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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 14, 15, 16, 17, 18, 21, 29, 2011; Jan 5, 11, 24, Feb 17, 23, 2012	2011_027192_0047	Complaint

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

DEBORA SAVILLE (192)

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 the Director of Care, Registered Nurses, Registered Practical Nurses, Registered Dietitian, Personal Support Workers, residents and family members related to Complaints H-001411-11, H-002045-11, H-001510-11 and H-1382-11.

Findings gathered through the course of this inspection, related to s.6(10)b, have been included in inspection report 2011_027192_0046 conducted concurrently with this inspection.

This inspection report contains findings related to LTCHA, 2007 S.O. 2007, c.8 s. 19(1), 6 (1)(c), and O.Reg 79/10, s. 131(1) and 50 (2) (b) (iii) identified during inspection 2011_027192_0054 conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, and observed care provided.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Pain

Personal Support Services

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

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. a) On a specified date in 2011 a specified resident was injured by another resident. The incident resulted in transfer to hospital for assessment of injuries sustained. The co-resident had previously demonstrated responsive behaviours on designated occasions.
On a specified date in 2011 the responsive behaviour was directed at the resident, but did not result in injury. Interventions initiated were not effective in protecting the resident from a co-resident.

b) A specified resident sustained sexual abuse by a Personal Support Worker employed by the home in 2011. The resident was the recipient of non-consensual touching and remarks of a sexual nature made by the employee. The resident indicated embarrassment by the event and felt uncomfortable.

c) In 2011 a specified resident was touched in a manner that made the resident feel uncomfortable, by a Personal Support Worker employed by the home. During interview the resident appeared physically and emotionally distressed by the incident.

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

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. Previously issued August 5, 2010; December 6, 2010 and March 8, 2011.

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 of care. [s.6(7)]

a) The Treatment Record for a specified resident indicates that an area of altered skin integrity is to be cleansed, and a specified treatment applied daily. The medical record and interview with the Registered Practical Nurse confirm that the treatment has not consistently been done daily since return from hospital in 2011. During this inspection a dressing was observed on the resident but not covering the area of altered skin integrity. The resident was complaining of pain in the area.

b) The physician order indicated that Capillary Blood Glucose was to be completed twice daily for a specified resident. Blood sugars were not documented as having been completed for 5 days in 2011 and for 6 days in 2011 were not consistently completed twice daily.

c) The plan of care for a specified resident indicates that a specified pain assessment is to be completed twice daily to evaluate the level of pain and effect of analgesic. The resident's designated diagnosis may result in pain for the resident. Analgesic is ordered and administered daily. During interview the Registered Practical Nurse indicated that the assessment form located with the resident's Medication Administration Record is only used for weekly assessments. During interview the resident indicates there is pain.

d) A specified resident sustained an injury. In 2011 the physician ordered a treatment twice daily. Documentation three days later indicates that the treatment was not yet available for the resident. The first application of the treatment was during the evening of the third day after it was ordered.

e) A specified resident has a physician's order to have Capillary Blood Glucose (CBG) monitored. The direction from the physician is confirmed on the quarterly medication reviews. A review of the CBG record indicates that the CBG is not consistently completed and recorded.

f) A specified resident was identified by the Physiotherapist to have pain with limited range of motion in specified joints, and x-ray confirmed the presence of a disease process. The Palliative Care Consultant was involved in assessment of the resident, recommending initiation of analgesic and assessment using a designated assessment tool twice daily for 5 days. The physician ordered the recommended analgesic. Analgesic was started. Pain assessments are not available in the progress notes for the resident, and interview confirms that the designated assessment and weekly pain assessment have not been completed for the resident.

g) The plan of care for a specified resident under Nutritional Care Plan - High Risk indicates that if blood sugars are elevated the Registered Dietitian (RD) is to be notified. Interview with the RD indicates that the resident was not seen related to elevations in capillary blood glucose (CBG). Progress notes confirm elevations in the resident's CBG on specified dates. No dietary referral was initiated. Staff interviewed indicated that there is no specific hypo/hyperglycemic protocol in the home and care provided in relation to changes in blood glucose are at the discretion of the nurse.

h) The plan of care for a specified resident indicates to "have resident wear non-slip footwear". A progress note, post fall in 2011 indicates the resident was ambulating only wearing socks and needs to be reminded to wear her shoes. Care was not provided as specified in the plan of care.

i) The home's Food and Fluid Intake Form indicates in red "If < 6 glasses/cups per day x 2 days refer to dietitian." A specified resident's Food and Fluid Intake Form for a designated period in 2011 indicates that the resident received 5 or fewer glasses of fluid daily for a 10 day period in 2011 and only sips of fluid were recorded as being taken for a specified period in 2011. There is no referral to the registered dietitian.

2. Previously issued December 6, 2010, March 8, 2011 and April 5, 2011

The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to

the resident. [s.6(1)c]

a) A specified resident has a wound on a designated area for which a dressing and protective device had been ordered. On a specified date in 2011, the physician ordered a change in the use of the device, to when in bed. During this inspection the resident was observed with the device in place while up in a wheelchair. It was noted that the dressing was not covering the wound, and that the device was not effective in protecting the designated area. The plan of care was not updated to provide clear direction to staff related to the use of the device.

b) A specified resident was identified to have altered skin integrity. No plan of care related to altered skin integrity has been developed, no goal established and there is no clear direction to staff related to altered skin integrity.

c) There is no direction within the plan of care related to position changes, or extremity support for a designated resident, who was experiencing edema in both feet. Documentation over a designated period of time indicates that the resident's extremities are at risk. A progress note on a specified date in 2011 indicates that positioning was effective in minimizing risk to the resident's extremities. This direction was not communicated in the plan of care to staff and others who provide direct care to the resident. The resident was observed in a specified wheelchair with her extremities dangling.

Additional Required Actions:

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

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 ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [r.131(1)]

a) A specified resident returned from hospital on a specified date 2011 with an order for analgesic as necessary for pain. When the Medication Administration Record was started for a specified month, the resident received medications that were not ordered for a period of 11 days.

b) A review of the progress notes indicates that a specified resident received medication on a specified date while having an episode of pain. The resident does not have an order for the specified medication in the medical record. The administration of the medication is not documented on the Medication Administration Record. Interview with a Registered Practical Nurse confirms that there is no order for the specified medication for the this resident and that the home would only give the medication on the direction of a physician.

c) On a specified date in 2011, a specified resident received medication that had not been prescribed for them. The resident sustained an unresponsive episode and was hospitalized.

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 ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. [r.134(a)]

A specified resident experienced an exacerbation in behaviours. It was identified that the resident was experiencing pain and analgesic was ordered. Pain assessment has not been completed for the resident and the effectiveness of analgesic and antianxiety medications administered are not routinely evaluated in the progress notes or on the back of the Medication Administration Record. A Registered Practical Nurse responsible for the resident's care indicated that medication would be evaluated on the Medication Administration Record or within the progress notes.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented. [r.50(2)(b)(iii)]

a) A specified resident returned from hospital following surgery on a specified date in 2011. At this time, the resident was noted to have areas of altered skin integrity. There is a late entry by the Registered Dietitian related to a dietary referral from a previous date in 2011. This note confirms knowledge of the recent surgery, but does not address the presence of altered skin integrity. Wound assessment completed in 2011 indicates that the designated area is a stageable pressure ulcer. The resident was not assessed, by the dietitian, on return from hospital related to altered skin integrity. Interview with the dietitian confirms she was unaware of these areas of altered skin integrity and their presence had not been included in her assessment.

b) A specified resident was identified to have altered skin integrity on return from hospital in 2011. The resident was not referred to the dietitian for assessment. The current nutritional plan of care does not address altered skin integrity. Interview with the Registered Dietitian confirms that no dietary referral related to altered skin integrity was made for the resident and no assessment was completed.

c) A specified resident was identified to have altered skin integrity including a stageable pressure ulcer. The resident was not referred to the dietitian for assessment and interventions related to altered skin integrity have not been added to the plan of care. The current nutritional plan of care indicates that the resident's skin is intact. Interview with the Registered Dietitian confirms that no dietary referral related to altered skin integrity was made from the resident and no assessment completed.

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 ensuring that a resident exhibiting altered skin integrity , including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

Issued on this 15th day of March, 2012

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2011_027192_0047
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Nov 14, 15, 16, 17, 18, 21, 29, 2011; Jan 5, 11, 24, Feb 17, 23, 2012
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 :	SHAWN GADSBY

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) (a)(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 :

The licensee shall prepare and submit a plan to ensure that residents are protected from abuse by anyone. The plan shall include, but not be limited to:

a) the protection of residents who may be put at risk as a result of responsive behaviours.
b) the protection of residents from sexual abuse.

The plan shall be implemented.

The plan shall be submitted electronically to Debora Saville, Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office, at debora.saville@ontario.ca by February 27, 2012.

Grounds / Motifs :

1. The licensee failed to protect a specified resident from abuse by anyone.

a) On a specified date in 2011 a specified resident was injured by another resident. The incident resulted in transfer to hospital for assessment of injuries sustained. The co-resident had previously demonstrated responsive behaviours on designated occasions. On a specified date in 2011 the responsive behaviour was directed at the resident, but did not result in injury. Interventions initiated were not effective in protecting the resident from a co-resident.

b) A specified resident sustained sexual abuse by a Personal Support Worker employed by the home in 2011. The resident was the recipient of non-consensual touching and remarks of a sexual nature made by the employee. The resident indicated embarrassment by the event and felt uncomfortable.

c) In 2011 a specified resident was touched in a manner that made the resident feel uncomfortable, by a Personal Support Worker employed by the home. During interview the resident appeared physically and emotionally distressed by the incident. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)(b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare and submit a plan ensuring that:

a) residents who require Capillary Blood Glucose monitoring, have it completed as directed by the physician responsible for the resident's care.

b) registered staff receive training related to the management of hypo/hyperglycemic events and the role of the interdisciplinary team in the treatment of diabetic residents.

c) wound care is provided according to each residents plan of care,

d) prescribed medications are initiated in a timely fashion,

e) Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) and other assessments are completed as ordered, and

f) that all residents demonstrating changes in fluid intake as outlined on the homes Food and Fluid Intake Form are referred to the Registered Dietitian for assessment.

The plan shall be implemented.

The plan shall be submitted electronically to Debora Saville, Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by February 27, 2012.

Grounds / Motifs :

1. Previously issued December 6, 2010, March 8, 2011.

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 of care. [s.6(7)]

a) The Treatment Record for a specified resident indicates that an area of altered skin integrity is to be cleansed, and a specified treatment applied daily. The medical record and interview with the Registered Practical Nurse confirm that the treatment has not consistently been done daily since return from hospital in 2011. During this inspection a dressing was observed on the resident but not covering area of altered skin integrity. The resident was complaining of pain in the area.

b) The physician order indicated that Capillary Blood Glucose was to be completed twice daily for a specified resident. Blood sugars were not documented as having been completed for 5 days in 2011 and for 6 days in 2011 were not consistently completed twice daily.

c) The plan of care for a specified resident indicates that a specified pain assessment is to be completed twice daily to evaluate the level of pain and effect of analgesic. The resident's designated diagnosis may result in pain for the resident. Analgesic is ordered and administered daily. During interview the Registered Practical Nurse indicated that the assessment form located with the resident's Medication Administration Record is only used for weekly assessments. During interview the resident indicates there is pain.

d) A specified resident sustained an injury. In 2011 the physician ordered a treatment twice daily. Documentation three days later indicates that the treatment was not yet available for the resident. The first application of the treatment was during the evening of the third days after it was ordered.

e) A specified resident has a physician's order to have Capillary Blood Glucose (CBG) monitored. The direction from the physician is confirmed on the quarterly medication reviews. A review of the CBG record indicates that the CBG is not consistently completed and recorded.

f) The plan of care for a specified resident under Nutritional Care Plan - High Risk indicates that if blood sugars are elevated the Registered Dietitian (RD) is to be notified. Interview with the RD indicates that the resident was not seen related to elevations in capillary blood glucose (CBG). Progress notes confirm elevations in the resident's CBG on specified dates. No dietary referral was initiated. Staff interviewed indicated that there is no specific hypo/hyperglycemic protocol in the home and care provided in relation to changes in blood glucose are at the discretion of the nurse.

g) The home's Food and Fluid Intake Form indicates in red "If < 6 glasses/cups per day x 2 days refer to dietitian." A specified resident's Food and Fluid Intake Form for a designated period in 2011 indicates that the resident received 5 or fewer glasses of fluid daily for a 10 day period in 2011 and only sips of fluid were recorded as being taken for a specified period in 2011. There is no referral to the registered dietitian.

h) A specified resident was identified by the Physiotherapist to have pain with limited range of motion in specified joints, and x-ray confirmed the presence of a disease process. The Palliative Care Consultant was involved in assessment of the resident, recommending initiation of analgesic and assessment using a designated assessment tool twice daily for 5 days. The physician ordered the recommended analgesic. Analgesic was started. Pain assessments are not available in the progress notes for the resident, and interview confirms that the designated assessment and weekly pain assessment have not been completed for the resident. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 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 Director

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
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 23rd day of February, 2012

Signature of Inspector / Signature de l'inspecteur : Debora Saville

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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