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 |
|---|---|---|---|
| Nov 17, 2015 | 2015_281542_0019 | 026475-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

JENNIFER LAURICELLA (542), CHAD CAMPS (609), FRANCA MCMILLAN (544)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): October 5, 6, 7, 8, 9, 13, 14, and 15, 2015.**

**The following logs were inspected concurrently with the Resident Quality Inspection: Log # 24768-15, #22062-15 and #28088-15.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Support Services, Infection Prevention and Control Lead, Registered Staff, Registered Dietitian, RAI Coordinator, Personal Support Workers (PSWs), Residents and Family Members.**

**The Inspectors reviewed various policies and procedures, health care records, conducted daily walk through of the resident care areas, observed staff to resident interactions and the provision of care to residents.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 213. Director of Nursing and Personal Care**

**Specifically failed to comply with the following:**

**s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,**
**(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).**
**(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).**
**(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least one year of experience working as a registered nurse in the long-term care sector and had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Over the course of the inspection it was brought to the attention of Inspector #542 and #544 by a staff member that the Director of Care (DOC) of the home did not meet the legislated requirements for the position.

Inspector #544 interviewed the Administrator, who confirmed that the Director of Care was hired on August 4, 2015. This hiring for the position of the DOC was in consultation with Sienna Corporation head office. The DOC did not have one year experience in the LTC sector as a registered nurse nor did they have at least three years experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Subsequent to the on-site inspection, a letter was received from the Medical Director for the home identifying several concerns related to the qualifications of the Director of Care. [s. 213. (4)]

***Additional Required Actions:***

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

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**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:**

**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; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(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).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care for resident #026 set out clear directions to staff and others who provide direct care to the resident.

Inspector #542 completed a health care record review for resident #026. The most current Resident-Assessment Instrument-Minimum Data Set (RAI-MDS) assessment indicated that resident #026 was frequently incontinent of urine, usually continent of bowel, wore briefs/pads and required extensive assistance by one staff for toileting. The most current care plan accessible to the direct care staff indicated that resident #026 required assistance with toileting, however did not indicate that any incontinent products were to be used. It was also documented that the resident was usually continent of

bladder and that staff were to ask if they urinated every shift. On October 14, 2015, Inspector #542 spoke with S#114 and S#115 who both indicated that the resident was occasionally incontinent of urine, wore a pull up during the day and a medium brief at night.

Inspector #542 spoke with the RAI-Coordinator who confirmed that all of the information with regards to bowel/bladder and toileting was to be located on the care plan. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #027 and #029 as specified in the plan.

On October 9, 2015, Inspector #542 completed a health record review for resident #027. The most current care plan accessible to the direct care staff indicated resident #027 was to have specific fall prevention interventions in place daily, to prevent injury related to falls from bed.

On October 9, 2015, Inspector #542 observed resident #027 in their room, with no fall prevention intervention in place.

On October 14, 2015, Inspector #542 spoke with S#113 who stated that the resident does not always use the specific fall prevention interventions. S#113 and Inspector #542 observed resident #027 on this same day and noted that the fall interventions were not in place.

Inspector #609 completed a review of the plan of care which revealed that resident #029 had decreased/ impaired vision related to the aging process and that eyeglasses were to be clean, appropriate and being worn by resident while awake and to be worn at all times.

Observations made throughout the day on October 8, 2015, and October 9, 2015, revealed no application of eyeglasses on resident #029.

An interview with S#108 confirmed that the care specified in the plan of care was not being provided related to eyeglass application for resident #029 and that the plan of care was not up to date and should have been. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided

to resident #029 as specified in the plan.

On October 8, 2015, Inspector #609 observed resident #029 wandering in the common area surrounding the nursing station in a resident home area. The Registered Practical Nurse (RPN) attempted to give resident #029 pain medications but the resident spit them out and the RPN continued on their medication pass.

Inspector #609 heard a loud slap from behind. The Registered Nurse (RN) present exclaimed that resident #029 slapped resident #057 who was passin by.
Inspector #609 observed resident #029 making threatening gestures at resident #057 who was observed with a pained expression and was rubbing their face. The RN immediately intervened and separated the two residents. The RPN came down the hall and the RN advised them that resident #029 had slapped resident #057. The RN then removed resident #057 from the area to complete an assessment. The RPN provided resident #029 with an intervention that distracted the resident.

The RPN then informed the Inspector that there was a resident who had fallen and the RPN left the area to attend to the fallen resident.

Resident #029 was left alone and unattended in the common area outside the nursing station. During that time the Inspector observed three other female residents pass by the resident. One female resident attempted to take something away from resident #029. Resident #029 turned away from the female resident as they continued to hold onto their possession.
Shortly after, eight residents were in the area surrounding resident #029 as volunteers were portering residents to the unit from an activity. A total of 25 minutes elapsed before staff were observed in the common room, during this time resident #029 was unobserved and unattended for a total of 25 minutes, in an agitated state, surrounded by residents.

A review of the responsive behaviour plan of care revealed staff were to allow the resident to wander where they could be observed and when behaviour became disruptive they were to remove the resident from public areas.

An interview on October 8, 2015 with the Director of Care (DOC) confirmed that it was the home's expectation that care as specified in the plan of care was to be provided to resident #029. The resident was left unattended or observed for 25 minutes in a public area after being abusive towards another resident. [s. 6. (7)]

4. Inspector #609 reviewed a Critical Incident (CI) report that was submitted to the Director on August 10, 2015. The CI revealed that resident #058 was abusive towards resident #065. Resident #065 was visibly shaken and upset from the incident.

The Director of Care (DOC) confirmed that the home was aware of resident #058's responsive behaviours and that they received detailed instructions from another source as to when resident typically exhibited these behaviours.

The critical incident also revealed that the physician was notified of the altercation, and that the physician was aware of the responsive behaviours of resident #058 and would likely need time to settle and would require close monitoring while doing so.

In an interview, the Director of Care (DOC) confirmed that it is the home's expectation that staff and others involved in the different aspects of care collaborate with each other, that the physician was aware of the requirement for heightened monitoring of the resident while they adjusted to the new home.

The Director of Care also confirmed that the home was aware of responsive behaviour of resident #058 and that prior to admission they gave instructions to the registered staff to complete their own comprehensive responsive plan of care for the resident based on the information obtained before admission. The Director of Care confirmed that the admission plan of care for resident #058 was not as detailed as the plan obtained from another source.

The care set out in the plan of care was not provided to resident #058 as specified in the plan. [s. 6. (7)]

5. The licensee has failed to ensure resident #029 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident #029's care needs change or care set out in the plan was no longer necessary.

Inspector #542 completed a health care record review for resident #029. The most current care plan available to the direct care staff indicated that resident #029 required specific interventions to prevent falls from bed.

On October 13, 2015, Inspector #542 observed the resident in their bed with no interventions in place to prevent falls from bed. Inspector #542 interviewed S#113 who indicated that the resident did not have the interventions in place. [s. 6. (10) (b)]

***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 there is a written plan of care for resident #026 that sets out clear directions to staff and others who provide direct care to resident #026, that the care set out in the plan of care is provided to resident #027, #029 and #058 as specified in the plan and that resident #029 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #542 completed a health care record review for resident #029. The most current care plan indicated that the resident was high risk for falls and that they were to have their call bell within reach when in bed.

On October 13, 2015, Inspector #542 observed resident #029 in their bed with their call bell located on the floor and not accessible to the resident. Inspector #542 brought S#113 to the resident's room and they confirmed that the resident did not have access to their call bell and immediately clipped it to the resident's bed.

On October 14, 2015, Inspector #542 observed resident #029 in their bed, with no access to their call bell. The call bell was found on the floor, out of the resident's reach. Inspector showed S#113, who again verified that the call bell was not accessible to the resident. [s. 17. (1) (a)]

***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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (3) The licensee shall ensure that,**
**(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).**
**(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).**
**(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

A review of the responsive behaviour program revealed no annual evaluation of the responsive behaviour program for the 2014 calendar year.

An interview with the Director of Care confirmed that it was the home's expectation that the responsive behaviour program was evaluated annually and in the case of the responsive behaviour program evaluation for 2014 this did not occur and should have. [s. 53. (3) (b)]

***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 responsive behavior program is evaluated annually and updated in accordance with evidence-based practices or prevailing practices, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

**Specifically failed to comply with the following:**

**s. 114. (3) The written policies and protocols must be,**
**(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).**
**(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).**

**Findings/Faits saillants :**

1. On October 13, 2015, Inspector #544 observed S#111 administer medications and treatments to three residents.

S#111 administered two medications to resident #059. S#111 signed for the administration of these two tablets before the resident ingested the pills.

S#111 then proceeded to administer two medications to resident #058. S#111 signed for the administration of these medications before resident #058 ingested the pills.

S#111 proceeded to resident #060 and administered two medications to them. S#111 signed for the administration of these medications before resident #060 actually took the pill and inhaled the inhalation medication.

S#112 was administering medication to resident #064. Two medications were administered to resident #064. S#112 signed for the administration of these medications before resident #064 actually ingested the pills.

Inspector #544 reviewed the home's medication policy from Rexall Specialty Pharmacy Policy and Procedure Manual, Policy 9.2, Medication Administration: General Guidelines and under the heading, Documentation it was written: "The staff member, who administers the medication dose, records the administration on the resident's eMar directly after the medication is given."
S#111 did not follow the home's policy in regards to the documentation of medications after the medications are given. [s. 114. (3) (a)]

***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 home's policy on Medication Administration is developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program by ensuring proper hand hygiene practices during medication administration.

Inspector #544 observed a medication pass on October 9, 2015. S#108 was dispensing medication to three different residents.

Resident #061, had two different eye drops instilled in each eye. S #108 did not participate in any hand hygiene activities after administering these eye drops nor did they wear any examination gloves while performing the administration of the eye drops.

S#108 then administered a medication to resident #062, who was to receive an injection, before the lunch meal. The resident also had their blood glucose level checked and another medication administered by S#108. The Inspector did not observe S#108 complete any hand hygiene practice before or after administering these medications and performing these tasks. S#108 did not wear examination gloves as per the home's policy.

S#108 then attended to resident #060 and administered a medication. S#108 did not perform any hand hygiene activities before or after administering this medication.

Inspector #544 reviewed the home's medication policy from Rexall Specialty Pharmacy Policy and Procedure Manual, Policy 9.2, Medication Administration, General Guidelines and under Procedure Nursing Preparation it is written, staff administering shall follow good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct with a resident and before and after administration of ophthalmic, topical, vaginal, rectal and parental preparations and medications given via enteral tubes. Examination gloves are worn when necessary refer to specific administration procedures for each route. Examination gloves are to be worn for the administration of topical, ophthalmic, injections, enteral, rectal and vaginal medications.

S#108 administered medications to three different residents, and came into direct contact with some of them without performing any hand hygiene practices before or after each contact. [s. 229. (4)]

**Issued on this 2nd day of December, 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**

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| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JENNIFER LAURICELLA (542), CHAD CAMPS (609), FRANCA MCMILLAN (544) |
| **Inspection No. / No de l'inspection :** | 2015_281542_0019 |
| **Log No. / Registre no:** | 026475-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Nov 17, 2015 |
| **Licensee / Titulaire de permis :** | Algoma Manor Nursing Home<br>145 Dawson Street, THESSALON, ON, P0R-1L0 |
| **LTC Home / Foyer de SLD :** | Algoma Manor Nursing Home<br>145 Dawson Street, THESSALON, ON, P0R-1L0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Pamela Ficociello |

To Algoma Manor Nursing Home, 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 :**

O.Reg 79/10, s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector;
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

**Order / Ordre :**

The licensee must ensure that there is a Director of Nursing and Personal Care on site immediately, who meets the qualifications as follows;

a) has at least one year experience working as a registered nurse in the long-term care sector;

b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and

c) has demonstrated leadership and communication skills.

**Grounds / Motifs :**

1. The licensee failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least one year of experience working as a registered nurse in the long-term care sector and had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Over the course of the inspection it was brought to the attention of Inspector #542 and #544 by a staff member that the Director of Care (DOC) of the home did not meet the legislated requirements for the position.

Inspector #544 interviewed the Administrator, who confirmed that the Director of Care was hired on August 4, 2015. This hiring for the position of the DOC was in consultation with Sienna Corporation head office. The DOC did not have one year experience in the LTC sector as a registered nurse nor did they have at least three years experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Subsequent to the on-site inspection, a letter was received from the Medical Director for the home identifying several concerns related to the qualifications of the Director of Care.

The decision to issue this compliance order was based on the scope which is widespread and has the potential to affect all residents in the home and the severity which indicates a potential for actual harm to all residents of the long-term care home. (542)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 01, 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

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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 17th day of November, 2015**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Jennifer Lauricella

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