Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Dec 12, 2014	2014_336580_0018	S-000123-14, S-000124-14	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road ELLIOT LAKE ON P5A 1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD ELLIOT LAKE ON P5A 1X2

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

VALA MONESTIMEBELTER (580)

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): September 8, 9, 10, 11 and 12, 2014.

This inspection is in relation to Log #S-000123-14, S-000124-14 and S-000125-14.

During the course of the inspection, the inspector(s) spoke with residents and their families, the Administrator/Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Dietary Assistant, Dietary Aides (DAs), the Head of Activity, Activity Aides (AAs) and Behaviour Support Ontario staff (BSO).

The following Inspection Protocols were used during this inspection:
Food Quality
Nutrition and Hydration
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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
O.Reg 79/10 s. 71. (1)	CO #002	2014_246196_0001	580
O.Reg 79/10 s. 71. (2)	CO #003	2014_246196_0001	580

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. Inspector #575 reviewed CI#2877-000018-11 regarding resident #005. Resident #005 had a fall. The inspector reviewed resident #005's health care record and noted that the plan of care clearly identifies that the resident's advanced directives include 'do not resuscitate'. Progress notes from the incident state that the resident was unresponsive and 'chest compressions given'. Additionally, interventions described in the resident's care plan under the problem heading 'Falls/Balance' identified that staff are to use the 'seizure flow record to record seizure activity'. Inspector #575 reviewed the resident's health care records and did not find a seizure flow record. The Administrator/DOC told the inspector that such a form did/does not exist.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan. [s. 6. (7)]

2. On September 10 and 11, 2014 Inspector #580 reviewed the following health care record for resident #007:
-the care plan which states that registered staff are to assess resident's skin for any open areas or problems that are noted during bathing and reported to the registered staff;
-the PSWs' bath list documentation states that small bruises were noted on resident #007;
-the registered staff's skin assessment in resident #007's progress notes specifies bruising in a different area.

The inspector observed resident care, reviewed the care plan, skin assessment bathing reports and the progress notes; the RPNs and PSWs confirmed to the inspector that PSWs report skin assessments completed during resident bathing to the RPNs in writing on the bathing reports; the inspector found no registered staff assessment of the bruised area noted by the PSWs; on September 10, 2014 the Administrator/Director of Care confirmed to the inspector that she was unable to find registered staff's skin assessment reports for resident #007 documented; the inspector found that the care is not consistent with the directions stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #007 as specified in the plan, specifically assessing skin condition of during care. [s. 6. (7)]

3. On September 10, 2014, Inspector #580 reviewed the following health care records for resident #008:
-the care plan which states that registered staff are to assess resident's skin for any open areas or problems that are noted during bathing and report this to the registered staff;
-the bath list with documentation by PSWs states "small skin tear" for resident #008;
-the inspector noted that the progress notes did not contain any skin assessment reports from the PSWs, any mention of a skin tear for resident #008, nor any skin assessment by registered staff.

On September 11, 2014 Inspector #580 observed an abrasion on the resident. The resident confirmed to the inspector that they did not know how it occurred but that they had it for approximately a week.

The inspector observed resident care, reviewed the care plan, skin assessment bathing reports and the progress notes; the RPNs and PSWs confirmed to the inspector that PSWs report skin assessments completed during resident bathing to the RPNs in writing on the bathing reports; the inspector found no registered staff skin assessment on September 10 or 11, 2014 for resident #008; the inspector found that the care is not consistent with the directions stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #008 as specified in the plan, specifically assessing skin condition during care. [s. 6. (7)]

4. On September 10, 2014 the DOC/Administrator told Inspector #580 that the staff get resident care information from the care plan.

On numerous occasions during the follow-up inspection, Inspector #580 observed resident #300 seated in a wheelchair in the lounge alone at a table with no activities, movies, or games and facing away from the television. On September 9, 2014 after the lunch meal, the resident was seated alone at a table while nine other residents were seated nearby in the lounge. On September 10, 2014 after the supper meal, the inspector observed resident #300 seated in a wheelchair in the lounge, alone at a table with one resident yelling loudly for over fifteen minutes, and there were numerous male

and female residents seated near resident #300.

On September 9, 2014 staff #927 told Inspector #580 that the resident care plan states that resident #300 is to be redirected to their room after meals but stated that it depends if there are others in the lounge or if the resident's behaviour is or is not inappropriate. Staff #918 told the inspector that resident #300 behaviours are not always present, that they are often pleasant and can sit with other residents, that cannot move as independently as before, and that they can be redirected. Staff #921 told the inspector that the care plan has "everything you need to know" about a resident, but was not able to find the care plan and told the inspector that the chart binder was the care plan, when in fact the actual care plan was in another binder. The PSW stated they were not aware of where it was and did not know that the care plan was in another binder exclusively for care plans. On September 10, 2014 staff #920 told the inspector that the care plan provides direction for care but did not know any specifics for resident #300 except that resident #300 gets exercises and likes to watch TV. Staff #916 told the inspector that staff get care direction from the care plan but was not aware what the care plan stated in regards to resident #300's responsive behaviours and was not aware of any other residents with responsive behaviours on the first floor. Staff #916 returned to speak with the inspector half an hour later to state that they had not understood the question and that in fact there were several other residents with responsive behaviours on the first floor but this staff did not know what their care plans state related to the responsive behaviours. Staff #911 told Inspector #580 that resident #300 can move their wheelchair around a room; that staff #911 tries to update the care plan monthly but has been too busy and that they should have updated resident #300's care plan.

On September 10, 2014 Inspector #580 reviewed resident #300's care plan which includes that resident is sometimes inappropriate, mostly in the evenings, that they are to be provided with movies and be involved in evening activities while staff is busy with other residents; is not tolerant of cognitively impaired co-residents; will get angry and aggressive and to remove the resident from stressful situations.

The inspector observed resident care, reviewed the care plan and the progress notes; spoke with RPNs and PSWs regarding this resident's responsive behaviour and care plan interventions and found that the care provided is not consistent with the directions as stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically responsive behaviours. [s. 6. (7)]

5. On September 10, 2014 after the supper meals, Inspector #580 observed resident #003 seated alone at the supper table.

On September 10, 2014 the DOC/Administrator told Inspector #580 that the staff get resident care information from the care plan. Staff #921 told Inspector #580 that the care plan has "everything you need to know" about a resident, but was not able to find the care plan and told the inspector that the chart binder was the care plan, when in fact the actual care plan was in another binder. The PSW stated they were not aware of where it was and did not know that the care plan was in another binder exclusively for care plans. The inspector reviewed the care plan of resident #003 which states that the resident is verbally abusive and socially inappropriate with interventions including setting limits for acceptable behaviour and approaching using a calm, non-threatening manner. Staff #922 stated that they think the care plan states that staff are to speak to the resident in a calm voice and staff #923 stated that they have no idea what the care plan states.

The inspector observed resident care, reviewed the care plan and the progress notes; spoke with RPNs and PSWs regarding this resident's responsive behaviour and care planned interventions and found that the care provided is not consistent with the directions as stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically responsive behaviours. [s. 6. (7)]

6. On September 10, 2014 the DOC/Administrator told Inspector #580 that the staff get resident care information from the care plan.

On September 10, 2014 at 1650 in the dining room, Inspector #580 observed resident #001 start to shout loudly at the supper table and continued being very loud and disruptive until the resident was removed from the dining room at 1700.

On September 10, 2014 the inspector reviewed the care plan of resident #001 which states that the resident has staggered meal times.

On September 10, 2014 staff #922 stated that they think the care plan states that resident #001 can be fed in their room and staff #923 stated that resident #001 is always brought to meals with other residents, and when resident #001 is disruptive in the dining room, the resident is returned to their room and fed later, and staff #923 was not 100%

sure of what the care plan states.

The inspector observed resident care, reviewed the care plan and the progress notes; spoke with RPNs and PSWs regarding this resident's responsive behaviour and care planned interventions and found that the care provided is not consistent with the directions as stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan, specifically responsive behaviours. [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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. On September 9, 2014 at 1558, Inspector #580 observed an unattended medication cart in the lounge near the nursing station on the Home's 2nd floor. There were several residents sitting in the lounge and staff #915, head of activity, walked by. The medication cart was unlocked and the inspector found the drawers unlocked including a drawer containing at least five residents' boxes of nitro patches. RPN staff #918 returned to the medication cart at 1614 (after at least six minutes) and stated "I guess you caught me". The inspector asked the RPN if the cart could be locked and the RPN showed the Inspector the locking mechanism.

The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a) (ii)]

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 to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

Issued on this 15th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALA MONESTIMEBELTER (580)
Inspection No. / No de l'inspection :	2014_336580_0018
Log No. / Registre no:	S-000123-14, S-000124-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 12, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE 70 Spine Road, ELLIOT LAKE, ON, P5A-1X2
LTC Home / Foyer de SLD :	ST. JOSEPH'S MANOR 70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WILMA FLINKERT

To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_246196_0001, CO #001;

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 shall ensure that the care set out in the plan of care is provided to residents #001, #003, #005, #007, #008, #300 as specified in the plan.

Grounds / Motifs :

1. On September 10, 2014 the DOC/Administrator told Inspector #580 that the staff get resident care information from the care plan.

On September 10, 2014 at 1650 in the dining room, Inspector #580 observed resident #001 start to shout loudly at the supper table and continued being very loud and disruptive until the resident was removed from the dining room at 1700.

On September 10, 2014 Inspector #580 reviewed the care plan of resident #001 which states that the resident has staggered meal times .

On September 10, 2014 staff #922 stated to the inspector that they think the care plan states that resident #001 can be fed in their room. Staff #923 stated to the inspector that resident #001 is always brought to meals with other residents, when resident #001 is disruptive in the dining room the resident is returned to their room and fed later, and that staff #923 is not 100% sure of what the care plan states.

The inspector observed resident care, reviewed the care plan and the progress notes; spoke with RPNs and PSWs regarding this resident's responsive behaviour and care planned interventions and found that the care provided is not

consistent with the directions as stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan, specifically responsive behaviours. (580)

2. On September 10, 2014 after the supper meals, Inspector #580 observed resident #003 seated alone at the supper table.

On September 10, 2014 the DOC/Administrator told Inspector #580 that the staff get resident care information from the care plan. Staff #921 told Inspector #580 that the care plan has "everything you need to know" about a resident, but was not able to find the care plan and told the Inspector that the chart binder was the care plan, when in fact the actual care plan was in another binder. The PSW stated they were not aware of where it was and did not know that the care plan was in another binder exclusively for care plans. The inspector reviewed the care plan of resident #003 which states that the resident is verbally abusive and socially inappropriate with interventions including setting limits for acceptable behaviour and approaching using a calm, non-threatening manner. Staff #922 stated that they think the care plan states that staff are to speak to the resident in a calm voice and staff #923 stated that they have no idea what the care plan states.

The inspector observed resident care, reviewed the care plan and the progress notes; spoke with RPNs and PSWs regarding this resident's responsive behaviour and care planned interventions and found that the care provided is not consistent with the directions as stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically responsive behaviours. (580)

3. On September 10, 2014 the DOC/Administrator told Inspector #580 that the staff get resident care information from the care plan.

On numerous occasions during the follow up inspection, Inspector #580 observed resident #300 seated in a wheelchair in the lounge alone at a table with no activities, movies, or games and facing away from the television. On September 9, 2014 after the lunch meal, the resident was seated alone at a

table while nine other residents were seated nearby in the lounge. On September 10, 2014 after the supper meal, the inspector observed resident #300 seated in a wheelchair in the lounge, alone at a table with one resident yelling loudly for over fifteen minutes, there were numerous male and female residents seated near resident #300.

On September 9, 2014 staff #927 told Inspector #580 that the resident care plan states that resident #300 is to be redirected to their room after meals but stated that it depends if there are others in the lounge or if the resident's behaviour is or is not inappropriate. Staff #918 told the inspector that resident #300 behaviours are not always present, that the resident is often pleasant and can sit with other residents, that the resident cannot move as independently as before, and that they can be redirected. On September 10, 2014 staff #921 told the inspector that the care plan has "everything you need to know" about a resident, but was not able to find the care plan and told the Inspector that the chart binder was the care plan, when in fact the actual care plan was in another binder. The PSW stated they were not aware of where it was and did not know that the care plan was in another binder exclusively for care plans. Staff #920 told the inspector that the care plan provides direction for care but did not know any specifics for resident #300 except that the resident gets exercises and likes to watch TV. Staff #916 told Inspector #580 that staff get care direction from the care plan but was not aware what the care plan stated in regards to resident #300's responsive behaviours and was not aware of any other residents with responsive behaviours on the first floor. Staff #916 returned to speak with the inspector half an hour later to state that they had not understood the question and that in fact there were several other residents with responsive behaviours on the first floor but they did not know what their care plans state related to the responsive behaviours. Staff #911 told the inspector that resident #300 can move their wheelchair around a room; that staff #911 tries to update the care plan monthly but has been too busy; that they should have updated resident #300's care plan.

On September 10, 2014 Inspector #580 reviewed resident #300's care plan which includes that resident is sometimes inappropriate, mostly in the evenings, that the resident is to be provided with movies and be involved in evening activities while staff is busy with other residents; is not tolerant of cognitively impaired co-residents; will get angry and aggressive and to remove the resident from stressful situations.

The inspector observed resident care, reviewed the care plan and the progress notes; spoke with RPNs and PSWs regarding this resident's responsive behaviour and care planned interventions and found that the care provided is not consistent with the directions as stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically responsive behaviours. (580)

4. On September 10, 2014, Inspector #580 reviewed the following health care records for resident #008:
-the care plan which states that registered staff are to assess resident's skin for any open areas or problems that are noted during bathing and report this to the registered staff;
-the bath list with documentation by PSWs for the bath day which states "small skin tear" for resident #008;
-the inspector noted that the progress notes did not contain any skin assessment reports from the PSWs, any mention of a skin tear resident #008, nor any skin assessment by registered staff.

On September 11, 2014 the inspector observed an abrasion on the resident. The resident confirmed to the inspector that they do not know how it occurred but that they had had it for approximately a week.

The inspector observed resident care, reviewed the care plan, skin assessment bathing reports and the progress notes; the RPNs and PSWs confirmed to the inspector that PSWs report skin assessments completed during resident bathing to the RPNs in writing on the bathing reports; the inspector found no registered staff skin assessment on September 10 or 11, 2014 for resident #008; the inspector found that the care is not consistent with the directions stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #008 as specified in the plan, specifically assessing skin condition during care.
(580)

5. On September 10 and 11, 2014 Inspector #580 reviewed the following health care records for resident #007:

-the care plan which states that registered staff are to assess resident's skin for any open areas or problems that are noted during bathing and reported to the registered staff;
-the PSW's bath list documentation which states that small bruises were noted on resident #007;
-the registered staff's skin assessment in resident #007's progress notes specifies bruising in a different area.

The inspector observed resident care, reviewed the care plan, skin assessment bathing reports and the progress notes; the RPNs and PSWs confirmed to the inspector that PSWs report skin assessments completed during resident bathing to the RPNs in writing on the bathing reports; the inspector found no registered staff assessment of both calves; on September 10, 2014 the Administrator / Director of Care confirmed to the inspector that she was unable to find registered staff's skin assessment reports for resident #007 documented; the inspector found that the care is not consistent with the directions stated in the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #007 as specified in the plan, specifically assessing skin condition of during care. (580)

6. Inspector #575 reviewed CI#2877-000018-11 regarding resident #005. Resident #005 had had a fall. The inspector reviewed resident #005's health care record and noted that the plan of care clearly identifies that the resident's advanced directives include 'do not resuscitate'. Progress notes from the incident state that the resident was unresponsive and 'chest compressions given'. Additionally, interventions described in the resident's care plan under the problem heading 'Falls/Balance' identified that staff are to use the 'seizure flow record to record seizure activity'. Inspector #575 reviewed the resident's health care records and did not find a seizure flow record. The Administrator/DOC told the inspector that such a form did/does not exist.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan. (580)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 12th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Vala MonestimeBelter

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