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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159 rue Cedar Bureau 403
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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
Feb 1, 2017	2016_273638_0022	033226-16	Critical Incident System

Licensee/Titulaire de permis

CHAPLEAU HEALTH SERVICES
C/O CHAPLEAU GENERAL HOSPITAL 6 BROOMHEAD ROAD CHAPLEAU ON P0M 1K0

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

THE BIGNUCOLO RESIDENCE
C/O Chapleau General Hospital P. O. Box 757, 6 Broomhead Road CHAPLEAU ON P0M 1K0

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 6 and 7, 2016.

The inspection was conducted as a result of a Critical Incident the home submitted to the Director related to improper care of a resident, which resulted in a decline in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Nursing Administrative Assistant (NAA), Registered Nurses (RNs) and Registered Practical Nurses (RPNs).

The inspector also conducted a daily tour of resident care areas, reviewed resident health care records, relevant human resource files, training logs, internal investigation notes, as well as licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. The licensee has failed to ensure that the residents of the home were not neglected by the licensee or staff.

Neglect is defined within the Ontario Regulation 79/10 (O. Reg 79/10) as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) was submitted to the Director in November 2016, which alleged improper care of a resident, resulting in actual harm to the resident. The CI report stated that resident #001 was found in November 2016, with a dressing applied to an area of altered skin integrity with no documentation when the dressing was applied. The resident then suffered a significant decline in their health status due to the area of altered skin integrity. The resident was deemed palliative and passed away shortly after.

a) Inspector #638 conducted a review of resident #001's health care records. Upon review of the skin observation record it was identified that the resident had an area of altered skin integrity documented on three consecutive days in November 2016.

In a review of the progress notes for resident #001, the Inspector was unable to identify any documentation on the resident or their health status for a ten day period in November 2016. The Inspector was unable to locate any skin and wound assessments completed for the resident when the first area of altered skin integrity was documented in the skin observation record and when the area of altered skin integrity was formally identified. The area of altered skin integrity went unaddressed for a total of six days.

The home's policy titled "Elder Abuse and Neglect – CLI-03-05002" issue date February 18, 2009, indicated that neglect was defined as the failure to have provided a resident with the treatment, care services, or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents of the home.

The Inspector reviewed the internal investigation notes regarding resident #001's care in November 2016, which indicated that a registered staff member cared for resident #001 during the night shifts when the area of altered skin integrity was identified in November 2016. In the investigation notes the registered staff member stated that they found an area of altered skin integrity on the resident. The investigation notes indicated that the registered staff member applied a dressing to the area of altered skin integrity and failed to document or communicate about the area of altered skin integrity.

During an interview with Inspector #638, the registered staff member stated that they had applied the dressing to resident #001, during their night shift in November 2016, and had changed the dressing during their second night shift the next day. The registered staff member stated that they should have documented about the area of altered skin integrity, completed the appropriate assessments, updated the resident's care plan and notified staff of the new area of altered skin integrity, however, they "forgot to notify and follow up" to ensure that the required care was provided to the resident.

In an interview with Inspector #638, another registered staff member stated that they cared for resident #001 during the day shift in November 2016, and was aware of the dressing which was covering the resident's area of altered skin integrity. When asked what the home's expectation was regarding undocumented dressings found on a resident, the registered staff member stated that they were expected to remove the dressing in order to assess the area, document the findings and notify staff of the impaired skin integrity concern. The registered staff member stated that these steps did not occur for resident #001's area of altered skin integrity.

The home's policy titled "Skin and Wound Care Maintenance – CLI-03-19003" issue date June 17, 2015, indicated that any resident who had been identified as having a wound or pressure ulcer would be assessed and documented on by the staff nurse who cared for the resident. A review of "Appendix VI: LTC Wound Care Algorithm" indicated that if a resident developed a new wound; a full wound assessment would be completed, the physician would be notified to assess and order appropriate wound care protocols. Furthermore, a wound assessment would have been completed in Point Click Care (PCC), wound care would have been added to daily PCC tasks and the resident's care plan would have been updated to identify the wound which would have included a resident specific focus, goal and interventions.

b) The Inspector conducted an interview with the registered staff member, who verified that they were the responding staff who discovered the dressing on resident #001 in November 2016. The registered staff member stated that they were assisting the resident with their daily hygiene routine and discovered the dressing on the resident. The registered staff member stated that the dressing was saturated in drainage, and an area of significant altered skin integrity.

Inspector #638 conducted a review of the skin and wound assessment completed when the registered staff member discovered the area of altered skin integrity in November 2016, which indicated that resident #001 had developed a significant decline to the area

of altered skin integrity.

Inspector #638 reviewed the physician's progress notes written in November 2016, which indicated that resident #001 had been rapidly deteriorating since the discovery of the area of altered skin integrity in November 2016, and indicated that the resident had developed worsening symptoms due to the area. Further review of the physician's progress notes indicated that the resident was transferred to a separate care area for appropriate treatment.

Inspector #638 conducted a review of the "Medical Certificate of Death" completed for resident #001, which indicated that the immediate cause of death was due to an infection related to the area of altered skin integrity.

In an interview with Inspector #638, the acting DOC stated "No" when asked if they felt as though the home protected resident #001 from neglect during this period of time in November 2016, due to a pattern of inaction regarding skin and wound care management and the expectations of the registered staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

A CI report was submitted to the Director in November 2016, which alleged improper care of a resident. Resident #001 was found with a dressing applied to an area of altered skin integrity with no completed documentation indicating when the dressing was applied, please refer to WN #1 for further details.

Inspector #638 conducted a review of resident #001's health care records. Upon review of the skin observation record for resident #001, it was identified that the resident had an area of altered skin integrity documented for three consecutive days in November 2016.

In a review of the progress notes for resident #001, the Inspector was unable to identify any documentation completed on the resident or their health status, for a specific ten day period. The Inspector was unable to locate any skin and wound assessments completed on the resident during this period of time, the area of altered skin integrity went unaddressed for six days.

The Inspector reviewed the internal investigation notes regarding resident #001's care in November 2016, which indicated that a registered staff member cared for resident #001 during the night shifts when the area of altered skin integrity was identified in November 2016. The registered staff member stated that they failed to complete the required assessments, documentation or even communicate about the area of altered skin integrity.

During an interview with Inspector #638, the registered staff member stated that they should have documented on the area of altered skin integrity, completed the appropriate skin and wound assessments, updated the resident's care plan and notified staff of the new area of altered skin integrity, however, they forgot to complete the required assessments.

The home's policy titled "Skin and Wound Care Maintenance – CLI-03-19003" issue date June 17, 2015, indicated that any resident who had been identified as having a wound or pressure ulcer would be assessed and documented on by the staff nurse who cared for the resident. A review of "Appendix VI: LTC Wound Care Algorithm" indicated that if a resident developed a new wound; a full wound assessment would have been completed in Point Click Care (PCC).

In an interview with Inspector #638, the acting DOC stated that when a resident presents with a new skin integrity issue, that the home's process is to complete a formal skin and wound assessment immediately upon discovery and document the assessment in Point Click Care (PCC). The acting DOC went on to state that this had not occurred for resident #001. [s. 50. (2) (b) (i)]

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 when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 assessments, to be implemented voluntarily.

WN #3: 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. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident had immediately reported the suspicion and the information upon which it was based to the Director.

A CI report was submitted to the Director in November 2016, which alleged improper care of a resident, which resulted in actual harm to the resident. The CI report stated that resident #001 was found with a dressing applied to an area of altered skin integrity with no documentation indicating when the dressing was applied. The resident then suffered a significant decline in their health status due to the area of altered skin integrity. The resident was deemed palliative and passed away shortly after.

Inspector #638 reviewed the home's CI report submitted in November 2016, which indicated that the critical incident had occurred eight days prior to being reported to the Director. Further review of the CI report indicated that the category of the incident indicated by the home was "Improper/Incompetent treatment of a resident that results in harm or risk to a resident".

During an interview with Inspector #638, a registered staff member stated that they discovered the area of altered skin integrity on resident #001 in November 2016, and had reported the findings to the registered staff member taking care of resident #001. The registered staff member stated that the registered staff member who cared for resident #001 completed an internal incident report which was submitted to the charge nurse for review which would then be reported to the Director as required.

The home's policy titled "LTC Critical Incidents and Mandatory Reports – LTC-02-12003" issue date December 19, 2005, indicated that the charge nurse was responsible in ensuring that a CI was submitted to the MOHLTC within the appropriate time frame allocated. Further review of the home's policy indicated that any improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the MOHLTC.

In an interview with Inspector #638, the acting DOC stated that they were aware of the suspected improper care of resident #001 when the registered staff member discovered the area of altered skin integrity in November 2016, and wanted all the details prior to submitting the CI report to the Director. The Inspector reviewed the legislative requirements within the LTCHA, 2007, with the acting DOC, which stated that any suspected improper or incompetent treatment or care of a resident which resulted in harm or risk of harm to the resident would immediately be reported to the Director. The acting DOC stated that they were not following the legislative requirements by only reporting the incident eight days after they became aware of the suspected improper care. [s. 24. (1)]

Issued on this 3rd day of February, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2016_273638_0022
Log No. / Registre no:	033226-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 1, 2017
Licensee / Titulaire de permis :	CHAPLEAU HEALTH SERVICES C/O CHAPLEAU GENERAL HOSPITAL, 6 BROOMHEAD ROAD, CHAPLEAU, ON, P0M-1K0
LTC Home / Foyer de SLD :	THE BIGNUCOLO RESIDENCE C/O Chapleau General Hospital, P. O. Box 757, 6 Broomhead Road, CHAPLEAU, ON, P0M-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gail Bignucolo

To CHAPLEAU HEALTH SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

a) Ensure that all residents of the home are protected from neglect by staff of the home.

b) Identify every resident of the home who has altered skin integrity to ensure that it is identified in their plan of care and that the appropriate assessments, treatments, interventions and evaluations are implemented to address the altered skin integrity.

c) Retrain all staff on the home's policies and procedures related to the prevention of abuse and neglect, specifically focusing on the definition of neglect.

d) Retrain all direct care staff on the home's policies and procedures related to the skin and wound care program, focusing on the roles and responsibilities of staff related to identification, assessment, treatment, documentation and evaluation of the skin and wound care needs of all residents in the home.

e) Maintain a record of all the required retraining, who completed the retraining, when the retraining was completed and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents of the home were not neglected by the licensee or staff.

Neglect is defined within the Ontario Regulation 79/10 (O. Reg 79/10) as the

failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) was submitted to the Director in November 2016, which alleged improper care of a resident, resulting in actual harm to the resident. The CI report stated that resident #001 was found in November 2016, with a dressing applied to an area of altered skin integrity with no documentation when the dressing was applied. The resident then suffered a significant decline in their health status due to the area of altered skin integrity. The resident was deemed palliative and passed away shortly after.

a) Inspector #638 conducted a review of resident #001's health care records. Upon review of the skin observation record it was identified that the resident had an area of altered skin integrity documented on three consecutive days in November 2016.

In a review of the progress notes for resident #001, the Inspector was unable to identify any documentation on the resident or their health status for a ten day period in November 2016. The Inspector was unable to locate any skin and wound assessments completed for the resident when the first area of altered skin integrity was documented in the skin observation record and when the area of altered skin integrity was formally identified. The area of altered skin integrity went unaddressed for a total of six days.

The home's policy titled "Elder Abuse and Neglect – CLI-03-05002" issue date February 18, 2009, indicated that neglect was defined as the failure to have provided a resident with the treatment, care services, or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents of the home.

The Inspector reviewed the internal investigation notes regarding resident #001's care in November 2016, which indicated that a registered staff member cared for resident #001 during the night shifts when the area of altered skin integrity was identified in November 2016. In the investigation notes the registered staff member stated that they found an area of altered skin integrity on the resident. The investigation notes indicated that the registered staff

member applied a dressing to the area of altered skin integrity and failed to document or communicate about the area of altered skin integrity.

During an interview with Inspector #638, the registered staff member stated that they had applied the dressing to resident #001, during their night shift in November 2016, and had changed the dressing during their second night shift the next day. The registered staff member stated that they should have documented about the area of altered skin integrity, completed the appropriate assessments, updated the resident's care plan and notified staff of the new area of altered skin integrity, however, they "forgot to notify and follow up" to ensure that the required care was provided to the resident.

In an interview with Inspector #638, another registered staff member stated that they cared for resident #001 during the day shift in November 2016, and was aware of the dressing which was covering the resident's area of altered skin integrity. When asked what the home's expectation was regarding undocumented dressings found on a resident, the registered staff member stated that they were expected to remove the dressing in order to assess the area, document the findings and notify staff of the impaired skin integrity concern. The registered staff member stated that these steps did not occur for resident #001's area of altered skin integrity.

The home's policy titled "Skin and Wound Care Maintenance – CLI-03-19003" issue date June 17, 2015, indicated that any resident who had been identified as having a wound or pressure ulcer would be assessed and documented on by the staff nurse who cared for the resident. A review of "Appendix VI: LTC Wound Care Algorithm" indicated that if a resident developed a new wound; a full wound assessment would be completed, the physician would be notified to assess and order appropriate wound care protocols. Furthermore, a wound assessment would have been completed in Point Click Care (PCC), wound care would have been added to daily PCC tasks and the resident's care plan would have been updated to identify the wound which would have included a resident specific focus, goal and interventions.

b) The Inspector conducted an interview with the registered staff member, who verified that they were the responding staff who discovered the dressing on resident #001 in November 2016. The registered staff member stated that they were assisting the resident with their daily hygiene routine and discovered the dressing on the resident. The registered staff member stated that the dressing

was saturated in drainage, and an area of significant altered skin integrity.

Inspector #638 conducted a review of the skin and wound assessment completed when the registered staff member discovered the area of altered skin integrity in November 2016, which indicated that resident #001 had developed a significant decline to the area of altered skin integrity.

Inspector #638 reviewed the physician's progress notes written in November 2016, which indicated that resident #001 had been rapidly deteriorating since the discovery of the area of altered skin integrity in November 2016, and indicated that the resident had developed worsening symptoms due to the area. Further review of the physician's progress notes indicated that the resident was transferred to a separate care area for appropriate treatment.

Inspector #638 conducted a review of the "Medical Certificate of Death" completed for resident #001, which indicated that the immediate cause of death was due to an infection related to the area of altered skin integrity.

In an interview with Inspector #638, the acting DOC stated "No" when asked if they felt as though the home protected resident #001 from neglect during this period of time in November 2016, due to a pattern of inaction regarding skin and wound care management and the expectations of the registered staff.

The scope of this issue was an isolated incident of inaction related to resident's care needs. There was more than one previous unrelated non compliance within the last 36 months. The severity was determined to have been actual harm to the health, safety and well-being of resident #001 as the cause of death was due to a significant decline in their health status due to an area of altered skin integrity. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
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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 1st day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ryan Goodmurphy

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