Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 3, 4, 5, 10, 12, 13, 16, 17, 19, 20, 2012	2012_078202_0006	Complaint

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive, BARRIE, ON, L4M-0C4

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administration, Director of Care, Environmental Services Manager, Nurse Manager, Personal Support Worker Lead, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, home policies related to bathing, alarm response time records

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that all residents are cared for in a manner consistent with his or her needs. [s.3.(1)(4)]

During the inspection on April 3, 2012 residents throughout the home were randomly interviewed. All residents interviewed expressed concerns toward the frequent long wait times that occur when requesting staff assistance. Residents reported that when they use the call bell they often wait for long periods and have waited for over an hour for staff to arrive. [s.3.(1)(4)]

Resident A's care plan directs staff to provide two person assistance for toileting as resident is unable to weight bear. Through an interview with resident A it was revealed that this resident no longer uses the call bell to request staff assistance due to the long wait times. Resident A revealed that when required to toilet, will transfer self onto the toilet without staff assistance.

Administration indicated in an interview that the home has an electronic call bell monitoring system. All residents in the home wear a call bell attached to their clothing and have been instructed to press the call bell when staff assistance is needed. Administration identified that home's call bell monitoring system allows for reports to be generated which reveal elapsed time from when a resident alarms the call bell and when staff respond to the call bell.

March 2012 call bell alarm reports reviewed for resident A revealed that staff response times range from 15 minutes to 2 hours and 22 minutes.

Resident B's written plan of care directs staff to provide pain medication routinely and as needed. Resident B revealed in an interview that when using the call bell to request pain medication there are frequently long wait times for staff to respond to the call . Resident B revealed that when the wait for staff is in excess of 20 minutes this resident will transfer self from bed to wheelchair, ambulate self into the hallway and to the nursing station looking for staff. Resident B revealed that there are times when searching for staff assistance, staff are located at the nursing station engaged in conversation. [s.3. (1)(4)]

March 2012 call bell report reviewed for resident B revealed staff response times range from 15 minutes to 2 hours and 18 minutes.

Resident C's written plan of care directs staff to assist resident C with toileting and to be provided product changes as needed. Resident C revealed in an interview that when using the call bell for staff assistance believes it does not work because the wait is so long. Resident C revealed that toileting self in bed occurs often because of the long wait periods for staff to arrive and assist. [s.3.(1)(4)]

March 2012 call bell alarm reports reviewed for resident C revealed staff response times range from 13 minutes to 46 minutes.

Through an interview resident D expressed concern regarding the long wait times when requesting staff assistance. Resident D's written plan of care directs staff to provide one person assistance when providing care. Resident D expressed fear for own safety because staff may not respond to the call bell in time if a resident were to fall onto the floor. [s.3.(1)(4)]

Staff interviews revealed that call bells are answered within 10 minutes. Staff interviews confirmed that there may be times when staff response to resident call bells may be longer than others at times when they are busy. [s.3.(1)(4)]

Administration revealed in an interview that staff response times to call bells are expected to be within 5-10 minutes. The administration revealed that on April 5, 2012 staff response to resident call bells was monitored and confirmed that residents were waiting for staff assistance greater than 30 minutes. [s.3.(1)(4)]

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 subsections:

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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.[s.6.(7)]

Resident A's written plan of care directs staff to provide a bath on Tuesday and Friday AM. Clinical record review revealed that resident A did not receive a bath on March 2 and 27, 2012. Staff interview confirmed that on days when staff are busy resident baths are often missed.[s.6.(7)]

Resident B's written plan of care directs staff to provide a bath on Wednesday and Saturday. Clinical record review and staff interview confirmed that resident B did not receive a bath on March 14, 17 and 24, 2012 as specified in her plan of care.[s. 6.(7)]

Resident C's written plan of care directs staff to provide a bath on Monday and Friday PM. Clinical record review revealed that on March 19 and 23, 2012 resident C did not receive a bath. Staff interviews confirmed that if they are rushed or short staffed they are unable to complete baths assigned to them.[s.6.(7)]

Resident D's care plan directs staff to provide two person assistance for toileting as resident is unable to weight bear. Resident D revealed in an interview that resident will no longer use the call bell to request staff assistance for toileting because the wait has been very long for staff to arrive and would not make it to the bathroom in time. Resident D stated that resident will often transfer self from wheelchair to toilet without staff assistance.

Staff interviews confirmed that they do not always communicate to registered staff when baths have not been provided to assigned residents. Staff interviews confirmed that when they are busy or short staffed the care set out in the plan of care is not always provided to residents.[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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan has been evaluated and updated at least annually. [s.31(3)(e)]

Staff interview revealed that direct care staff are unable to complete care for all residents within their assignment due to staffing constraints. Staff interview and clinical record review confirmed that staff have not been providing baths to residents when they are busy or when a staff member has called in sick.

During the inspection on April 3, 2012 residents expressed concern toward the frequent long wait times that occur when requesting staff assistance. Residents reported that when they use the call bell they often wait for long periods and have waited for over an hour for staff to arrive.

Administration revealed in an interview that the staffing mix may not be consistent with resident assessed care and safety needs. Administration revealed in an interview that the home provides a staffing mix based on the provincial standards and has a higher staff to resident ratio than most homes. Administrator confirmed that the home does not evaluate and update the written staffing plan annually. [s.31.(3)(e)]

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 written staffing plan is evaluated and updated at least annually, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.[s.33.(1)]

Resident A's written plan of care directs staff to provide a bath on Tuesday and Friday AM. Clinical record review for resident A revealed that baths were not provided on March 2, and 27, 2012. Staff interview confirmed that baths are often missed when they are busy or do not have time.

Resident B's written plan of care directs staff to provide a bath on Wednesday and Sunday AM. Clinical record review revealed that resident B did not receive a bath on March 14, 17 and 24, 2012. [s.33.(1)]

Resident C's written plan of care directs staff to provide a bath on Monday and Friday PM. Clinical record review and staff interview confirmed that resident C did not receive a bath on March 19 and 23, 2012 as scheduled. [s.33.(1)]

Resident D's written plan of care identifies that she is to be provided a bath on Tuesday and Saturday morning.

Clinical record review for November 2011-March 2012 revealed that resident D did not receive a bath on November 5, 12 and 29, 2011, December 27, 31, 2011, February 11, 14, 18, 25, 28, 2012 and March 3, 10, 13, 17, 20, 27, 31 2012. [s.33.(1)]

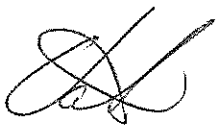
Staff interviews revealed that resident D was to receive baths on Tuesday and Saturday morning by a family hired private caregiver. Staff interviews confirmed that they did not know if the family hired private care giver actually provided resident D with a bath.

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

Issued on this 10th day of May, 2012

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



Ontario

Ministry of Health and Long-Term Care

Ministére 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

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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2012_078202_0006
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Apr 3, 4, 5, 10, 12, 13, 16, 17, 19, 20, 2012
Licensee / Titulaire de permis :	THE ONTARIO MISSION OF THE DEAF 2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	BOB RUMBALL HOME FOR THE DEAF 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHIRLEY CASSEL

To THE ONTARIO MISSION OF THE DEAF, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are are cared for in a manner consistent with his or her needs. Plan to be submitted to valerie.johnston@ontario.ca by May 4, 2012.

Grounds / Motifs :

1. The licensee failed to ensure that all residents are cared for in a manner consistent with his or her needs. [s.3.(1)(4)]

During the inspection on April 3, 2012 residents throughout the home were randomly interviewed. All residents interviewed expressed concerns toward the frequent long wait times that occur when requesting staff assistance. Residents reported that when they use the call bell they often wait for long periods and have waited for over an hour for staff to arrive. [s.3.(1)(4)]

Resident A's care plan directs staff to provide two person assistance for toileting as resident is unable to weight bear. Through an interview with resident A it was revealed that this resident no longer uses the call bell to request staff assistance due to the long wait times. Resident A revealed that when required to toilet, will transfer self onto the toilet without staff assistance.

Administration indicated in an interview that the home has an electronic call bell monitoring system. All residents in the home wear a call bell attached to their clothing and have been instructed to press the call bell when staff assistance is needed. Administration identified that home's call bell monitoring system allows for reports to be generated which reveal elapsed time from when a resident alarms the call bell and when staff respond to the call bell.

March 2012 call bell alarm reports reviewed for resident A revealed that staff response times range from 15 minutes to 2 hours and 22 minutes.

Resident B's written plan of care directs staff to provide pain medication routinely and as needed. Resident B revealed in an interview that when using the call bell to request pain medication there are frequently long wait times for staff to respond to the call . Resident B revealed that when the wait for staff is in excess of 20 minutes

this resident will transfer self from bed to wheelchair, ambulate self into the hallway and to the nursing station looking for staff. Resident B revealed that there are times when searching for staff assistance, staff are located at the nursing station engaged in conversation. [s.3. (1)(4)]

March 2012 call bell report reviewed for resident B revealed staff response times range from 15 minutes to 2 hours and 18 minutes.

Resident C's written plan of care directs staff to assist resident C with toileting and to be provided product changes as needed. Resident C revealed in an interview that when using the call bell for staff assistance believes it does not work because the wait is so long. Resident C revealed that toileting self in bed occurs often because of the long wait periods for staff to arrive and assist. [s.3.(1)(4)]

March 2012 call bell alarm reports reviewed for resident C revealed staff response times range from 13 minutes to 46 minutes.

Through an interview resident D expressed concern regarding the long wait times when requesting staff assistance. Resident D's written plan of care directs staff to provide one person assistance when providing care. Resident D expressed fear for own safety because staff may not respond to the call bell in time if a resident were to fall onto the floor. [s.3.(1)(4)]

Staff interviews revealed that call bells are answered within 10 minutes. Staff interviews confirmed that there may be times when staff response to resident call bells may be longer than others at times when they are busy. [s.3.(1)(4)]

Administration revealed in an interview that staff response times to call bells are expected to be within 5-10 minutes. The administration revealed that on April 5, 2012 staff response to resident call bells was monitored and confirmed that residents were waiting for staff assistance greater than 30 minutes. [s.3.(1)(4)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 18, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 20th day of April, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

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