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

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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
Jul 22, 2015;	2015_346133_0007 (A1)	O-001596-15	Complaint

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Compliance Order #001 has been amended. The Compliance Order was issued to the licensee pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 87, and was specifically related to emergency plans that provide for dealing with the loss elevator service, which is an essential service for the home. The compliance date was originally July 27th, 2015. The compliance date is now September 30th, 2015. No other changes to the reports have been made.

Issued on this 22 day of July 2015 (A1)

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

Original report signed by the inspector.

Ontario

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 24 - 26, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Manager, the Director of Care, registered and non registered nursing staff, and a resident.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **1 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 LTCHA, 2007, s. 87. Emergency plans

Specifically failed to comply with the following:

s. 87. (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with emergencies; and 2007, c. 8, s. 87. (1).
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency. 2007, c. 8, s. 87. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 87, in that

the licensee has failed to ensure that there are emergency plans in place for the home that comply with the regulations.

2. In accordance with O. Reg. 79/10, s. 230 (2), the licensee shall ensure that the emergency plans for the home are in writing.

In accordance with O. Reg. 79/10, s. 230 (4) 1. viii. the licensee shall ensure that the emergency plans provide for the loss of essential services. Essential services, as outlined in O. Reg. 79/10, s. 19 (1) (c), include elevators.

At the time of the inspection, the emergency plan in place that provides for dealing with recurring short term losses of elevator service was not in writing.

Over the course of the complaint inspection, March 24th – 26th, 2015, and as a result of a previous complaint inspection (#2014_346133_0013), conducted by inspector #133 in October 2014, it has been established that there is a recurrence of short term losses of elevator service at the home. Inspector #133 reviewed and discussed documentation relating to elevator malfunctions with the home's Environmental Manager. The home's elevator was not available for use by residents or staff during the following periods in 2014 and 2015, due to malfunctions:

a) August 31st, 2014 (9:30pm) – September 2nd, 2014 (11:00am). The elevator was not operable during this period.

b) September 14th, 2014 (6.5 – 8.5 hour period). The elevator was not operable during this period.

c) January 18th, 2015 (6:00 pm) – January 19th, 2015 (2:30pm). The elevator was taken out of service, related to resident and staff usage, due to possible risk. The elevator was used to transport food and equipment only.

d) March 6th, 2015 (7 hour period). The elevator was taken out of service, related to resident and staff usage, due to possible risk. The elevator was used to transport food and equipment only.

e) March 7th, 2015 (5 hour period). The elevator was taken out of service, related to resident and staff usage, due to possible risk. The elevator was used to transport food and equipment only.

On March 25th, 2015, the Administrator provided Inspector #133 with a copy of the home's written emergency plan that provides with dealing with the prolonged loss of elevator service. The plan is titled "Elevator Malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013. The plan is based on the home's July 2009 elevator malfunction contingency plan, developed in advance of a 4 week elevator service outage, to allow for cylinder replacement. The stated purpose of the plan qualifies that it is in place to help management staff deal with a prolonged loss of elevator use. Within the procedure section, it is stated "should the elevator be out of service for a prolonged period of time, determined by KONE, the administration needs to assess the situation and contact the Ministry of Health. In the outcome section, it is stated that "managers to provide a contingency plan in the event of an extensive period of time without an elevator". The Environmental Manager informed the Inspector that the Elevator Malfunction plan was not formally activated in response to the losses of elevator service noted above because the home expected that the elevator would be quickly repaired. For example, the Navan fire department was not notified and communication to all concerned did not occur, which are components of the plan, as prolonged loss was not anticipated. It is noted that residents were served their meals in the activity rooms on the care units, which is a component of the plan.

Relating to the recurrence of short term losses of elevator service at the home, the Administrator and Environmental Manager indicated to the inspector that all staff know what to do when the elevator goes out of service, that there is a plan in place, including a plan for the provision of care to residents who may have to remain in the basement following a loss of elevator service during meal times. The plan is however not in writing.

The recurrence of short term losses of elevator service at the home is related to the elevator's control system. It has been previously established by Inspector #133 that the elevator control system requires replacement (see complaint inspection # 2014_346133_0013, log # O-000935-14, inspection conducted in October 2014). The elevator control system is responsible for coordinating all aspects of elevator service such as travel, speed, and accelerating, decelerating, door opening speed and delay, leveling and hall lantern signals.

On March 26th, 2015, Inspector #133 met with a representative of KONE Inc., at the home, which is the company contracted to provide elevator maintenance. The KONE representative confirmed that all of the elevator service calls have been related to the control system. The representative explained that parts for the system are obsolete,

yet so far, KONE technicians have been able to find replacement parts when needed. The KONE representative informed the inspector that the home's elevator dates from 1964. The elevator cylinder was replaced in 2009, all other parts and systems are original.

Sarsfield Colonial Home is a 46 bed Long Term Care Home., with resident bedrooms on the 1st – 3rd floors. The home's main exit/entrance is on the main level. The resident's dining room is in the basement. The elevator serves the basement level, and the 1st-3rd floor units. There is a ramp and a set of stairs between the main level and the basement level. There are also stairs between the main level and the 3 floors. The elevator is used to porter all residents to and from the basement so they can access the dining room and the home's main exit doors. The elevator is also used by staff to transport supplies and equipment, by visitors to access the care units, and by service providers and emergency responders.

The elevator is an essential service to the home. The licensee has failed to ensure that the emergency plan in place that provides for dealing with the recurrence of short term losses of elevator service is in writing.

3. In accordance with O. Reg. 79/10, s. 230 (5), the licensee shall ensure that the emergency plans address four specified components, including plan activation, and a communications plan.

On March 24th, 2015, Inspector #133 began a complaint inspection, related in part to alleged elevator malfunctions and safety concerns for the residents as a result of the alleged elevator malfunctions.

On March 25th, 2015, the Administrator provided Inspector #133 with a copy of the home's written emergency plan that provides with dealing with the prolonged loss of elevator service. The plan is titled "Elevator Malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013. Inspector #133 previously reviewed this plan in October 2014 (inspection #2014_346133_0013), for a similar complaint related to the elevator. As a result of the October 2014 inspection, the licensee was issued a Written Notification and a Voluntary Plan of Correction (VPC), related to the emergency plan. On March 25th, 2015, the Administrator, who is also the licensee, informed Inspector #133 that a plan to achieve compliance had not been developed or implemented, and that the emergency plan, previously reviewed by Inspector #133 in October 2014, remained unchanged.

The emergency plan, as noted above, does not address plan activation. The plan states "Should the elevator be set out of service for a prolonged period of time, determined by KONE, the administrator needs to assess the situation and contact the Ministry of Health". This statement does not quantify when the plan will be activated. There is no other statement related to the notion of plan activation within the plan. The plan outlines what should happen once the plan is activated, but does not specify when the plan will be activated.

The emergency plan, as noted above, does not address a communications plan. The plan states "communication to all concerned, employees, family members, services, residents….needs to be done as soon as possible by notices, newsletters, memos……". While this statement reflects the need to communicate about a prolonged elevator malfunction to all concerned, it does not outline an actual communication plan. As well, the plan refers to contacting the Ministry of Health, yet it does not speak specifically to the reporting requirements outlined in O. Reg.79/10 , s. 107, nor it is specified who will be responsible for such communications. The plan does not specify who will be contacted, how they will be contacted, and when they will be contacted.

4. In accordance with O. Reg. 79/10, s. 230 (6), the licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually.

On March 25th, 2015, the Administrator provided Inspector #133 with a copy of the home's written emergency plan that provides with dealing with the malfunction of the home's elevator. The plan is titled "elevator malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013. The Administrator acknowledged that the plan has not been evaluated and updated since July 2013.

5. The widespread non-compliance described above presents a potential risk to the residents. The licensee has a history of non-compliance related to the emergency plan in place that provides for dealing with the prolonged loss of elevator service. As a result of inspection # 2014_346133_0013, conducted in October 2014, a Written Notification and Voluntary Plan of Correction was issued to the licensee, pursuant to O. Reg. 79/10, s. 230 (5) [s. 87. (1)]

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (2) in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

On March 26th, 2015, Inspector #133 observed that the door leading to the 2nd and 3rd floor utility rooms had no locks on them. The rooms contained a toilet, a mop bucket, a sink, soiled laundry bag stand and storage cupboards. On March 26th, 2015, at 12:59pm, the inspector observed that the door leading to the 1st floor utility room was equipped with a slide bolt lock towards the top of the door frame. The slide bolt lock was not engaged. A slide bolt lock is not an acceptable means of restricting unsupervised access to an area by residents, as it does not prevent unauthorized entry. The 1st floor utility room contained a toilet, a garbage can, a utility sink, storage cupboards, and a soiled laundry bag stand. Cleaning products stored within these rooms were noted to be within secured cupboards.

Following this observation, discussion was held with the Administrator and the Director of Care, both of whom acknowledged that these utility rooms are not intended for resident access. [s. 9. (1) 2.]

Issued on this 22 day of July 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA LAPENSEE (133) - (A1)

Inspection No. / No de l'inspection : 2015_346133_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001596-15 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jul 22, 2015;(A1)

Licensee / Titulaire de permis : TAMINAGI INC.
05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1

LTC Home / Foyer de SLD : SARSFIELD COLONIAL HOME
2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : CHANTAL CRISPIN

To TAMINAGI 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)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 87. (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with emergencies; and
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency. 2007, c. 8, s. 87. (1).

Order / Ordre :

In order to ensure that there are emergency plans in place for the home that comply with the regulations, the licensee will:

a) ensure that the emergency plan for the home that provides for dealing with the recurring short term loss of elevator service is in writing.

b) ensure that the emergency plans for the home that provide for dealing with loss of elevator service address the following components: plan activation, lines of authority, communications plan, specific staff roles and responsibilities.

c) ensure that the emergency plans for the home that provide for dealing with the loss of elevator service are evaluated and updated at least annually.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 87, in that the licensee has failed to ensure that there are emergency plans in place for the home that comply with the regulations.

2. In accordance with O. Reg. 79/10, s. 230 (2), the licensee shall ensure that the emergency plans for the home are in writing.

In accordance with O. Reg. 79/10, s. 230 (4) 1. viii. the licensee shall ensure that the emergency plans provide for the loss of essential services. Essential services, as outlined in O. Reg. 79/10, s. 19 (1) (c), include elevators.

At the time of the inspection, the emergency plan in place that provides for dealing with recurring short term losses of elevator service was not in writing.

Over the course of the complaint inspection, March 24th – 26th, 2015, and as a result of a previous complaint inspection (#2014_346133_0013), conducted by inspector #133 in October 2014, it has been established that there is a recurrence of short term losses of elevator service at the home. Inspector #133 reviewed and discussed documentation relating to elevator malfunctions with the home's Environmental Manager. The home's elevator was not available for use by residents or staff during the following periods in 2014 and 2015, due to malfunctions:

a) August 31st, 2014 (9:30pm) – September 2nd, 2014 (11:00am). The elevator was not operable during this period.

b) September 14th, 2014 (6.5 – 8.5 hour period). The elevator was not operable during this period.

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d) March 6th, 2015 (7 hour period). The elevator was taken out of service, related to resident and staff usage, due to possible risk. The elevator was used to transport food and equipment only.

e) March 7th, 2015 (5 hour period). The elevator was taken out of service, related to

resident and staff usage, due to possible risk. The elevator was used to transport food and equipment only.

On March 25th, 2015, the Administrator provided Inspector #133 with a copy of the home's written emergency plan that provides with dealing with the prolonged loss of elevator service. The plan is titled "Elevator Malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013. The plan is based on the home's July 2009 elevator malfunction contingency plan, developed in advance of a 4 week elevator service outage, to allow for cylinder replacement. The stated purpose of the plan qualifies that it is in place to help management staff deal with a prolonged loss of elevator use. Within the procedure section, it is stated "should the elevator be out of service for a prolonged period of time, determined by KONE, the administration needs to assess the situation and contact the Ministry of Health. In the outcome section, it is stated that "managers to provide a contingency plan in the event of an extensive period of time without an elevator". The Environmental Manager informed the Inspector that the Elevator Malfunction plan was not formally activated in response to the losses of elevator service noted above because the home expected that the elevator would be quickly repaired. For example, the Navan fire department was not notified and communication to all concerned did not occur, which are components of the plan, as prolonged loss was not anticipated. It is noted that residents were served their meals in the activity rooms on the care units, which is a component of the plan.

Relating to the recurrence of short term losses of elevator service at the home, the Administrator and Environmental Manager indicated to the inspector that all staff know what to do when the elevator goes out of service, that there is a plan in place, including a plan for the provision of care to residents who may have to remain in the basement following a loss of elevator service during meal times. The plan is however not in writing.

The recurrence of short term losses of elevator service at the home is related to the elevator's control system. It has been previously established by Inspector #133 that the elevator control system requires replacement (see complaint inspection # 2014_346133_0013, log # O-000935-14, inspection conducted in October 2014). The elevator control system is responsible for coordinating all aspects of elevator service such as travel, speed, and accelerating, decelerating, door opening speed and delay, leveling and hall lantern signals.

On March 26th, 2015, Inspector #133 met with a representative of KONE Inc., at the home, which is the company contracted to provide elevator maintenance. The KONE representative confirmed that all of the elevator service calls have been related to the control system. The representative explained that parts for the system are obsolete, yet so far, KONE technicians have been able to find replacement parts when needed. The KONE representative informed the inspector that the home's elevator dates from 1964. The elevator cylinder was replaced in 2009, all other parts and systems are original.

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The elevator is an essential service to the home. The licensee has failed to ensure that the emergency plan in place that provides for dealing with the recurrence of short term losses of elevator service is in writing.

3. In accordance with O. Reg. 79/10, s. 230 (5), the licensee shall ensure that the emergency plans address four specified components, including plan activation, and a communications plan.

On March 24th, 2015, Inspector #133 began a complaint inspection, related in part to alleged elevator malfunctions and safety concerns for the residents as a result of the alleged elevator malfunctions.

On March 25th, 2015, the Administrator provided Inspector #133 with a copy of the home's written emergency plan that provides with dealing with the prolonged loss of elevator service. The plan is titled "Elevator Malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013. Inspector #133 previously reviewed this plan in October 2014 (inspection #2014_346133_0013), for a similar complaint related to the elevator. As a result of the October 2014 inspection, the licensee was issued a Written Notification and a Voluntary Plan of Correction

(VPC), related to the emergency plan. On March 25th, 2015, the Administrator, who is also the licensee, informed Inspector #133 that a plan to achieve compliance had not been developed or implemented, and that the emergency plan, previously reviewed by Inspector #133 in October 2014, remained unchanged.

The emergency plan, as noted above, does not address plan activation. The plan states "Should the elevator be set out of service for a prolonged period of time, determined by KONE, the administrator needs to assess the situation and contact the Ministry of Health". This statement does not quantify when the plan will be activated. There is no other statement related to the notion of plan activation within the plan. The plan outlines what should happen once the plan is activated, but does not specify when the plan will be activated.

The emergency plan, as noted above, does not address a communications plan. The plan states "communication to all concerned, employees, family members, services, residents….needs to be done as soon as possible by notices, newsletters, memos……". While this statement reflects the need to communicate about a prolonged elevator malfunction to all concerned, it does not outline an actual communication plan. As well, the plan refers to contacting the Ministry of Health, yet it does not speak specifically to the reporting requirements outlined in O. Reg.79/10 , s. 107, nor it is specified who will be responsible for such communications. The plan does not specify who will be contacted, how they will be contacted, and when they will be contacted.

4. In accordance with O. Reg. 79/10, s. 230 (6), the licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually.

On March 25th, 2015, the Administrator provided Inspector #133 with a copy of the home's written emergency plan that provides with dealing with the malfunction of the home's elevator. The plan is titled "elevator malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013. The Administrator acknowledged that the plan has not been evaluated and updated since July 2013.

5. The widespread non-compliance described above presents a potential risk to the residents. The licensee has a history of non-compliance related to the emergency plan in place that provides for dealing with the prolonged loss of elevator service. As a result of inspection # 2014_346133_0013, conducted in October 2014, a Written Notification and Voluntary Plan of Correction was issued to the licensee, pursuant to

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

O. Reg. 79/10, s. 230 (5) (133)

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

Sep 30, 2015(A1)

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

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 22 day of July 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

Service Area Office /
Bureau régional de services : Ottawa