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
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

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
Jun 26, 2014;	2013_246196_0021 (A1)	S-000478-13,S-000492-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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 CO #001 has been amended. The original date was June 30, 2014. The new compliance date is August 29, 2014.

Issued on this 26 day of June 2014 (A1)

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

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
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

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
Jun 26, 2014;	2013_246196_0021 (A1)	S-000478-13,S-000492-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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): December 10, 11, 12,13, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Service Manager (ESM), Maintenance staff member, Housekeeping staff, RAI coordinator, Residents and family members

During the course of the inspection, the inspector(s) conducted a walk through tour of all resident care areas, observed the provision of care and services to residents, observed the interactions between staff and residents, reviewed the health care records of several residents, reviewed various home policies and procedures

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. Resident rooms within the long-term care home are equipped with electrical incremental heating, ventilation and air conditioning (HVAC) units.

According to management staff member #100, the pipes produce condensation in the summer while the air conditioning is operating, which results in a collection of water in the drip pans of the incremental units (I.U). Some of these drip pans had been leaking and in turn have resulted in water leaking through onto the drywall board and mould developing around the windows of the home. It was also reported to the inspector that these units are original to the home and are linked throughout the building.

Management staff member #103 was interviewed by the inspector and confirmed that the condensation should gather in the drip trays of the I.U.s but many of the trays are rusted through, some are missing and therefore the water leaks out onto the drywall, the wall surface cracks and "black" mould appears. It was also reported that as soon as the mould appears it is addressed and removed by the maintenance staff.

Management staff member #103 reported to the inspector that an outside HVAC contractor attends the home on a quarterly basis to change the filters in the I.U.s, but that no other maintenance is routinely done by the contractor. If there is heavy build up on the coil fins it would necessitate cleaning, approximately six units have been cleaned this past fall and about the same number in the spring. No records are kept of this cleaning of the fins or the units. Drip trays are not routinely cleaned and there is no schedule for cleaning of the U.I.s. Management staff member #103 told the inspector that the maintenance staff might vacuum out some of the units when the temperature settings are to be changed in the spring and fall each year, they might

change a fan motor if it stops working but staff do not do any preventative maintenance to these I.U.s.

On December 13, 2013, staff member #104 conducted a tour of several resident rooms with the inspector. To demonstrate the area of concern with the condensation water leaking inside the units, the I.U. in one room was uncovered. It was observed that the drip pan had rust coloured buildup of material in it and the coil fins had heavy buildup of dust and debris.

At the time of inspection, the home was unable to provide an operational manual for the York brand Incremental Units which are used in the home. An email was sent to the inspector by management staff member #103 and it included a copy of a manual for a similar type I.U., "Unitrane Fan-Coil Air Conditioners". This manual outlined the manufacturer's specifications for monthly, six month and annual recommendations for repair, maintenance and cleaning. It included monthly checks of the "primary and auxiliary drain pans to be sure that they are clean and free to carry the flow of condensate through the drain lines" and yearly "inspection the coil fins for excessive dirt or damage. Remove dirt and straighten fins".

The licensee failed to ensure that procedures are developed and implemented to ensure that, the electrical HVAC (heating, ventilation and air conditioning) Incremental Units are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications. [s. 90. (2) (a)]

2. Resident rooms within the long-term care home are equipped with electrical incremental heating, ventilation and air conditioning (HVAC) units.

According to management staff member #100, the pipes produce condensation in the summer while the air conditioning is operating, which results in a collection of water in the drip pans of the incremental units (I.U.). Some of these drip pans had been leaking and in turn have resulted in water leaking through onto the drywall board and mould developing around the windows of the home. It was also reported to the inspector that these units are original to the home and are linked throughout the building.

An interview was conducted with staff member #104 on December 13, 2013 and it was identified that there have been issues with mould in the home over the previous three years and that approximately twenty to thirty rooms within the home have had

some amount of mould removal done by maintenance staff. The areas that had developed mould have been around the windows where the piping for the I.U.s are encased. According to staff member #104, there hasn't been any air testing done nor testing to determine what type of mould is present.

Management staff member #103 was interviewed by the inspector and confirmed that the condensation should gather in the drip trays of the I.U.s but many of the trays are rusted through and therefore the water leaks out onto the drywall, the wall surface cracks and "black" mould appears. It was also reported that as soon as the mould appears it is addressed and removed by the maintenance staff. In addition, management staff member #103 reported that mould removal would no longer be done by the staff and it will be contracted outside the home.

Management staff member #103 told the inspector that an outside HVAC contractor attends the home on a quarterly basis to change the filters in the I.U.s, but that no other maintenance is routinely done by the contractor. If there is heavy build up on the fins it would necessitate cleaning, approximately six units have been cleaned this past fall and about the same number in the spring. No records are kept of this cleaning of the fins or the units. Drip trays are not routinely cleaned and there is no schedule for cleaning of the U.I.s. The management staff member #103 told the inspector that maintenance staff might vacuum out some of the units when the temperature settings are to be changed in the spring and fall each year, they might change a fan motor if it stops working but staff do not do any preventative maintenance to these I.U.s.

The licensee failed to ensure that procedures are developed and implemented to ensure that, heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection. [s. 90. (2) (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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A Critical Incident report was submitted to the Director in the fall of 2013 for an alleged incident of verbal abuse towards resident #001. The report outlines an incident in which resident #001 was upset by the actions of a staff member. The home conducted an investigation and was inconclusive with regards to the allegations of abuse. It was identified, however, as a result of the investigation, that the staff member demonstrated poor practice while assisting resident #001 with their meal.

Resident #001 was not provided with dining service that respected the resident's dignity.

The licensee failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

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 that ensures that resident #001 and every resident is treated in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. During a tour of resident care areas, in December 2013, several personal items, belonging to residents, were observed to be unlabelled. The shared washroom in a resident room had three combs and one hair brush, unlabelled, with hair and debris on them, on the counter beside the sink. Another resident room had a blue toothbrush and two disposable razors on the counter beside the sink in the shared washroom, used and unlabelled. In addition, a resident room had a pink denture cup with an upper denture inside, unlabelled. Under the sink was a blue slipper bed pan on the floor also unlabelled. Another resident room had a bedpan hanging from a hook in the shared washroom, unlabelled.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

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 that ensures that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

Issued on this 26 day of June 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. 2007, c. 8

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133) - (A1)
Inspection No. / No de l'inspection :	2013_246196_0021 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	S-000478-13,S-000492-13 (A1)
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 26, 2014;(A1)
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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. 2007, c. 8

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 : Jonathon Riabov

To REVERA LONG TERM CARE 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 :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

(A1)
The licensee will ensure that procedures are developed and implemented to ensure that all electrical HVAC system incremental units are kept in good repair and are maintained and cleaned at a level that meets manufacturer s specifications and that the heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

Grounds / Motifs :

1. Resident rooms within the long-term care home are equipped with electrical incremental heating, ventilation and air conditioning (HVAC) units.

According to management staff member #100, the pipes produce condensation in the summer while the air conditioning is operating which results in a collection of water in the drip pans of the incremental units (I.U.). Some of these drip pans had been leaking and in turn have resulted in water leaking through onto the drywall board and mould developing around the windows of the home. It was also reported to the inspector that these units are original to the home and are linked throughout the building.

Management staff member #103 was interviewed by the inspector and confirmed that the condensation should gather in the drip trays of the I.U.s but many of the trays are rusted through, some are missing and therefore the water leaks out onto the drywall, the wall surface cracks and "black" mould appears. It was also reported that as soon as the mould appears it is addressed and removed by the maintenance staff.

Management staff member #103 reported to the inspector that an outside HVAC contractor attends the home on a quarterly basis to change the filters in the I.U.s, but that no other maintenance is routinely done by the contractor. If there is heavy build up on the coil fins it would necessitate cleaning, approximately six units have been cleaned this past fall and about the same number in the spring. No records are kept of this cleaning of the fins or the units. Drip trays are not routinely cleaned and there is no schedule for cleaning of the U.I.s. Management staff member #103 told the inspector that maintenance staff might vacuum out some of the units when the temperature settings are to be changed in the spring and fall each year, they might

change a fan motor if it stops working, but staff do not do any preventative maintenance to these I.U.s.

On December 13, 2013, staff member #104 conducted a tour of several resident rooms with the inspector. To demonstrate the area of concern with the condensation water leaking inside the units, the I.U. in one room was uncovered. It was observed that the drip pan had rust coloured buildup of material in it and the coil fins had heavy buildup of dust and debris.

At the time of inspection, the home was unable to provide an operational manual for the York brand Incremental Units which are used in the home. An email was sent to the inspector by management staff member #103 and it included a copy of a manual for a similar type I.U., "Unitrane Fan-Coil Air Conditioners". This manual outlined the manufacturer's specifications for monthly, six month and annual recommendations for repair, maintenance and cleaning. It included monthly checks of the "primary and auxiliary drain pans to be sure that they are clean and free to carry the flow of condensate through the drain lines" and yearly "inspection the coil fins for excessive dirt or damage. Remove dirt and straighten fins".

The licensee failed to ensure that procedures are developed and implemented to ensure that, the electrical HVAC (heating, ventilation and air conditioning) Incremental Units are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications.
(196)

2. Resident rooms within the long-term care home are equipped with electrical incremental heating, ventilation and air conditioning (HVAC) units.

According to management staff member #100, the pipes produce condensation in the summer while the air conditioning is operating which results in a collection of water in the drip pans of the incremental units (I.U.). Some of these drip pans had been leaking and in turn have resulted in water leaking through onto the drywall board and mould developing around the windows of the home. It was also reported to the inspector that these units are original to the home and are linked throughout the building.

An interview was conducted with staff member #104 on December 13, 2013 and it was identified that there have been issues with mould in the home over the previous three years and that approximately twenty to thirty rooms within the home have had some amount of mould removal done by the maintenance staff. The areas that had developed mould have been around the windows where the piping for the I.U.s are encased. According to staff member #104, there hasn't been any air testing done nor testing to determine what type of mould is present.

Management staff member #103 was interviewed by the inspector and confirmed that the condensation should gather in the drip trays of the I.U.s but many of the trays are rusted through and therefore the water leaks out onto the drywall, the wall surface cracks and "black" mould appears. It was also reported that as soon as the mould appears it is addressed and removed by the maintenance staff. In addition, it was reported by management staff member #103 that mould removal would no longer be done by the staff and it will be contracted outside the home.

Management staff member #103 told the inspector that an outside HVAC contractor attends the home on a quarterly basis to change the filters in the I.U.s, but that no other maintenance is routinely done by the contractor. If there is heavy build up on the fins it would necessitate cleaning, approximately six units have been cleaned this past fall and about the same number in the spring. No records are kept of this cleaning of the fins or the units. Drip trays are not routinely cleaned and there is no schedule for cleaning of the U.I.s. Management staff member #103 told the inspector that maintenance staff might vacuum out some of the units when the temperature settings are to be changed in the spring and fall each year, they might change a fan motor if it stops working but staff do not do any preventative maintenance to these I.U.s.

The licensee failed to ensure that procedures are developed and implemented to ensure that, heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection. (196)

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

Aug 29, 2014(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

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

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 26 day of June 2014 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE - (A1)

Service Area Office / Bureau régional de services : Sudbury