Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 31, 2014	2014_380593_0017	S-007162-14	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 12th - 14th, 2014

Three complaint logs and one critical incident log were completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Worker's (PSW), Residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Safe and Secure Home

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to an incident of witnessed verbal abuse towards Residents #003 and #004 by staff member #102. It was reported that staff member #103 witnessed staff member #102 tell Residents #003 and #004 to shut-up on two different occasions.

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

During an interview with Inspector #593 November 12, 2014, staff member #103 advised that they were in the dining room of the one of the home's units. Staff member #102 was behind the desk at the nurse's station and Resident #004 was at the nurse's station exhibiting responsive behaviours. At this time, staff member #102 said to Resident #004 "shut-up, shut-up now I am tired of hearing from you". Later that same day, in the dining room of the same unit, staff member #103 witnessed Resident #003 exhibiting responsive behaviours and staff member #102 telling them to "shut-up now, why are you being disruptive I am going to take you back to your room".

During an interview with Inspector #593 November 13, 2014, the home's Director of Care (DOC) advised that through an internal investigation, they were able to substantiate from several staff members that staff member #102 did speak to residents inappropriately on more than one occasion. They further advised that staff member #102 had made prior verbally abusive comments towards residents and there were prior disciplines and counseling regarding this behaviour however staff member #102 never made any attempt to correct this behaviour or even acknowledge that they did anything wrong.

A review of staff member #102's employment record found the following:

• A written discipline was issued in 2013 regarding an incident where staff member #102 threw food at staff member #104 while feeding a resident. The food landed on the snack cart as well as staff member #104. This incident was also witnessed by staff members #105 and #106 and there were also three residents present.

• A written discipline was issued in 2013 regarding a complaint from a family member that staff member #102 was loud and rude to Resident #003, telling the resident that they were sick of hearing them and then push them in their wheelchair into a room. Two staff members validated this complaint and added that the staff member also took away a

personal belonging of Resident #003's, telling them that it was fake and that they could no longer have it. It was also reported that the resident started crying when they were pushed in their wheelchair into another room by staff member #102.

• A written discipline was issued in 2014 regarding staff member #102 yelling and speaking poorly to other staff members.

• A written discipline was issued in 2014 regarding staff member #102 speaking inappropriately to other staff members.

Furthermore, during the home's investigation into the reported verbal abuse towards two residents, additional allegations were brought forward by other staff members in the home regarding staff member #102's behaviour towards residents in the home:

• Staff member #107 reports witnessing staff member #102 saying "go ahead, die" to Resident #003 when the resident was exhibiting responsive behaviours and reports witnessing staff member #102 telling Resident #004 to "shut-up" several times.

• Staff member #106 reports witnessing staff member #102 saying "do it already" when Resident #005 was repeating "I'm going to fall"; asking Resident #007 "do you want me to feed you like a baby?"; has told Resident #004 to "shut-up" when the resident is calling out and has observed staff member #102 give Resident #006 a light tap on the hand when the resident grabbed the blanket from the staff member.

• Staff member #108 reports witnessing staff member #102 saying "go ahead, die" to Resident #003 when the resident was exhibiting responsive behaviours and has witnessed staff member #102 tap Resident #003 on the hand.

A review of the home's education records on Residents' Rights and Elder Abuse found that this training was provided for staff in the home in July 2013 and July 2014. Staff member #102 did not complete this training in 2013 or 2014. Furthermore staff members #106, #107 and #108 did not complete this training in July 2014 and staff members #107 and #108 did not complete this training in 2013. It should be noted that staff members #106, #107 and #108 came forward to the licensee regarding allegations of abuse towards residents in the home by staff member #102 however these allegations were not reported immediately as per the home's Zero Tolerance of Abuse and Neglect Policy.

A review of the home's Zero Tolerance of Abuse and Neglect Policy review date

September 15, 2014 found that St Gabriel's Villa is committed to promoting a zero tolerance of abuse or neglect of residents and residents will be free from abuse by staff and that any employee who witnesses, or becomes aware of, or suspects resident abuse shall report it immediately to the DOC/Admin/delegate. In addition, the home's policy states that the Residents' Bill of Rights and the Policy on Zero Tolerance of Abuse and Neglect will be reviewed with each new employee and annually thereafter and additionally the education will include the home's policy and procedure for reporting.

As evidenced by staff member #102's employment record and staff interviews, staff member #102 was known to exhibit verbally abusive behaviours towards residents and other staff members in the home including verbal abuse towards Residents #003 and #004 on more than one occasion. Furthermore, staff member #102 had not received the home's mandatory education on the home's Zero Tolerance of Abuse and Neglect Policy in 2013 or 2014. The licensee has failed to protect Residents #003 and #004 from verbal abuse by staff member #102 with known and documented verbally abusive behaviours towards residents in the home. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to an incident of witnessed verbal abuse towards Residents #003 and #004 by staff member #102. It was reported that staff member #103 witnessed staff member #102 tell Residents #003 and #004 to shut-up on two different occasions. Staff member #103 reported this to their supervisor and they both took this information to the DOC however this did not happen until six days after the incidents occurred.

During an interview with Inspector #593 November 13, 2014, the home's Director of Care (DOC) advised that the witnessed verbal abuse towards Residents #003 and #004 was reported by staff member #103 and their supervisor however this was not reported until six days after the incident occurred. The DOC advised that they are unsure why staff member #103 did not immediately report this verbal abuse however believes it may have been because they were unsure and possibly afraid of backlash. The DOC also confirmed that staff member #103 is included in the annual training on the home's Policy: Prevention of Abuse and Neglect and this training includes mandatory reporting and whistleblowing protection. This was confirmed by review of the home's training records.

Furthermore, during the home's investigation into the reported verbal abuse towards two residents, additional allegations were brought forward by other staff members in the

home regarding staff member #102's verbally abusive behaviour towards residents in the home. These additional allegations were not reported by the staff members to the licensee or the Director of the MOHLTC at the time they occurred.

A review of the home's Zero Tolerance of Abuse and Neglect Policy review date September 15, 2014 found that staff members in the home are to report any witnessed, suspected or alleged abuse to a supervisor/manager immediately and that section 24 (1) of the LTCHA requires a person to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur including abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. In addition, the home's policy states that the Residents' Bill of Rights and the Policy on Zero Tolerance of Abuse and Neglect will be reviewed with each new employee and annually thereafter and additionally the education will include the home's policy and procedure for reporting and whistle-blowing against retaliation.

Furthermore, non-compliance was previously identified under LTCHA, 2007 S.O. 2007, s. 24. During an inspection completed on April 26, 2013 under inspection #2013_140158_0007 in relation to failing to report suspicions of abuse or neglect immediately to the Director of the MOHLTC.

The licensee of St Gabriel's Villa of Sudbury submitted a critical incident report for this critical incident involving witnessed verbal abuse from staff member #102 towards Residents #003 and #004. This critical incident report was submitted six days after the staff member #103 witnessed the verbal abuse towards Residents #003 and #004. As such, the licensee has failed to immediately report the abuse of a resident to the Director. [s. 24. (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 ensuring that all staff members within the home are aware of mandatory reporting requirements and whistle-blowing protection as per the Long-Term Care Homes Act, 2007, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A complaint was received by the MOHLTC regarding a power outage occurring August 30, 2014 in the home about concerns during the power outage including insufficient flashlights for staff to use, communication issues, lack of emergency powered lighting, the generator being broken, staff being unsure of their roles and responsibilities and general concern for resident and staff safety.

A second complaint was received by the MOHLTC regarding the same power outage and concerns that staff did not have access to flashlights when the home was in total darkness.

A review of the Family Council Minutes dated September 15, 2014 found documented concerns regarding the same power outage including:

a) What is being done to address and prevent future issues during a power outage?
b) Staff requires education i.e what to do during a power outage; where are the flashlights located etc.
c) Flashlights to be located and working at each nursing station.
d) Members would like to suggest for management staff to consider battery operated emergency lights in the hallway as a backup should the generator fail to work again.
e) Members would like to know why a back-up plan was not put into place, even though staff had knowledge of the generator not working.

During an interview with Inspector #593 November 13, 2014, Resident #001 advised that at approximately 10:30pm the evening of August 30, 2014 the power and subsequently the lights went out in the home, the power was out for approximately two hours and as they found out during the power outage the home's generator was broken. Resident #001 advised that the home was in complete darkness. Resident #001 advised that they had a flashlight and a staff member in the home was aware of this and they came to their room to borrow their flashlight as the staff member could not locate one. Resident #001 advised that as staff were unable to locate flashlights, they were retrieving their own from their cars as well as borrowing them from other residents in the home. Resident #001 expressed concerns that staff were unsure of what to do, that staff could be overheard asking what they should do and repeating that they did not know what to do. Resident #001 was also concerned that staff were trying to communicate via the walkie talkies however the batteries were dead and therefore staff had to navigate into the maintenance area in the dark to find batteries. They further advised that some staff were borrowing resident cell phones so that they could call their homes to advise they would be late getting home. This was due to staff being unaware of the location of a working phone within the home.

During an interview with Inspector #593 November 13th, 2014, staff member #100 advised that they were working during the power outage and blackout that occurred August 30, 2014 and that they were advised that the generator could not be fixed as it required a part that was not yet available. They further advised that staff did not have access to any phones as the battery in the cell phone that the RN is allowed to carry was nearly depleted. They further advised that they had to borrow flashlights from residents as they were unable to locate any in the dark. As far as they are aware, there have been no additional flashlights added to the home since this incident. They feel that there was no real direction with what to do during the blackout and that there are no home policies or procedures regarding this that they were aware of.

During an interview with Inspector #593 November 13, 2014, staff member #101 advised that they were working during the power outage and blackout that occurred August 30, 2014. They advised that they were made aware that the back-up generator was not working. They advised that the home was in complete darkness, they had no access to flashlights for the first hour of the power outage and that the phones were not working. They further advised that there has been no direction from management since this incident regarding flashlight accessibility, there has been no education since regarding what to do should this happen again and advises that they do not feel better prepared should this incident happen again in the home.

During an interview with inspector #593, November 14th 2014, the home's Administrator advised that there has been no education for staff regarding power outages and blackouts since this incident occurred. Regarding prior education, the home's Administrator advised that the home conducts monthly fire drills however they are unsure how effective this would be in a power outage and blackout. They further advised that new power outage contingency plans are currently under review and are soon to be available in the home. Once these plans are finalized, staff are to receive education regarding this. They did confirm, that these power outage contingency plans were not in use and available to staff August 30, 2014 when the power outage and subsequent blackout occurred.

As evidenced by resident and staff Interviews and documentation reviews, staff members working the evening of the blackout were unable to immediately locate flashlights, were unable to communicate within the facility or outside the facility and had no direction regarding their role and responsibility during the power outage and subsequent blackout. As such, the home has failed to ensure that the emergency plans address plan activation, communication plans and specific staff roles and responsibilities. [s. 230. (5)]

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 all staff members within the home are educated on the homes emergency plans regarding power outage, location of essential equipment during a power outage and their roles and responsibilities during a power outage, to be implemented voluntarily.

Issued on this 20th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2014_380593_0017
Log No. / Registre no:	S-007162-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 31, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, 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)

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 is hereby ordered to comply with St Gabriel's Villa Policy titled: Zero Tolerance of Abuse and Neglect (review date September 15, 2014), specifically to the following sections but not limited to only them:
* Mandatory Reporting under the LTCHA
* Internal Investigation Process
* Procedures: Section 1- Education and Training about Prevention of Abuse and Neglect; Staff, Resident and Family education

Grounds / Motifs :

1. This non-compliance is supported by the following findings:

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in relation to an incident of witnessed verbal abuse towards Residents #003 and #004 by staff member #102. It was reported that staff member #103 witnessed staff member #102 tell Residents #003 and #004 to shut-up on two different occasions.

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

During an interview with Inspector #593 November 12, 2014, staff member #103 advised that they were in the dining room of the one of the home's units. Staff member #102 was behind the desk at the nurse's station and Resident #004 was at the nurse's station exhibiting responsive behaviours. At this time, staff

member #102 said to Resident #004 "shut-up, shut-up now I am tired of hearing from you". Later that same day, in the dining room of the same unit, staff member #103 witnessed Resident #003 exhibiting responsive behaviours and staff member #102 telling them to "shut-up now, why are you being disruptive I am going to take you back to your room".

During an interview with Inspector #593 November 13, 2014, the home's Director of Care (DOC) advised that through an internal investigation, they were able to substantiate from several staff members that staff member #102 did speak to residents inappropriately on more than one occasion. They further advised that staff member #102 had made prior verbally abusive comments towards residents and there were prior disciplines and counseling regarding this behaviour however staff member #102 never made any attempt to correct this behaviour or even acknowledge that they did anything wrong.

A review of staff member #102's employment record found the following:

• A written discipline was issued in 2013 regarding an incident where staff member #102 threw food at staff member #104 while feeding a resident. The food landed on the snack cart as well as staff member #104. This incident was also witnessed by staff members #105 and #106 and there were also three residents present.

• A written discipline was issued in 2013 regarding a complaint from a family member that staff member #102 was loud and rude to Resident #003, telling the resident that they were sick of hearing them and then push them in their wheelchair into a room. Two staff members validated this complaint and added that the staff member also took away a personal belonging of Resident #003's, telling them that it was fake and that they could no longer have it. It was also reported that the resident started crying when they were pushed in their wheelchair into another room by staff member #102.

• A written discipline was issued in 2014 regarding staff member #102 yelling and speaking poorly to other staff members.

• A written discipline was issued in 2014 regarding staff member #102 speaking inappropriately to other staff members.

Furthermore, during the home's investigation into the reported verbal abuse

towards two residents, additional allegations were brought forward by other staff members in the home regarding staff member #102's behaviour towards residents in the home:

• Staff member #107 reports witnessing staff member #102 saying “go ahead, die” to Resident #003 when the resident was exhibiting responsive behaviours and reports witnessing staff member #102 telling Resident #004 to “shut-up” several times.

• Staff member #106 reports witnessing staff member #102 saying “do it already” when Resident #005 was repeating “I’m going to fall”; asking Resident #007 “do you want me to feed you like a baby?”; has told Resident #004 to “shut-up” when the resident is calling out and has observed staff member #102 give Resident #006 a light tap on the hand when the resident grabbed the blanket from the staff member.

• Staff member #108 reports witnessing staff member #102 saying “go ahead, die” to Resident #003 when the resident was exhibiting responsive behaviours and has witnessed staff member #102 tap Resident #003 on the hand.

A review of the home’s education records on Residents' Rights and Elder Abuse found that this training was provided for staff in the home in July 2013 and July 2014. Staff member #102 did not complete this training in 2013 or 2014. Furthermore staff members #106, #107 and #108 did not complete this training in July 2014 and staff members #107 and #108 did not complete this training in 2013. It should be noted that staff members #106, #107 and #108 came forward to the licensee regarding allegations of abuse towards residents in the home by staff member #102 however these allegations were not reported immediately as per the home's Zero Tolerance of Abuse and Neglect Policy.

A review of the home’s Zero Tolerance of Abuse and Neglect Policy review date September 15, 2014 found that St Gabriel's Villa is committed to promoting a zero tolerance of abuse or neglect of residents and residents will be free from abuse by staff and that any employee who witnesses, or becomes aware of, or suspects resident abuse shall report it immediately to the DOC/Admin/delegate. In addition, the home’s policy states that the Residents' Bill of Rights and the Policy on Zero Tolerance of Abuse and Neglect will be reviewed with each new employee and annually thereafter and additionally the education will include the home's policy and procedure for reporting.

As evidenced by staff member #102's employment record and staff interviews, staff member #102 was known to exhibit verbally abusive behaviours towards residents and other staff members in the home including verbal abuse towards Residents #003 and #004 on more than one occasion. Furthermore, staff member #102 had not received the home's mandatory education on the home's Zero Tolerance of Abuse and Neglect Policy in 2013 or 2014. The licensee has failed to protect Residents #003 and #004 from verbal abuse by staff member #102 with known and documented verbally abusive behaviours towards residents in the home. [s. 19. (1)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 31st day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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