialized wheel chair, with a safety device in place.

A review of the plan of care included an order from the MD for both the safety device and for a specialized wheel chair. A progress note identified concerns with ingesting food and fluids and the current care plan included an intervention regarding the use of the specialized wheel chair. In addition, the care plan indicated that the registrant was to obtain an order to discontinue any safety devices when it was no longer needed.

An interview was conducted with the DOC and they confirmed that there was no MD order to discontinue the specialized wheel chair safety device despite no longer using it. [s. 6. (7)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.
Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to minimize the restraining of residents is complied with.

A review of the home's policy NUR 400 titled "Minimizing Restraint - PASD Use" with revision date of November 2015 indicated:

a/. Once a need has been identified, registered staff will consult with a physician or registered nurse in the extended class regarding an order for a specific restraint device.
b/. That consent for the specific restraint device must be obtained from resident or Substitute Decision Maker (SDM) and to refer to NUR 105 Restraint Use Consent form.
c/. That staff may only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
d/. That while restrained, the resident must be monitored at least every hour by a member of the registered nursing staff or by another staff member as authorized by a member of the registered nursing staff for that purpose and to document on NUR 400 Physical Restraint/PASD USE form.
e/. That the resident's condition is reassessed and the effectiveness of restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the resident's condition or circumstances and to document on NUR 400 Physical Restraint/PASD USE form.

Resident #001 was observed on a particular day, seated upright in a specialized wheel chair and with a safety device in place.

The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of safety devices in use, there was no documentation of restraint use on Dec. 1st day shift although the registrant had initialed on that shift that the resident was reassessed, no staff initials Dec. 2 and Dec. 3, 2015 that would have indicated who had applied the restraint, nor the time it was applied and throughout the week the hourly monitoring by staff was not consistently documented. In addition, the registrant's initial was absent from 7 of 21 shifts which would have indicated that the resident's condition and the effectiveness of the restraining was reassessed.

Resident #008 was observed on a particular day, seated in a specialized wheel chair upright and a safety device in place.

The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of restraint devices in use, the hourly monitoring of the resident was not documented consistently and the registrant's initial was absent from 7 of 21 shifts, which would have indicated that the resident's condition and the effectiveness of the restraining was reassessed.

Resident #009 was observed on a particular day seated upright in a specialized wheel chair with a safety device in place.

The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of restraint devices in use, there was no documentation on the day shift of Dec. 1, 2015, although the registrant had initialed on that shift that the resident was reassessed. In addition, the hourly monitoring of the resident was not documented consistently and the registrant's initial was absent from 7 of 21 shifts, which would have indicated that the resident's condition and the effectiveness of the restraining was reassessed.

Resident #006 was observed on a particular day reclined in a specialized wheel chair with a seat belt in place.

The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of restraint devices in use, the hourly monitoring of the resident was not documented

consistently and the registrant's initial was absent from 7 of 21 shifts, which would have indicated that the resident's condition and the effectiveness of the restraining was reassessed.

Resident #010 was observed on a particular day with a seat belt in place.

The plan of care was reviewed and consent from the Substitute Decision Maker (SDM) for the use of a seat belt was not included. The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of restraint in use. In addition, on Dec. 1st day shift, there was no documentation of restraint use although staff on that evening shift had documented that the resident was "UOA" (up on arrival) with a restraint in place at the start of this shift. The hourly monitoring of the resident was not documented consistently and the registrant's initial was absent from 9 of 21 shifts, which would have indicated that the resident's condition and the effectiveness of the restraining was reassessed.

Resident #011 was observed on a particular day, upright in a specialized wheel chair, with a seat belt in place. An interview was conducted with the DOC and they confirmed that a seat belt was in use on resident #011.

The plan of care included an order from the MD for the use of a specific type of safety device and a specialized wheel chair and consent for these same devices from the SDM. The care plan identified the use of a specific type of safety device and a specialized wheel chair.

The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of restraint in use. There was no documentation on the day shift of Dec. 1st to reflect the use of the restraint despite the registrant initials to indicate that the resident was reassessed. On Dec. 3, 2015, at 0700hrs, "UOA" (up on arrival) was documented, but the time of restraint application was not recorded nor whom had applied the restraint device. The hourly monitoring was not documented consistently and the registrant's initial was absent from 7 of 21 shifts, which would have indicated that the resident's condition and the effectiveness of the restraining was reassessed.

Resident #004 was observed on a particular day reclined in a specialized wheel chair with a seat belt in place.

The plan of care included an order from the MD for the use of a seat belt and a specialized wheel chair and consent for these safety devices from the SDM. The care plan did not include reference to the use of either safety device.

An interview was conducted with the Administrator and the DOC and they confirmed that the care plan did not include information about the use of a seat belt nor a specialized wheel chair and that there was no restraint/PASD use form in the flow sheet binder for documentation.

Resident #012 was observed on a particular day upright in a specialized wheel chair with a seat belt in place.

The restraint/PASD use form for the week of Dec. 1 to 7, 2015, did not identify the type of restraint devices in use and the hourly monitoring by staff was not documented consistently. In addition, the registrant's initial was absent from 7 of 21 shifts which would indicate the resident's condition and the effectiveness of the restraining was reassessed. [s. 29. (1) (b)]

Additional Required Actions:

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 ensure that their written policy to minimize the restraining of residents was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

The lunch service on December 9, 2015, was observed and the puree texture of the egg salad sandwich was the consistency of a watery cream soup.

This was brought to the attention of the administrator and in turn the team lead for food services and both confirmed that the texture was too watery.

An interview was conducted with the team lead for the food and nutrition department at the hospital site and it was reported that the cook had thought the egg salad puree was too watery but it was provided to the home anyways. [s. 72. (3) (a)]

Issued on this 18th day of January, 2016

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

Original report signed by the inspector.

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) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2015_246196_0017
Log No. / Registre no:	030822-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 11, 2016
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	NORTHWOOD LODGE 51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kandice Henry

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_380593_0023, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.6(7) of the LTCHA. This plan is to include:

1. A training program for direct care staff in the home, including but not limited to PSWs, dietary aides and registered staff. This training must include:

*Procedure to be followed for the provision of snacks and beverages to residents in the home
*Communication among disciplines to ensure that changes in a resident's plan of care are communicated
*Education of the registered staff regarding the supervision of PSWs and dietary aides to ensure that care set out in the plan of care is provided to the residents as specified in their plans

2. Identification of the persons or persons who will provide this training and education.

3. A schedule including dates of the training/education that will ensure that all PSW, dietary aides and registered staff are included.

4. An auditing process to be undertaken by the management team that will identify if this training/education had been integrated into day to day practice and a plan for corrective action to be developed should the training/education not be effective.

This plan is to be submitted in writing to Long-Term Care Nursing Inspector Lauren Tenhunen. This plan must be received by January 15, 2016 and fully implemented by January 29, 2016.

Grounds / Motifs :

1. 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.

Resident #001 was observed sitting upright in a specialized wheel chair, with a safety device in place.

A review of the plan of care included an order from the MD for both the safety device and for a specialized wheel chair. A progress note identified concerns

with ingesting food and fluids and the current care plan included an intervention regarding the use of the specialized wheel chair. In addition, the care plan indicated that the registrant was to obtain an order to discontinue any safety devices when it was no longer needed.

An interview was conducted with the DOC and they confirmed that there was no MD order to discontinue the specialized wheel chair safety device despite no longer using it. [s. 6. (7)]

(196)

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.

The provision of HS (evening) nourishment and snacks was observed on a particular date.

PSW #107 was observed to obtain a beverage with a specific type of fluid consistency from the nourishment cart and then proceed to assist resident #001 with it. The PSW reported to the inspector that the juice may have been too thin but that the resident needed to have a drink. PSW #107 was not observed to review the nourishment round sheet prior to providing this consistency of juice. Inspector than observed Dietary Aide #109 remove the juice, and provided the correct consistency of juice instead.

A review of the plan of care identified that resident #001 required a different fluid consistency type than what PSW #107 had provided and the nourishment round sheet identified this same type of fluid consistency.

An interview was conducted with the Administrator and they confirmed that staff are to refer to the nourishment round sheet when providing food and fluids to residents to ensure that the correct diets and fluid consistency are given. [s. 6. (7)]

(196)

3. 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.

Resident #011 was observed sitting upright in a specialized wheel chair, with a seat belt in place. An interview was conducted with the DOC and they confirmed that a seat belt was in use on resident #011.

The plan of care was reviewed and included an order from the MD for the use of a specific safety device and specialized wheel chair and consent for these same devices from the SDM (Substitute Decision Maker). The care plan identified the use of a specific safety device and a specialized wheel chair and did not identify the use of a seat belt. [s. 6. (7)]

(196)

4. 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.

The provision of HS (evening) nourishment and snacks was observed on a particular evening.

PSW #107 assisted resident #005 with apple juice that was a specific type of consistency. PSW #107 was not observed to review the nourishment round sheet prior to providing this consistency of juice.

The nourishment round sheet was reviewed and identified a different type of fluid consistency than PSW #107 provided. The current plan of care identified the resident required a different type of fluid consistency than what was provided.

An interview was conducted with the Administrator and they confirmed that staff are to refer to the nourishment round sheet when providing food and fluids to residents to ensure that the correct diets and consistency are given. [s. 6. (7)]

(196)

5. 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.

Resident #001 was observed on a day during the inspection, tilted back in a wheelchair with their feet off the floor.

A review of the plan of care for resident #001 identified that the resident was not to be tilted back in the wheelchair because of a medical condition. PSW #107 confirmed to the inspector that the resident was tilted back in the wheelchair and RPN #104 reported that they had tilted the resident back in their chair.

An interview was conducted with the Administrator and they indicated that staff were to review the care plan change binder before their shift for information about changes to a resident's plan of care. They also confirmed that resident #001's wheelchair use was noted in this binder. [s. 6. (7)]

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6. 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.

During the inspection, RPN #104 was observed to provide resident #002 with a beverage with a specific type of fluid consistency, after which the resident coughed.

A review of the plan of care for resident #002 identified that a different type of fluid consistency was to be provided and the kitchen roster identified this same type of fluid consistency for beverages.

During discussion, the DOC confirmed that the type of fluid consistency, provided by RPN #104 was incorrect and the resident should have been provided with a different fluid consistency. [s. 6. (7)]

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, c.8., s. 6. (7) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, has been previously identified under inspection #:

- 2014_211106_0006 with compliance order served April 25, 2014
- 2015_246196_0007 with compliance order served May 25, 2015
- 2015_380593_0023 with compliance order served October 8, 2015

The decision to re-issue this compliance order was based on the scope which affected five residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including three compliance orders, NC continues with this area of the legislation.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 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
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.

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

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 11th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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