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 prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Apr 25, 2014;	2014_140158_0003 (A1)	S-0458-13,S-0459-13	Follow up

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

KELLY-JEAN SCHIENBEIN (158) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

date removed from S. 6 (1)(c) # 4:
it was identified that resident # 06 was experiencing loose stools on February 22, 25 and 26, 2014. Changed to it was identified that resident # 06 was experiencing loose stools on February 22 and 25, 2014.

Issued on this 25 day of April 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
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PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

KELLY-JEAN SCHIENBEIN (158) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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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): February 25, 26, 27 and 28, 2014

Logs # S-000458-13, S-000459-13, S-000525-13, S-000526-13, S-000527-13 and S-000528-13 were reviewed by Inspector # 158, Inspector # 579 and Inspector # 580 during this Follow Up Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, Program Managers, Registered staff (RN, RPN), Personal Support Workers (PSW), Physiotherapy staff, residents and Family members.

During the course of the inspection, the inspector(s) conducted tours of the home areas, reviewed various policies and procedures, observed the provision of care to residents by staff, observed resident/staff interactions and reviewed the health care records for several residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 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).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On February 26, 2014, Inspector # 579 observed that, upon entering resident # 07 room, 2 staff were present with resident # 07 in the bathroom. Inspector # 579 asked staff # 105 and # 106 how they had transferred the resident and they replied that they needed to ask the RPN about the transfer as the logo for resident # 07 was missing, (this inspector had observed the missing logo earlier upon entering the room). The staff was informed by the RPN that resident # 07 was a 2 person transfer. When asked by Inspector # 579 where they would look up the care plan, the 2 staff said that the care plans were no longer printed and that they use the Kardex's in the binders and that they do not have access to the computerized care plans.
On February 26, 2014, the Inspector # 158 and # 579 reviewed resident # 07 care plan, which indicated that the assistance of three staff was required for toileting resident # 07. Resident # 07 kardex indicated that 2 staff was required. It was further noted by Inspector # 579, that the recent physiotherapy assessment indicated that the care plan should be reviewed as there were discrepancies between the interventions for transfers and toileting.
Although, a new kardex was printed out on February 26, 2014, a discrepancy in the toileting transfer assistance still remained between the kardex and the current care plan.
The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident # 07 regarding the toileting/transfer assistance. [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
The physiotherapist assessed resident # 09 and identified that resident # 09 was at a high risk to fall. Inspector # 579 spoke with staff # 108 who identified depending on resident # 09 condition,(at the time of the transfer) either 1 staff or 2 staff assist resident # 09 to transfer from the wheel chair to the bed. On February 26, 2014, Inspector # 158 and Inspector # 579 reviewed resident # 09 health care record, which included the care plan, the kardex and the posted transfer logos. Although, the kardex and the care plan identified either 1 or 2 staff were required when transferring resident # 09, the posted logo identified that, assistance of one staff with the specific direction to use the transfer belt was documented.
The licensee did not ensure that resident # 09 plan of care set out clear direction related to the transferring of resident # 09. [s. 6. (1) (c)]

3. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
Inspector # 158 and # 580 reviewed resident # 08 health care record, which included

MDS assessments, resident # 08 care plan, kardex and the posted logo direction for transferring resident # 08.
The recent MDS assessment completed by staff # 101, indicated that resident # 08 was at a high risk to fall and that the resident had numerous falls in the last six months.
It was identified by staff # 107 that they refer only to the posted transfer logo and the kardex for direction, when providing care to any resident.
It was identified on the kardex, that one of the interventions to reduce resident # 08 self-transferring/self-releasing of the wheel chair seat belt, was to conceal the seat belt's button. This was not identified on resident # 08 care plan.
Although, it was identified in resident # 08 care plan under transferring to never use a specific sling, this direction was not documented on the kardex.
The licensee failed to ensure that the plan of care (resident # 08 care plan, kardex and posted logo) set out clear directions to staff and others who provide direct care during the transferring of resident # 08. [s. 6. (1) (c)]

4. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
On February 24, 25 and 26, 2014, Inspectors # 158, # 579 and Inspector # 580 observed a number of isolation carts and signage on resident doors indicating the use of contact precautions in various home areas.
On February 26, 2014, Inspector # 158 reviewed resident # 06 health care record, which included MDS assessments, lab reports, progress notes, kardex and care plan.
It was identified in the assessments and lab reports that the resident was positive for a transmittable infection.
In review of resident # 06 progress notes, it was identified that resident # 06 was currently experiencing gastro-intestinal symptoms. The Inspector was present for the shift report and noted that the resident's symptoms were not communicated to the oncoming shift.
It was identified by staff # 103 and staff # 104 that they were not aware that they have access to the computerized care plans and that they rely on the printed kardex found in the binders on the unit and what is communicated at shift report.
The Inspector compared resident # 06 care plan (computer) with the printed kardex and found that, although infection control interventions were documented on the computerized care plan, these interventions were not documented on the printed kardex, which the direct staff use.
The licensee did not ensure that clear direction regarding infection control interventions were set out in resident # 06 kardex, which the staff use when providing

direct care to resident # 06. [s. 6. (1) (c)]

5. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
On February 25, 2014, the Inspector was informed by an anonymous source, that resident # 02, who is cognitively impaired, has short term memory loss and is positive for a transmittable infection, uses the public washroom, located near the resident's bedroom.
The Inspector observed resident # 02 leave their room at 16:00h, wander down the hall and enter the public washroom. The Inspector waited outside the door and heard the resident use the toilet, then the resident exited the washroom. The Inspector did not hear the running of water or the towel dispenser being used. The resident was unable to answer the Inspector's question regarding why they used this particular washroom.
The Inspector reviewed resident # 02 health care record, including lab results, assessments, progress notes, care plans and the kardex. It was identified that the resident was confirmed as being positive for the transmittable infection 3 weeks ago.
A review of resident # 02 progress notes showed that resident # 02 was tested for the transmittable infection because the resident had previously been observed by staff to use equipment designated for another resident who was positive with the same transmittable infection. It was further documented that resident # 02 was observed to be using the empty bed in the room, and that resident # 02 continued to use the public washroom.
On February 25, 2014, Inspector # 158 reviewed resident # 02 printed kardex, the December 2013 care plan as well as, the "edited care plan".
At the time of the review, the care plans did not identify resident # 02 positive infectious status or the necessary precautions to be taken. Although the care plans identified resident # 02 behaviours of wandering and resisting care, they did not include the resident's refusal of using the washroom in their room, the resident's use of the public washroom or the resident's inability to use/follow contact precautions.
On February 27, 2014, Inspector # 158 noted that resident # 02 care plan was updated only after the issue was identified to management by the Inspector.
In review of this updated version, this care plan did contain infection control interventions, however, the care plan failed to provide clear directions to manage resident # 02 inability to follow contact precautions related to short term memory loss, wandering and refusal of care.
The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to resident # 02 related to the management of the

behaviours and the resident's positive infectious status. [s. 6. (1) (c)]

6. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
On February 25, 2014, Inspector # 158 observed that isolation signage was posted outside resident # 03 door.
Resident # 03 health care record, which included the progress notes, care plan and kardex were reviewed by Inspector # 158.
It was documented in resident # 03 progress notes that isolation precautions were initiated as resident # 03 was observed by staff # 102 to have several respiratory symptoms.
It was confirmed by staff # 102 that isolation precautions remained in effect as resident # 03 still displayed respiratory symptoms.
A review of resident # 03 care plan and kardex showed that there was no identification of the Respiratory illness nor isolation precautions.
The licensee did not ensure that plan of care set out clear directions to staff and others who provide direct care to resident # 03 related to his current infection. [s. 6. (1) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 s. 19. (1)	CO #002	2013_138151_0030	158
O.Reg 79/10 s. 36.	CO #004	2013_246196_0003	158
LTCHA, 2007 s. 6. (4)	CO #001	2013_246196_0003	158
LTCHA, 2007 s. 6. (5)	CO #002	2013_246196_0003	158
LTCHA, 2007 s. 6. (7)	CO #003	2013_246196_0003	158

Issued on this 25 day of April 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : KELLY-JEAN SCHIENBEIN (158) - (A1)

Inspection No. / No de l'inspection : 2014_140158_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-0458-13,S-0459-13 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Apr 25, 2014;(A1)

Licensee / Titulaire de permis : THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

LTC Home / Foyer de SLD : PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

Name of Administrator / Nom de l'administratrice ou de l'administrateur : TONY PARMAR

To THE CITY OF GREATER SUDBURY, 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: 2013_138151_0030, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that resident # 02, # 03, # 06 and any resident with an infection which can be transmitted, have a written plan of care related to isolation precautions that gives clear direction to staff providing care; and that residents # 07, # 08 and # 09 have a written plan of care that gives clear direction to staff providing care related to the residents requirement for transferring assistance. This plan is to be submitted to Inspector Kelly-Jean Schienbein (158), Health System Accountability and Performance Division, Sudbury Service Area Office, 159 Cedar Street, Suite 403, Sudbury, ON P3E 6A5 by April 1, 2014.

Grounds / Motifs :

1. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
On February 25, 2014, Inspector # 158 observed that isolation signage was posted outside resident # 03 door.
Resident # 03 health care record, which included the progress notes, care plan and kardex were reviewed by Inspector # 158.
It was documented in resident # 03 progress notes that isolation precautions were initiated as resident # 03 was observed by staff # 102 to have several respiratory symptoms.
It was confirmed by staff # 102 that isolation precautions remained in effect as resident # 03 still displayed respiratory symptoms.
A review of resident # 03 care plan and kardex showed that there was no identification of the Respiratory illness nor isolation precautions.
The licensee did not ensure that plan of care set out clear directions to staff and others who provide direct care to resident # 03 related to their current infection. (158)

2. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
On February 25, 2014, the Inspector was informed by an anonymous source, that resident # 02, who is cognitively impaired, has short term memory loss and is positive for a transmittable infection, uses the public washroom, located near the resident's bedroom.
The Inspector observed resident # 02 leave their room at 16:00h, wander down the hall and enter the public washroom. The Inspector waited outside the door and heard the resident use the toilet, then the resident exited the washroom. The Inspector did not hear the running of water or the towel dispenser being used. The resident was unable to answer the Inspector's question regarding why they used this particular washroom.
The Inspector reviewed resident # 02 health care record, including lab results, assessments, progress notes, care plans and the kardex. It was identified that the resident was confirmed as being positive for the transmittable infection 3 weeks ago.
A review of resident # 02 progress notes showed that resident # 02 was tested for the transmittable infection because the resident had previously been observed by

staff to use equipment designated for another resident who was positive with the same transmittable infection. It was further documented that resident # 02 was observed to be using the empty bed in the room, and that resident # 02 continued to use the public washroom.
On February 25, 2014, Inspector # 158 reviewed resident # 02 printed kardex, the December 2013 care plan as well as, the "edited care plan".
At the time of the review, the care plans did not identify resident # 02 positive infectious status or the necessary precautions to be taken. Although the care plans identified resident # 02 behaviours of wandering and resisting care, they did not include the resident's refusal of using the washroom in their room, the resident's use of the public washroom or the resident's inability to use/follow contact precautions.
On February 27, 2014, Inspector # 158 noted that resident # 02 care plan was updated only after the issue was identified to management by the Inspector.
In review of this updated version, this care plan did contain infection control interventions, however, the care plan failed to provide clear directions to manage resident # 02 inability to follow contact precautions related to short term memory loss, wandering and refusal of care.
The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to resident # 02 related to the management of the behaviours and the resident's positive infectious status. (158)

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

(A1)

3. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On February 24, 25 and 26, 2014, Inspectors # 158, # 579 and Inspector # 580 observed a number of isolation carts and signage on resident doors indicating the use of contact precautions in various home areas.

On February 26, 2014, Inspector # 158 reviewed resident # 06 health care record, which included MDS assessments, lab reports, resident # 06 progress notes, kardex and care plan.

It was identified in the assessments and lab reports that the resident was MRSA positive.

In review of resident # 06 progress notes, it was identified that resident # 06 was experiencing loose stools on February 22 and 25, 2014. There was no mention of resident # 06 previous loose stools during the February 26 14 shift report.

It was identified by staff # 103 and staff # 104 that they were not aware that they have access to the computerized care plans and that they rely on the printed kardex found in the binders on the unit and what is communicated at shift report.

The Inspector compared resident # 06 care plan (computer) with her printed kardex and found that, although infection control interventions were documented on the computerized care plan, these interventions were not documented on the printed kardex, which the direct staff use.

The licensee did not ensure that clear direction regarding infection control interventions were set out in resident # 06 kardex, which the staff use when providing direct care to resident # 06. (158)

4. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
Inspector # 158 and # 580 reviewed resident # 08 health care record, which included MDS assessments, resident # 08 care plan, kardex and the posted logo direction for transferring resident # 08.
The recent MDS assessment completed by staff # 101, indicated that resident # 08 was at a high risk to fall and that the resident had numerous falls in the last six months.
It was identified by staff # 107 that they refer only to the posted transfer logo and the kardex for direction, when providing care to any resident.
It was identified on the kardex, that one of the interventions to reduce resident # 08 self-transferring/self-releasing of the wheel chair seat belt, was to conceal the seat belt's button. This was not identified on resident # 08 care plan.
Although, it was identified in resident # 08 care plan under transferring to never use a specific sling, this direction was not documented on the kardex.
The licensee failed to ensure that the plan of care (resident # 08 care plan, kardex and posted logo) set out clear directions to staff and others who provide direct care during the transferring of resident # 08. (158)

5. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
The physiotherapist assessed resident # 09 and identified that resident # 09 was at a high risk to fall. Inspector # 579 spoke with staff # 108 who identified depending on resident # 09 condition,(at the time of the transfer) either 1 staff or 2 staff assist resident # 09 to transfer from the wheel chair to the bed. On February 26, 2014, Inspector # 158 and Inspector # 579 reviewed resident # 09 health care record, which included the care plan, the kardex and the posted transfer logos. Although, the kardex and the care plan identified either 1 or 2 staff were required when transferring resident # 09, the posted logo identified that, assistance of one staff with the specific direction to use the transfer belt was documented.
The licensee did not ensure that resident # 09 plan of care set out clear direction related to the transferring of resident # 09. (158)

6. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
On February 26, 2014, Inspector # 579 observed that, upon entering resident # 07 room, 2 staff were present with resident # 07 in the bathroom. Inspector # 579 asked staff # 105 and # 106 how they had transferred the resident and they replied that they needed to ask the RPN about the transfer as the logo for resident # 07 was missing, (this inspector had observed the missing logo earlier upon entering the room). The staff was informed by the RPN that resident # 07 was a 2 person transfer.
When asked by Inspector # 579 where they would look up the care plan, the 2 staff said that the care plans were no longer printed and that they use the Kardex's in the binders and that they do not have access to the computerized care plans.
On February 26, 2014, the Inspector # 158 and # 579 reviewed resident # 07 care plan, which indicated that the assistance of three staff was required for toileting resident # 07. Resident # 07 kardex indicated that 2 staff was required. It was further noted by Inspector # 579, that the recent physiotherapy assessment indicated that the care plan should be reviewed as there were discrepancies between the interventions for transfers and toileting.
Although, a new kardex was printed out on February 26, 2014, a discrepancy in the toileting transfer assistance still remained between the kardex and the current care plan.
The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident # 07 regarding the toileting/transfer assistance. (158)

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

May 01, 2014

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

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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
Toronto ON M5S 2B1
Télécopieur : 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 :

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 25 day of April 2014 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : KELLY-JEAN SCHIENBEIN

Service Area Office /
Bureau régional de services : Sudbury