Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 24, 25, 28, 29, 30, 31, Jun 1, 2012	2012_034117_0019	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE BOURGET
2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Caressant Care Regional Manager / Acting Administrator, the Caressant Care Long-Term Care Consultant / Acting Director of Care, the Environmental Services Manager, the RAI Coordinator, the Activity Director, to several Registered Nurses (RN), to several Personal Support Workers (PSW), to a housekeeper and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records for several identified residents and reviewed two Critical Incident Reports.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with the LTCHA 2007, section 3 (1) (2) it relates that four identified residents were not protected from emotional, physical and verbal abuse by staff.

1- Resident #05 was physically abused by two staff members during the provision of care. Four interviewed staff members #05, # 06, #07 and # 17, report that the resident was tearful and agitated. They stated that the resident told them that two identified staff members # 08 and #20 had roughly washed the resident. They stated that the resident #05 expressed feelings of distress during the provision of care. They stated that this occurred sometime in late March/ early April 2012. They stated that they had reported the incident to the home's then Director of Care.

One of the identified staff member #08 stated during an interview with MOHLTC inspector # 117, that the resident #05 does not like to receive personal care but that he/she, staff #08, is able to wash the resident. Staff member #08 also indicated that the resident does not like it when he/she and another staff member #19 provide care because they ensure that the resident #05 is properly washed. Progress notes in the resident #05 health care records, indicated that the resident was very upset with staff on two specified days in April 2012 [log # O-001179-12]

2- Resident #03 was emotionally abused by a staff member on an identified day in May, 2012. During the evening of the identified day, resident #03 requested toileting assistance. A staff member #08 verbally scolded the resident for being soiled and addressed the resident in a derogatory manner.

Resident #03 talked about the incident the next day with the unit RN. It is reported that the resident was still upset by the event of the previous day. The RN reported the incident to the home's administration, who subsequently initiated an investigation into the incident. Two staff members #13 and # 17 independently reported the incident to the home's administration. During interviews with MOHLTC inspector #117, staff #13 and #17 stated that the resident was upset by the staff member #08 derogatory comments. Resident #03 did express his/her distress over the incident to the MOHLTC inspector #117 during May 28, 2012, interview.

It is noted that the long-term care home current administration has finished their investigation and internal disciplinary measures have been applied. The home has also submitted a Critical Incident Report to the Director in May, 2012, regarding the above incident. [log # O-001179-12]

3- Resident #04 was emotionally abused by a nursing staff during the provision of care. Health care records for an identified day in May, 2012 notes that Resident #04 expressed concerns to the day Registered Practical Nurse regarding an identified staff member being verbally abusive if their incontinence briefs were not changed before a certain time of day. It is noted in the progress notes that the resident's concerns were reported to the Director of Care that same day.

Three staff members # 07, #08 and # 14 stated to MOHLTC inspector #117, that the resident did tell them of staff #19 being verbally abusive towards the resident #04 if his/her continence products were not changed prior to to a certain time of day. Staff members #07 and #14 stated that they were witness to the staff member #19 becoming verbally abusive because the resident had not requested to have his/her continence product changed. Both staff members stated that the resident's product was dry and the resident had not requested any toileting assistance. [log # O-001179-12]

4- Resident #02 was emotionally and physically abused by a staff member on an identified day in April, 2012. On the identified day April 2012, the resident #02 informed his/her family member that staff member #19 had uttered threats of not providing care to the resident. That same evening, resident #02 required toileting assistance. Resident #02 had a bowel movement and was not provided toileting assistance from 19:00 to 21:40. The Family member reports that the staff member #19 had been aware of the resident's needs and had come several times into the resident's room to provide care to the other co-residents. Resident #02's family member reported to the home that the resident was fearful of this employee and took the threats of not providing care very seriously.

The home's Director of Care conducted an internal investigation and reported the incident to the Director via Critical Incident. Internal disciplinary measures were applied in regards to the identified staff member. [log # O-001120-12 cross

reference inspection # 2012-034117-0018]

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA 2007, section 23 (1) (a) (i) in that every alleged, suspected or witnessed incident of i) abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.

Resident #04 was emotionally abused by a nursing staff during the provision of care. Health care records for an identified day in May, 2012 notes that Resident #04 expressed concerns to the day Registered Practical Nurse regarding an identified staff member being verbally abusive if their incontinence briefs were not changed before a certain time of day. It is noted in the progress notes that the resident's concerns were reported to the Director of Care that same day.

Three staff members # 07, #08 and # 14 stated to MOHLTC inspector #117, that the resident did tell them of staff #19 being verbally abusive towards the resident #04 if his/her continence products were not changed prior to to a certain time of day. Staff members #07 and #14 stated that they were witness to the staff member #19 becoming verbally abusive because the resident had not requested to have his/her continence product changed. Both staff members stated that the resident's product was dry and the resident had not requested any toileting assistance. [log # O-001179-12]

Resident #05 was physically abused by two staff members during the provision of care. Four interviewed staff members #05, # 06, #07 and # 17, report that the resident was tearful and agitated. They stated that the resident told them that two identified staff members # 08 and #20 had roughly washed the resident. They stated that the resident #05 expressed feelings of distress during the provision of care. They stated that this occurred sometime in late March/ early April 2012. They stated that they had reported the incident to the home's then Director of Care.

One of the identified staff member #08 stated during an interview with MOHLTC inspector # 117, that the resident #05 does not like to receive personal care but that he/she, staff #08, is able to wash the resident. Staff member #08 also indicated that the resident does not like it when he/she and another staff member #19 provide care because they ensure that the resident #05 is properly washed. Progress notes in the resident #05 health care records, indicated that the resident was very upset with evening staff on two specified days in April 2012. [log # O-001179-12]

The home's Director of Care and Administrator failed to investigate two reported incidents of alleged staff to resident abuse. It is noted that the Administrator left the home's employment in mid-April 2012 and the Director of Care left the home's employment in early May 2012. At the time of this inspection, no information was found in the home's administrative offices related to the above incidents by the home's Regional Manager and LTC consultant.

Issued on this 1st day of June, 2012

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

Lynn Duchesne

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

Ministère de la Santé et des Soins de longue durée

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

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) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2012_034117_0019
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	May 24, 25, 28, 29, 30, 31, Jun 1, 2012
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE BOURGET 2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~GERRY MILLER~~ Wendy Patterson

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee needs to implement a plan to ensure that residents' right to be free from abuse during the provision of care is well understood by PSWs #08, #19 and #20, that this is shown during the provision of care to the residents. Furthermore, education must be given to all PSW staff in relation to Resident Rights in general and specifically in relation to resident abusel. Finally, a monitoring system must be in place so that registered staff who have direct supervision overnon-registered staff provide necessary leadership to ensure ongoing compliance in this area.

This plan must be submitted in writing to Inspector Lyne Duchesne at 347 Preston St, 4th floor, Ottawa, ON, K1S 3J4 or by fax at 613-569-9670 on or before June 8, 2012.

Grounds / Motifs :

1. The Licensee failed to comply with the LTCA 2007, section 3 (1) (2) it relates that four identified residents were not protected from emotional, physical and verbal abuse by staff.

1- Resident #05 was physically abused by two staff members during the provision of care. Four interviewed staff members #05, # 06, #07 and # 17, report that the resident was tearful and agitated. They stated that the resident told them that two identified staff members # 08 and #20 had roughly washed the resident. They stated that the resident #05 expressed feelings of distress during the provision of care. They stated that this occurred sometime in late March/ early April 2012. They stated that they had reported the incident to the home's then Director of Care.

One of the identified staff member #08 stated during an interview with MOHLTC inspector # 117, that the resident #05 does not like to receive personal care but that he/she, staff #08, is able to wash the resident. Staff member #08 also indicated that the resident does not like it when he/she and another staff member #19 provide care because they ensure that the resident #05 is properly washed. Progress notes in the resident #05 health care records, indicated that the resident was very upset with staff on two specified days in April 2012 [log # O-001179-12]

2- Resident #03 was emotionally abused by a staff member on an identified day in May, 2012. During the evening of the identified day, resident #03 requested toileting assistance. A staff member #08 verbally scolded the resident for being soiled and addressed the resident in a derogatory manner.

Resident #03 talked about the incident the next day with the unit RN. It is reported that the resident was still upset by the event of the previous day. The RN reported the incident to the home's administration, who subsequently initiated an investigation into the incident. Two staff members #13 and # 17 independently reported the incident to the home's administration. During interviews with MOHLTC inspector #117, staff #13 and #17 stated that the resident was upset by the staff member #08 derogatory comments. Resident #03 did express his/her distress over the incident to the MOHLTC inspector #117 during May 28, 2012, interview.

It is noted that the long-term care home current administration has finished their investigation and internal disciplinary measures have been applied. The home has also submitted a Critical Incident Report to the Director in May, 2012, regarding the above incident. [log # O-001179-12]

3- Resident #04 was emotionally abused by a nursing staff during the provision of care. Health care records for an identified day in May, 2012 notes that Resident #04 expressed concerns to the day Registered Practical Nurse regarding an identified staff member being verbally abusive if their incontinence briefs were not changed before a certain time of day. It is noted in the progress notes that the resident's concerns were reported to the Director of Care that same day.

Three staff members # 07, #08 and # 14 stated to MOHLTC inspector #117, that the resident did tell them of staff #19 being verbally abusive towards the resident #04 if his/her continence products were not changed prior to to a certain time of day. Staff members #07 and #14 stated that they were witness to the staff member #19 becoming verbally abusive because the resident had not requested to have his/her continence product changed. Both staff members stated that the resident's product was dry and the resident had not requested any toileting assistance. [log # O-001179-12]

4- Resident #02 was emotionally and physically abused by a staff member on an identified day in April, 2012. On the identified day April, 2012, the resident #02 informed his/her family member that staff member #19 had uttered threats of not providing care to the resident. That same evening, resident #02 required toileting assistance. Resident #02 had a bowel movement and was not provided toileting assistance from 19:00 to 21:40. The Family member reports that the staff member #19 had been aware of the resident's needs and had come several times into the resident's room to provide care to the other co-residents.. Resident #02's family member reported to the home that the resident was fearful of this employee and took the threats of not providing care very seriously.

The home's Director of Care conducted an internal investigation and reported the incident to the Director via Critical Incident. Internal disciplinary measures were applied in regards to the identified staff member. [log # O-001120-12 cross reference inspection # 2012-034117-0018] (117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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.

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

Ministère de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 1st day of June, 2012

Signature of Inspector / Signature de l'inspecteur : Lyne Duchesne

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

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