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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 23, 2016	2016_405189_0003	004985-16, 029669-15, 008360-16	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WOODHAVEN
380 Church Street MARKHAM ON L6B 1E1

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 18, 21, 24, 29, April 4, 2016.

This Critical Incident Inspection is related to allegations of abuse and improper treatment

The following intakes were inspected concurrently during this inspection: Critical Incident (CI) intake #029669-15, #008360-16, #004985-16.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Police, Registered staff, restorative aide, personal support workers, residents, family members.

During the course of the inspection, the inspector conducted a tour of the home areas, observed resident and staff interactions, reviewed clinical health records, reviewed video surveillance clips, criminal reference checks, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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 has failed to ensure that resident #001 was protected from abuse by anyone and not neglected by the licensee or staff.

On an identified date, Critical Incident System (CIS) was submitted to the Director related to an allegation of abuse. The Critical Incident was as follows:

On an identified date, Power of Attorney for resident #001 informed the Social Worker about a concern related to improper care to the resident. The POA spoke with the social worker and informed that he/she had emailed the Administrator and Social Worker about concerns of an injury to the resident's identified area with unknown cause. POA also reported that the resident was showing signs of emotional distress last week and was crying when he/she visited. The POA had put a hidden camera inside the resident's room and captured an incident of improper care and suspected neglect by PSW #104, and had reported the concern through email to the home.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “verbal abuse” means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by another other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Resident #001 requires total assistance with personal care, grooming, dressing, feeding, and transfers. Resident #001 is unable to express self verbally.

The inspector requested the home’s investigation. Inspector was provided with video surveillance tapes by the Administrator. The inspector observed multiple incidents of verbal and physical abuse on the video surveillance clips that had been placed in the resident's room.

Interview with the Administrator revealed that PSW #104 was no longer employed by the licensee. The Administrator, Director of Care, Assistant Director of Care confirmed that abuse had taken place, and confirmed that the resident was not protected from abuse. [s. 19. (1)]

2. On an identified date, Critical Incident System (CIS) was submitted to the Director related to an allegation of abuse.

A review of resident #002's progress notes reflected multiple incidents of responsive behaviour exhibited by resident #002 towards co-residents..

Interviews with PSW #110, #118, #119, registered staff #103, #106, #120 and ADOC #114 reported that the strategy to manage resident #002 responsive behaviour is to monitor and redirect the resident when the behaviour is witnessed. The care plan to address the responsive behaviour was developed after the second incident. The licensee failed to protect the resident despite a known pattern of responsive behaviour. [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. 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. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 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.

On an identified date, Critical Incident System (CIS) was submitted to the Director related to an allegation of abuse. The Administrator provided video surviellence clips for the inspector to review.

A review of video clips on an identified date revealed that PSW # 116 was feeding

resident #001 who was lying down in the bed. Staff #105 entered the room and began to have a personal conversation with PSW #116. Staff #105 then proceeded to sit at the end of the resident's bed while the resident was in the bed and continued his/her conversation with PSW #116. PSW #104 also entered into the room and joined the conversation. Video clips revealed that all three staff engaged in a personal conversation with the resident present in bed for 30 minutes. Interviews with PSW #104, #116, and staff #105 confirmed it was inappropriate to carry on a personal conversation in the resident's room with the resident present in the bed. Interview with the Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed that resident #001 was not treated with dignity and respect. [s. 3. (1) 1.]

2. Review of video clips on an identified date revealed that PSW #116 was feeding resident #001 who was lying in bed. While feeding the resident, PSW #116 was observed to scrape food off the bed linen and then proceeded to feed the scraped food back to the resident.

Video clips on an identified date revealed that, PSW #104 was feeding resident #001. While feeding the resident, PSW #104 was observed to be eating and drinking an unknown item in the room with the resident. Interview with PSW #104 revealed that he/she was eating a sandwich in the room, and confirmed that it was not appropriate to eat while in the resident's room.

Video clips of an identified date revealed that PSW #104, PSW #116 and staff #105 were in resident #001's room having a personal conversation. While having the personal conversation, PSW #116 was feeding the resident. As PSW #116 continued to feed the resident, the resident began to cough. PSW #116 moved away from the resident and ran behind the bed, and began to laugh. PSW #116 told the other staff that he/she moves when he/she sees the resident coughing.

Interview with the DOC confirmed that staff scraping food from the bed linen and feeding the food back to the resident is not acceptable, and confirmed that the manner in which PSW #116 and PSW #104 acted did not treat resident #001 with respect and 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 to ensure that the following rights of residents are fully respected and promoted: 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, to be implemented voluntarily.

WN #3: 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. The Licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The written plan of care for resident #001 indicated that the resident requires two staff to transfer via mechanical lift. The written plan of care also indicated that the resident requires two person assistance for dressing and continence care due to his/her medical condition.

A) Review of video clips from an identified time period, revealed that PSW #104 transferred the resident from bed to chair using the ceiling lift and without a second person to assist with transfers. Interview with PSW #104, revealed that he/she would receive assistance with transfers from PSWs #107 and #116, however interviews with both PSWs #107 and #116 reported that they do not assist PSW #104 with transfers. Interview with the Director of Care (DOC) confirmed that PSW #104 transferred the resident without a second person assisting, and that the care set out in the plan of care was not provided.

B) Review of video clips from an identified time period, revealed that PSW #104

provided personal and continence care to the resident without a second person to assist with care. Interview with PSW #104 confirm that he/she often provided personal care to the resident without a second person assisting. Interview with the Director of Care (DOC) confirmed that PSW #104 provided personal and continence care to the resident without a second person assisting, and that the care set out in the plan of care was not provided. [s. 6. (7)]

2. On an identified date, resident #005 who had a history of fever and cough, was assessed by the Nurse Practitioner . The Nurse Practitioner ordered medications, vital signs to be taken every shift for 7 days, diagnostic and laboratory testing to be taken on an identified date

Interview with ADOC and with Resident Care Coordinator(RCC) revealed that the home’s scheduled laboratory days are on Tuesday. The ADOC informed the inspector that when an order is received from the Nurse Practitioner or the Physician for laboratory testing, the order is transcribed into the laboratory book for the next routine schedule date, or if the lab is date specific, the home's portable laboratory machine in used by the RN to conduct the lab testing.

The Nurse Practitioner ordered the lab to be taken on an identified date. The registered staff who transcribed the ordered, placed the date for the lab to be taken on next scheduled lab date. The lab testing was taken on the scheduled lab date, however the critical results was not reported to the home by the laboratory in a timely manner. The resident was assessed again by the physician and the physician ordered for the lab to be taken in home using the home's portable lab machine. Registered staff # 121 reported to the inspector that the staff were unable to use the portable lab machine to take the lab testing as the strips in the machine were expired and no other strips were available.

Resident #005 was admitted to the hospital from an identified time period. Once the resident returned back to the home post hospitalization, the hospital physician ordered for the resident's lab test to be taken on an identified date The inspector checked the laboratory book and noted the resident's name was not transcribed for labs to be taken on the next scheduled lab date and the lab testing was also not taken as required by the hospital on the specified date. The ADOC and RCC confirmed with the inspector that the order for lab testing was not completed as prescribed by the physician. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program policies were complied with.

A review of Policy #LTC-CA-WQ-200-07-14 titled Responsive Behaviour – Aggressive or Violent Episodes states the following:

1. Management strategies for dealing with violent or aggressive behaviour episodes will be planned for each resident who is at risk of having a violent or aggressive episode. Every resident who has an Aggressive behaviour Score of 2 or greater will have interventions listed in their care plan for managing episodes.
2. Residents who display violent or aggressive behaviour will be referred to external community partners where they exist for further assessment and interventions.
3. Following a new or changed aggressive outburst, staff involved in the situation will have a responsive behaviour debrief to look for triggers to the behaviour, what interventions worked, what didn’t work and then update the care plan accordingly.

According to resident #002's progress notes and interviews with staff, the first incident of resident #002 displaying responsive behaviour directed towards another resident was on an identified date.

It is not until the second incident with resident #004 that the home referred resident #002 to Behaviour Support Ontario (BSO) for further support with managing resident's behaviour.

As per interview with registered staff #103 , the BSO RPN visited the resident on an identified date, and verbally recommended the home refer the resident to Ontario Shores for further assessment. Resident #002's family refused referral to Ontario Shores.

A review of resident #002's progress notes and chart found no evidence the Responsive Behaviour Debrief was completed for resident #002 after the first incident.

As per review of resident #002's progress notes from an identified time period, strategies in place were not effective at managing the resident's responsive behaviours directed at co residents. There is no evidence the home initiated any referral to the psychogeriatric external program as per policy #LTC-CA-WQ-200-07-14 titled Responsive Behaviour – Aggressive or Violent Episodes related to resident #002's responsive behaviours until a second incident occurred.

2. The licensee has failed to ensure that the home's portable lab testing procedures were complied with.

On an identified date, Critical Incident System (CIS) was submitted to the Director related to an allegation of improper/incompetent treatment of a resident. Resident #005 developed fever and a hoarse voice. Resident #005 was assessed by the Nurse Practitioner and diagnosed . The Nurse Practitioner ordered for lab testing to be taken in the home on an identified date.

Interview with registered staff # 115 reported that as part of his/her job routine on nights, he/she will conduct an audit of the home's portable lab machine to ensure that supplies are available and equipment is in working order. Registered staff # 115 reported that he/she noted in January 2016 that the lab testing strips would expire in February 2016 and for the DOC to reorder more strips.

Inspector interviewed ADOC #113 who stated that the home's procedure is to have the INR strips available and reordered on a monthly basis. The ADOC stated that the DOC reordered the lab testing strips on an identified date and ADOC confirmed that the strips were not available in the home when the physician requested the lab to be taken. The home's procedure for availability of medical supplies was not complied with. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure when resident #002 demonstrated responsive behaviours, the behavioural triggers were identified, where possible; strategies were developed and implemented to respond to these behaviours, where possible; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #002 started exhibiting responsive behaviours towards co resident's on an identified date. During an interview with registered staff #103, it was reported that resident #002 and resident #003 will walk in the hallway often, and resident #002 will also attempt to bring resident #003 in his/her room.

During an interview with PSW #110, resident #002 was described as being inappropriate with co residents on the unit. PSW #110 stated that resident #002 will walk in the hallway with resident #003, sit in the family room with resident #003, and take resident #003 into his/her room, and when staff intervene, resident #002 will become upset. The inspector asked PSW #110 what interventions were in place to manage resident #002's behaviours and PSW #110 indicated that staff were to monitor the resident and redirect the resident and co resident. PSW #110 was unaware of any other interventions to manage resident #002's responsive behaviour directed at co residents.

During an interview with registered staff #106, it was reported that when staff intervene to separate resident #002 and resident #003, resident #002 becomes angry and resistive to the intervention.

Interview with the home's Assistant Director of Care (ADOC) #114 and DOC indicated that resident #002 does have responsive behaviours, and is often seen in the hallway with resident #003. ADOC reported that staff are to monitor resident #002's whereabouts and to intervene if resident behaviour is inappropriate.

Resident #002's written plan of care was reviewed. There were no triggers identified for resident #002's responsive behaviour directed at co residents.

All staff interviewed indicated that the interventions to manage resident #002 behaviour were to monitor and redirect the resident. There are no other interventions to manage resident #002 responsive behaviour. [s. 53. (4) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks were conducted prior to hiring the staff member and/or accepted volunteer who is 18 years of age or older.

Record review of five criminal reference checks revealed dietary aide #117 did not have a criminal reference check conducted prior to hiring the staff member. The Administrator confirmed that this was not completed. [s. 75. (2)]

Issued on this 3rd day of August, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2016_405189_0003
Log No. / Registre no:	004985-16, 029669-15, 008360-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 23, 2016
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE WOODHAVEN 380 Church Street, MARKHAM, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHELLE STROUD

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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) (b)

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 :

Develop, submit and implement a plan to ensure the following:

a) Develop and implement a system to monitor staff/resident interactions and the provision of care/services to ensure residents are cared for with courtesy, respect and dignity.

b) Develop and implement steps to ensure that all residents in the home are protected from abuse and/or neglect by the staff, including training on the home's abuse policies, and training related to the requirements to provide care to all residents, as identified in their plan of care.

c) Ensure all staff are educated on how to identify and report resident to resident abuse.

d) Ensure that any resident including resident #002 currently exhibiting responsive behaviours is assessed and interventions are implemented to ensure safety of co residents.

Plan to be submitted via email to nicole.ranger@ontario.ca by July 7, 2016

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone and not neglected by the licensee or staff.

On an identified date, Critical Incident System (CIS) was submitted to the Director related to an allegation of abuse. The Critical Incident was as follows:

On an identified date, Power of Attorney for resident #001 informed the Social Worker about a concern related to improper care to the resident. The POA spoke with the social worker and informed that he/she had emailed the Administrator and Social Worker about concerns of an injury to the resident's identified area with unknown cause. POA also reported that the resident was showing signs of emotional distress last week and was crying when he/she visited. The POA had put a hidden camera inside the resident's room and captured an incident of improper care and suspected neglect by PSW #104, and had reported the concern through email to the home.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “verbal abuse” means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Resident #001 requires total assistance with personal care, grooming, dressing, feeding, and transfers. Resident #001 is unable to express self verbally.

The inspector requested the home's investigation. Inspector was provided with video surveillance tapes by the Administrator. The inspector observed multiple incidents of verbal and physical abuse on the video surveillance clips that had been placed in the resident's room.

Interview with the Administrator revealed that PSW #104 was no longer employed by the licensee. The Administrator, Director of Care, Assistant Director of Care confirmed that abuse had taken place, and confirmed that the resident was not protected from abuse. [s. 19. (1)]
(189)

2. On an identified date, Critical Incident System (CIS) was submitted to the Director related to an allegation of abuse.

A review of resident #002's progress notes reflected multiple incidents of

responsive behaviour exhibited by resident #002 towards co-residents..

Interviews with PSW #110, #118, #119, registered staff #103, #106, #120 and ADOC #114 reported that the strategy to manage resident #002 responsive behaviour is to monitor and redirect the resident when the behaviour is witnessed. The care plan to address the responsive behaviour was developed after the second incident. The licensee failed to protect the resident despite a known pattern of responsive behaviour.
(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 02, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 23rd day of June, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : NICOLE RANGER

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