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

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347 Preston St, 4th Floor
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 22, 2013	2013_225126_0002	O-000160-13	Complaint

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 11, 16, 17, 18, 19, 2013

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care, Nursing Consultant, Food Service Manager,several nursing staff, residents and family members.

During the course of the inspection, the inspector(s) reviewed residents health care records, policy and procedure on Resident abuse (02-06-01), Resident abuse zero tolerance presentation guide for orientation(given to new staff), Restraint policy (dated May 2010, no policy number) and observed care and services provided to residents.

The purpose of this inspection was to conduct 6 complaints and 1 critical incident.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Critical Incident Response

Food Quality

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, Chapter 8, s.19.(1) in that the home staff did not protect resident from abuse/neglect.

In November 2012, Resident #3 requested to use the urinal and the two Personal Support Worker's (PSW) in the room did not provide assistance with care as requested which resulted in Resident #3 urinating on himself/herself. Resident #3 reported to Inspector #126 that he/she was upset by this incident because he/she can usually manage well when assistance is provided.

In November 2012, the Director received a Critical Incident reporting the above incident of neglect. The previous Administrator, had written in the CI that "all staff to be re educated in the zero tolerance for abuse and neglect. As of April 19, 2013, the education session on abuse/neglect has not been done in the home as confirmed by the Acting Administrator.

In February 2013, two external agency staff reported an incident of alleged abuse (verbal and physical) that occurred on a specific date in February 2013.In the home's investigation notes, it is documented that PSW S#001 was rough with Resident #1 (slapping his/her leg) and was also observed using inappropriate language in the hallway and in front of residents.

In February 2013, the Director Of Care(DOC) interviewed PSW S#002 about the incident that occurred on specific date in February 2013. PSW S#002 reported that he/she overheard Resident #01 saying "stop slapping my legs" to PSW S#001. PSW S#002 reported incident to Registered Practical Nurse(RPN) S#003 who stated that nothing will be done.
PSW S#002 also reported that last week in the dinning room he/she overheard PSW S#001 tell Resident #2 "you as well won't eat your supper, but you sure as hell will eat this and threw down desert".

In a written note given to the Administrator in February 2013 by RPN S#003, it is documented that RPN S#003 interviewed resident #1 on a specific date in February 2013 in relation to the incident that occurred that evening. Resident# 1 stated that PSW S#001 "he/she was rough with his/her legs and felt he/she had been rough in the past as well". Resident# 1 also stated that PSW S#001 had sworn at him/her in the past. RPN S#003 conclude by writing " I chose not to pursue any further action as I felt I did not have sufficient evidence to proceed".

In March 2013, an incident of physical abuse occurred between two residents, resulting in no injury.

As per the home policy on "Resident Abuse" #02-06-01, "Annually all staff will receive training and education regarding abuse prevention and identification as part of the Home's annual in service activities". Discussion with several nursing staff and they reported they have not receives re-education on abuse in 2012 or as of April 19, 2013.

During the course of the inspection, interviewed staff informed Inspector #126 that they have observed and witnessed by other nursing staff members several incidents of verbal abuse but they did not report or act upon them immediately because of fear of reprisal or that no actions would be taken. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007 Chapter 8, s. 6. (1) (a) in that the home did not ensure that there is a written plan of care for each resident and that sets out clear directions to staff and others who provide direct care to the resident.

In April 2013, the Power of Attorney (POA) of Resident #1 indicated to Inspector #126 that last week when he/she came in the home to visit the resident, the POA observed the resident sitting in his/her wheel chair without the seat belt being applied.
Discussion with Resident #1 stated that he/she does have a front seat belt for positioning that he/she is able to undo. Resident #1 health care record was review and no documentation was found in the plan of care related to the resident need to have a seat belt on when in the wheel chair for positioning.
Discussion with the Acting Administrator who verified with the RAI Coordinator that the application of the seat belt for positioning was not documented in the plan of care nor in the assessment. [s. 6. (1) (c)]

2. In March 2013, an incident of physical abuse occurred between two residents resulting in no injury.
In both residents plan of care, there is no documentation about the need to keep both residents separated during meal time and to be monitored at all time.
Care plan reviewed with RAI Coordinator and Inspector #126 and no documentation found about keeping residents separated. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed with LTCHA 2007, S.O.2007, Chapter 8, s76. (4) 3. in that the home did not ensure that all staff have received retraining annually on the home policy to promote zero tolerance of abuse and neglect of residents.

In February 2013 an incident of physical and verbal abuse occurred. Several staff were aware of the incident and did not take any action nor report the incident of abuse immediately. Discussion with four Registered Nursing staff and several PSWs indicated that they have not received retraining on the policy to promote zero tolerance of abuse and neglect to residents. They could not remember when the last training took place.

In November 2012, the Director received a Critical Incident (CI) that reported neglect. The previous Administrator, wrote in the CI that "all staff to be re educated in the zero tolerance for abuse and neglect. Discussion with several nursing staff and they reported they have not receives re-education on abuse in 2012 or as of April 19, 2013.

In April 2013, discussion with the Acting Administrator, who was in the role of the Activity Manager in the past, indicated that he had not received retraining on the policy to promote zero tolerance of abuse and neglect to resident in the last year. [s. 76. (4)]

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 education on abuse/neglect is done annually., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.24. (1)2. in that the home did not immediately report to the Director ,one incidents of abuse of a resident by anyone and one incident of neglect of a resident by staff that resulted in harm or risk of harm.

On a specific date in November 2012 there was an incident of resident neglect and the Director was notified on a specific date in December 2012.

On a specific date in March 2013 there was an incident of physical abuse between two resident's and the Director was notified 3 days later.

Both incidents were not immediately reported to the Director. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that, (c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 51. (2) (c) in that the home did not provide assistance to a resident who is unable to toilet independently, some or all the time, from staff to manage continence.

On specific date in April 2013 in the afternoon, Resident #7 was observed asking for assistance to go to the bathroom. RPN S#004, told Resident #7 that he/she would get some help to assist with toileting. Approximately ten minutes later, Resident #7 was still asking for assistance to go the toilet. Resident # 7 was observed wheeling himself/herself down to his/her room. Inspector #126 asked if RPN S#005 could provide assistance to the Resident as he/she was the only staff in the hallway. When Resident #7 came out of the room, he/she thanked the Inspector for her help and said that sometimes it takes a long time to receive assistance.
Discussion with RPN S#005 indicated that he/she had tried to get some help but didn't found anyone to help the resident with toileting needs until Inspector intervention. [s. 51. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 97.(1) (b) in that the home did not notify the Substitute Decision Maker of alleged abuse of Resident #1.

On a specific date in February 2013, two staff notified the Administrator and the Director of Care of an incident of alleged abuse from staff to resident. The Power of Attorney was notified of the incident of alleged abuse several days after the incident. [s. 97. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.98 in that the home did not notify the appropriate police force immediately of an incident of alleged abuse.

On specific date in February 2013, two nursing staff notified the Administrator and the Director of Care of an incident of alleged abuse from staff to resident. The Police were notified several days after.

On a specific date in March 2013, an incident of resident to resident physical abuse occurred in the dining room at supper. The Power of Attorney (POA) was notified of the incident by the Registered Practical Nurse. The POA notified the Police of the incident not the home. [s. 98.]

Issued on this 9th day of May, 2013

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

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) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2013_225126_0002
Log No. / Registre no:	O-000160-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 22, 2013
Licensee / Titulaire de permis :	DEEM MANAGEMENT LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	WELLINGTON HOUSE NURSING HOME 990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARYLIN BENN

To DEEM MANAGEMENT LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall protect residents from abuse and neglect by anyone by educating all staff on the policy to promote zero tolerance of abuse and neglect of residents, which shall include:
-what constitutes abuse and neglect
-explanation of the duty under section 24 to make mandatory reports, section 97 & 98 notification re incidents and section 76 retraining
-procedures for investigating and responding to alleged, suspected or witnessed and neglect of resident
-clear direction of the consequences who abuse or neglect resident
-explanation

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA 2007, S.O. 2007, Chapter 8, s.19.(1) in that the home staff did not protect resident from abuse/neglect.

In November 2012, Resident #3 requested to use the urinal and the two Personal Support Worker's (PSW) in the room did not provide assistance with care as requested which resulted in Resident #3 urinating on himself/herself. Resident #3 reported to Inspector #126 that he/she was upset by this incident because he/she can usually manage well when assistance is provided.

In November 2012, the Director received a Critical Incident reporting the above incident of neglect. The previous Administrator, had written in the CI that "all staff to be re educated in the zero tolerance for abuse and neglect. As of April 19, 2013, the education session on abuse/neglect has not been done in the home as confirmed by the Acting Administrator.

In February 2013, two external agency staff reported an incident of alleged abuse (verbal and physical) that occurred on a specific date in February 2013.In the home's investigation notes, it is documented that PSW S#001 was rough with Resident #1(slapping his/her leg) and was also observed using inappropriate language in the hallway and in front of residents.

In February 2013, the Director Of Care(DOC) interviewed PSW S#002 about the incident that occurred on specific date in February 2013. PSW S#002 reported that he/she overheard Resident #01 saying "stop slapping my legs" to PSW S#001. PSW S#002 reported incident to Registered Practical Nurse(RPN) S#003 who stated that nothing will be done.
PSW S#002 also reported that last week in the dinning room he/she overheard PSW S#001 tell Resident #2 "you as well won't eat your supper, but you sure as hell will eat this and threw down desert".

In a written note given to the Administrator in February 2013 by RPN S#003, it is documented that RPN S#003 interviewed resident #1 on a specific date in February 2013 in relation to the incident that occurred that evening. Resident# 1 stated that PSW S#001 "he/she was rough with his/her legs and felt he/she had been rough in the past as well". Resident# 1 also stated that PSW S#001 had sworn at him/her in the past. RPN S#003 conclude by writing " I chose not to pursue any further action as I felt I did not have sufficient evidence to proceed".

In March 2013, an incident of physical abuse occurred between two residents, resulting in no injury.

As per the home policy on "Resident Abuse" #02-06-01, "Annually all staff will receive training and education regarding abuse prevention and identification as part of the Home's annual in service activities". Discussion with several nursing staff and they reported they have not receives re-education on abuse in 2012 or as of April 19, 2013.

During the course of the inspection, interviewed staff informed Inspector #126 that they have observed and witnessed by other nursing staff members several incidents of verbal abuse but they did not report or act upon them immediately because of fear of reprisal or that no actions would be taken. [s. 19. (1)] (126)

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 : Jun 30, ~~2014~~ 2013

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

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2012_199161_0003, CO #006;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that there is a written plan of care that sets out clear directions to staff and others related to the residents #1, #4 and #8.

This plan shall be submitted in writing by May 15, 2013 to Inspector Linda Harkins, Ministry of Health and Long Term Care, performance and Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario, K1S 3 J4 or by fax 613.569.9670

This Order was first issued on December 4, 2012 and remain non compliant therefore is re-issued.

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA 2007, S.O. 2007 Chapter 8, s. 6. (1) (a) in that the home did not ensure that there is a written plan of care for each resident and that sets out clear directions to staff and others who provide direct care to the resident.

In April 2013, the Power of Attorney (POA) of Resident #1 indicated to Inspector #126 that last week when he/she came in the home to visit the resident, the POA observed the resident sitting in his/her wheel chair without the seat belt being applied.
Discussion with Resident #1 stated that he/she does have a front seat belt for positioning that he/she is able to undo. Resident #1 health care record was review and no documentation was found in the plan of care related to the resident need to have a seat belt on when in the wheel chair for positioning.
Discussion with the Acting Administrator who verified with the RAI Coordinator that the application of the seat belt for positioning was not documented in the plan of care nor in the assessment. [s. 6. (1) (c)]

2. In March 2013, an incident of physical abuse occurred between two residents resulting in no injury.
In both residents plan of care, there is no documentation about the need to keep both residents separated during meal time and to be monitored at all time.
Care plan reviewed with RAI Coordinator and Inspector #126 and no documentation found about keeping residents separated. [s. 6. (1) (c)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun ~~03~~ 30, 2013

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 22nd day of April, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

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