Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2017;	2017_57610a_0002 (A1)	021280-16, 002619-17	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

KELLY HAYES (583) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 30, 31, February 1, 3, 8, 9, 13, 15, and 16, 2017

During this CI inspection, CI # 021280-16 was also inspected.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Administrator, the Chief Nurse Executive (CNE), the attending physician, the Associate Director of Nursing (ADOC), registered nurses, registered practical nurses, recreation therapy staff, and personal support staff.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
2 VPC(s)
3 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. 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 residents were protected from abuse by anyone.

Resident #001 and resident #002 resided in the same home area.
Resident #001 had identified care requirements. Assessments had been completed and a plan of care was in place. Subsequent to the development and implementation of this plan, and over a period of 5 weeks, resident #001 experienced three occurrences when their care needs were different than usual, in terms of time, presentation and response to interventions. The Home's policy directed that a number of assessment instruments were available to staff, to facilitate assessment of residents when care needs change. Staff confirmed that these assessments were not used to facilitate assessment of resident #001, when their care needs were different during this five week period. Resident #001 demonstrated these different care needs a fourth time and on this occasion, resident #002 was involved and both residents required transfer to hospital for assessment and treatment.
Resident #002 was not protected from abuse by anyone when they were abused by resident #001. [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 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 that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible.

Resident #109 had identified care requirements. The clinical record identified a goal to address the identified care requirements however, triggers related to the care requirements were not identified, as confirmed by the CNE.

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (c) 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.

A) Resident #001 demonstrated identified care requirements on multiple occasions in 2016. The Home had a policy that outlined a process to facilitate assessment of residents who demonstrated the identified care requirements. The CNE confirmed that the process outlined in the home's policy was not followed and resident #001 did not receive the assessment available for their identified care requirements.
B) Resident #001 demonstrated identified care requirements. In an identified five week period, the resident demonstrated, on three occasions, specific activity patterns related to their care requirements. The Home had a policy that provided for the use of observation instruments to facilitate the assessment of residents demonstrating these activity patterns. Staff confirmed the availability of these

instruments and also confirmed the instruments were not used to facilitate assessment of resident #001 when they demonstrated identified activity patterns.
Actions were not taken to respond to the needs of resident #001 when they demonstrated identified activity patterns and care requirements, including assessment, reassessment and interventions.
C) Resident #109 demonstrated identified care requirements. In an identified 3 week period, the resident demonstrated specific activity patterns, on multiple identified occasions.
The Home had a policy that provided for the use of observation instruments to facilitate the assessment of residents demonstrating these activity patterns. Staff confirmed the availability of these instruments and also confirmed the instruments were not used to facilitate assessment of resident #109 when they demonstrated identified activity patterns.
Actions were not taken to respond to the needs of resident #109 when they demonstrated identified activity patterns and care requirements, including assessment, reassessment and interventions.

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 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 :

(A1)
1. The licensee failed to ensure that 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 to ensure that the plan policy, protocol, procedure, strategy or system is complied with.

Under section 87(1)(a) of Long Term Care Homes Act 2007 the licensee is required to ensure that there are emergency plans in place for the home that comply with the regulations, including, measures for dealing with emergencies.
The home's policy titled Workplace Violence CODE WHITE, directs that a Code White is to be initiated if, following attempts to de-escalate threatening behaviors (by a resident, patient, family or visitor) have been unsuccessful AND\OR immediately, if the threat is significant and/or imminent. Also included in the policy is that verbal or physical aggression, including striking out towards residents or staff constitutes a high risk and if de-escalation techniques are not working, staff may call a code white by dialing '80'.
On an identified date, staff at the home encountered an incident where they required the support of additional staff to assist with a high risk incident. Rather than dial `80`and page code white, which would initiate immediate response of staff from across the organization, a series of multiple phone calls were made to engage additional staff support.
The home's code white policy was not complied with when staff were dealing with a high risk incident involving residents. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented: 1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).

A) Resident #001 had identified care requirements. Review of the document the home referred to as the care plan, included a goal that the resident would experience fewer episodes activities associated with these care requirements. An associated intervention for this goal was 'hourly safety checks for whereabouts'. Further review of the clinical record revealed the absence of documentation of hourly safety checks. The RCC and DOC confirmed that staff complete hourly checks as part of the Home's policy and it is not documented. The provision of care as set out in the plan of care, was not documented.

B) Resident #110 had identified care needs. Review of the document the Home refered to as the care plan, included a goal to ensure resident safety, with an associated intervention to check resident frequently for whereabouts. Further review of the clinical record revealed the absence of documentation related to frequent checks for whereabouts. The CNE confirmed that staff complete hourly checks as part of the Home's policy and that it is not documented. Provision of care set out in the plan of care was not documented. [s. 6. (9) 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 provision of care, as set out in the plan of care, is documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Resident #110 had identified care requirements. Review of the clinical record revealed that resident #110 sustained an injury that resulted in transfer to hospital for assessment and intervention. The resident returned to the home the same day. At that time, resident #110 required changes to the care they were receiving. Regulation 107(3)(4) requires that the Director is informed no more than one business day after an incident that causes injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition. The home submitted a critical incident report to the Director two days after becoming aware of the change in the residents health condition. The Director was not informed within one business day of an incident that caused injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition. [s. 107. (3) 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 that he Director is immediately informed of an incident that causes injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone,

Resident 001 and 002 resided on the same home area. On an identified date, an interaction between the residents resulted in the transfer of both residents to hospital for assessment and treatment. The Home has a policy related to this type of interaction which indicates "all communication and discussions with residents, staff, families or other persons involved, must be documented during or as soon as possible after the occurrence, in order to ensure accuracy of information, documentation should be in ink, with numbered pages. Where possible, obtain pure version statements. Pure version statements are written by the person them self, in their own words, and signed. It is absolutely essential that the person reporting prepares a very clear, written, signed statement'.
Staff #106 was the most responsible registered staff on site and reported during interview that they called the administrator on call (AOL), (resident care coordinator, staff #109), to report the incident. The AOL confirmed that they spoke on the telephone with staff #101, who was present at the time of the interaction. The AOL confirmed they did not speak with the other staff who were present during the occurrence and did not ask staff to document the events, as they experienced them. Staff #107, also present at the time of the interaction, confirmed they were first asked to write and sign their report of the incident 18 days after the incident. The CNE confirmed that at the time of the occurrence, written documentation was not requested from the staff involved and that the notes from the AOL did not include interviews with the staff directly involved in the incident.
The licensee failed to ensure that the witnessed abuse of resident #002 was immediately investigated. [s. 23. (1) (a)]

Issued on this 10 day of May 2017 (A1)

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

Ordre(s) de l'inspecteur

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

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) : KELLY HAYES (583) - (A1)

Inspection No. / No de l'inspection : 2017_57610a_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 021280-16, 002619-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : May 10, 2017;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

LTC Home / Foyer de SLD : ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : David Bakker

To ST. JOSEPH'S HEALTH SYSTEM, 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. 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 prepare, submit and implement a plan to ensure that all residents are protected from physical abuse by anyone. The plan shall include:
a) strategies for residents with responsive behaviors, to prevent physical abuse towards any resident,
b) staff education on identification of risks associated with resident to resident physical abuse, including, who will be responsible for providing the education, dates that the education will be completed, and
c) an auditing process to ensure that residents with exacerbations of behaviors are re-assessed, new interventions initiated and the plan of care revised.
The licensee shall submit the plan electronically to Inspector Irene Schmidt at HamiltonSAO.moh@ontario.ca, by May 30, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Resident #001 and resident #002 resided in the same home area.
Resident #001 had identified care requirements. Assessments had been completed and a plan of care was in place. Subsequent to the development and implementation of this plan, and over a period of 5 weeks, resident #001 experienced three occurrences when their care needs were different than usual, in terms of time, presentation and response to interventions. The Home's policy directed that a number of assessment instruments were available to staff, to facilitate assessment of residents when care needs change. Staff confirmed that these assessments were not used to facilitate assessment of resident #001, when their care needs were different during this five week period. Resident #001 demonstrated these different care needs a fourth time and on this occasion, resident #002 was involved and both residents required transfer to hospital for assessment and treatment.

(510a)

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

May 30, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee shall provide responsive behavior education for all registered staff,
reviewing all aspects of responsive behaviors, including:
1) application of policy, which provides a variety of suggested clinically relevant assessment instruments to support resident centred assessment, and
2) the use of the all identified clinically appropriate assessment instruments, including identification and initiation of interventions, revision of care plans, assessment of effectiveness of interventions and further intervention identification, as indicated.
The licensee shall audit clinical records for residents demonstrating responsive behaviors to ensure assessments are completed, interventions initiated, plan of care updated and effectiveness of interventions evaluated.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (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.

Resident #109 demonstrated identified care requirements and, in an identified 3 week period, the resident demonstrated specific activity patterns, on multiple identified occasions.
The Home had a policy that provided for the use of observation instruments to facilitate the assessment of residents demonstrating these activity patterns. Staff confirmed the availability of these instruments and also confirmed the instruments were not used to facilitate assessment of resident #109 when they demonstrated identified activity patterns.
Actions were not taken to respond to the needs of resident #109 when they demonstrated identified activity patterns and care requirements, including assessment, reassessment and interventions.
(510a)

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (c) 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.

A) Resident #001 demonstrated identified care requirements on multiple occasions in 2016. The Home had a policy that outlined a process to facilitate assessment of residents who demonstrated the identified care requirements. The CNE confirmed that the process outlined in the home's policy was not followed and resident #001 did not receive the assessment available for their identified care requirements.
B) Resident #001 demonstrated identified care requirements. In an identified five week period, the resident demonstrated, on three occasions, specific activity patterns related to their care requirements. The Home had a policy that provided for the use of observation instruments to facilitate the assessment of residents demonstrating these activity patterns. Staff confirmed the availability of these instruments and also confirmed the instruments were not used to facilitate assessment of resident #001 when they demonstrated identified activity patterns.
Actions were not taken to respond to the needs of resident #001 when they demonstrated identified activity patterns and care requirements, including assessment, reassessment and interventions.

(510a)

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

May 30, 2017

Order # / Ordre no : 003 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall provide code white education for all staff, reviewing all aspects of code white situations, and providing mock code white drills on each resident home area.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that 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 to ensure that the plan policy, protocol, procedure, strategy or system is complied with.

Under section 87(1)(a) of Long Term Care Homes Act 2007 the licensee is required to ensure that there are emergency plans in place for the home that comply with the regulations, including, measures for dealing with emergencies.
The home’s policy titled Workplace Violence CODE WHITE, directs that a Code White is to be initiated if, following attempts to de-escalate threatening behaviors (by a resident, patient, family or visitor) have been unsuccessful AND\OR immediately, if the threat is significant and/or imminent. Also included in the policy is that verbal or physical aggression, including striking out towards residents or staff constitutes a high risk and if de-escalation techniques are not working, staff may call a code white by dialing ‘80’.
On January 28, 2016, at approximately 0145 hours, resident #002 was asleep in their

bed on Pine Grove Home area, when resident #001 was observed to enter their room, and was then observed, punching resident #002. Staff redirected resident #001 away from resident #002 to the lounge area, but were unable to de-escalate resident #001, who chased staff #105 and #107, attempted to grab staff members and was turning over chairs and tables. Staff #107 reported that when they had access to a telephone they called the registered staff for support. Registered staff #106 was the most responsible registered staff on site. They reported they received a phone call between 0135 hours and 0145 hours, indicating staff were unable to contact staff #101, the registered staff assigned to Pine Grove home area, to advise them of an incident. Staff #106 suggested they call another phone. Staff #106 received another call at about 0150 hours reporting that they had still not contacted staff #101. At this time, staff #106 directed them to page registered staff overhead. Registered staff #101 reported they responded to the overhead page for registered staff and found resident #001 in the room of another resident, #003, poised to strike. When staff #101called resident #001, they turned their attention to the staff and followed them out of the room of resident #003, who remained unharmed. In addition, they reported that resident #101 continued to be resistant to de-escalation strategies and was eventually apprehended by a police officer, who had been called to assist. Staff #106 and the chief nurse executive (CNE) confirmed a code white was not paged overhead, during this episode of physical aggression that staff were unable to de-escalate.
During this high risk incident, where resident #001 was demonstrating physical aggression toward residents and staff, at least five phone calls were made in an attempt to summon help when, had the policy been complied with, one call to '80' to initiate a code white, would have mobilized response by multiple staff from across the organization, in a more timely manner.
The home's code white policy was not complied with when staff were unable to de-escalate the threatening behaviors of resident #001. (510a)

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

May 30, 2017

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
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Toronto ON M5S 2B1
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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 10 day of May 2017 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY HAYES - (A1)

Service Area Office / Bureau régional de services : Hamilton