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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 2, 2018	2017_621547_0019	027263-17	Follow up

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 6,7,11,12,13,18, 19, 20, 21, 2017

This follow-up inspection was conducted in the home related to an order CO #001 from inspection #2017_621547_0016 related to the Licensee's duty to protect the resident from abuse and neglect.
A critical incident report #025999-17 related to improper/incompetent treatment of a resident resulting in a fracture was conducted concurrently during this inspection and information was added to this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident care and the Program Manager of Personal Care, the Resident Assessment Instrument (RAI) Coordinator, a Psycho-Geriatric Outreach nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and families.

In addition the inspector reviewed resident health care records, the units 24 hour shift report books and internal investigation documents related to these critical incidents. The inspector observed the delivery of resident care and services and staff to resident as well as resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_621547_0016	547

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to resident #005 demonstrating responsive behaviours for resident safety.

The home reported a critical incident on a specified date regarding improper/incompetent treatment of resident #005 that resulted in an injury.(Log#025999-17)

Resident#005 was admitted to the home on a specified date with several medical diagnoses. Resident #005's plan of care indicated the resident required total assistance for all Activities of Daily Living (ADL's) with two person staff assistance. The resident's care plan identified aggressive behaviours related to cognitive losses with specified interventions.

Inspector #547 observed resident #005 seated in a wheelchair on two specified dates in the lounge as well as in the dining room demonstrating these responsive behaviours.

On December 13, 2017 RPN #117 indicated to inspector #547 that she is the regular staff on the resident's unit, and indicated the resident likely was injured from the actions done during his/her responsive behaviours.

On December 13, 2017 PSW #119 indicated to Inspector #547 that resident #005 is known for these specified actions while seated in a wheelchair or while in bed. PSW

#119 indicated that she did not require another staff member to assist with personal care when caring for the resident, as she can manage the resident on her own.

On December 18, 2017 PSW #121 indicated to inspector #547 that he provided the resident care regularly during the day shifts. He was aware of the interventions in resident #005’s plan of care regarding two staff members required when care is being provided to resident #005, but that this was rarely required as the resident has not had aggressive behaviours with staff during care.

On December 20, 2017 PSW #118 indicated to inspector #547 that the resident demonstrated responsive behaviours of aggression during personal care with her. PSW #118 indicated on a specified date, she assisted RPN #132 with personal care for resident #005 when the resident suddenly demonstrated aggressive responsive behaviours as specified. The resident was not upset or anything, but simply agitated with personal care. PSW #118 indicated that interventions identified for the resident's aggressive behaviour were not always necessary. That night, RPN #132 was her partner while caring for the resident and was doing something else at the time and that was why the resident was able to be aggressive with PSW #118. Resident #005 was noted on a specified date to have an injury for unknown reasons.

The resident health care records had no documented incidents in which the resident may have sustained this injury. The PMPC’s investigation package into this incident indicated that the interviewed staff members had no recollection as to when this resident may have injured the specified area. Resident #005’s X-Ray report documented a specified fracture.

The resident's current plan of care documented a need to have two staff members during personal care for hygiene and dressing. It was noted that the specified spontaneous responsive behaviours were not identified nor approaches on how to manage these behaviours for staff direction. The resident’s plan of care further does not direct personal support staff to be cautious when mobilizing or repositioning the resident due to this spontaneous behaviour for the resident’s safety.

RN #101 indicated on December 20, 2017 to inspector #547 that resident #005’s specified responsive behaviours are spontaneous and unpredictable, which needed to be identified in the resident's plan of care for safety that required strategies to be developed. [s. 53. (4) (b)]

2. The Licensee has failed to ensure that resident #003 demonstrating responsive behaviours, has actions taken to respond to the needs of the resident, including assessment, reassessments and interventions and that resident #003’s responses to interventions are documented.

Resident #003 was evaluated related to a follow-up to order (Log #027263-17), for CO #001 from Inspection #2017_621547_0016 regarding duty to protect resident #003 from abuse and neglect.

Resident #003 was admitted to the home on a specified date with several medical diagnoses. Resident #003 was identified in the resident's plan of care to have responsive behaviour triggers related to resistance of receiving personal care by nursing staff. Despite these intervention strategies in place, behaviours were documented in the resident's progress notes and the resident care flow sheets almost daily during a specified period of time, as the resident was not manageable and personal care was refused. Resident #003’s plan of care also identified a hearing deficit as one of the resident's responsive behaviour triggers however interventions and treatment were not implemented due to the resident's responsive behaviours.

Regarding diagnostic specimens:

Resident #003 had a previous infection on a specified date identified in report #2017_621547_0016 whereby the home took over a month to treat the resident whereby the same symptoms were identified as an end result.

On December 11, 2017 Inspector #547 reviewed resident #003's health care records and observed the documentation in the resident's progress notes during this specified period of time related to responsive behaviours preventing the nursing staff from obtaining a diagnostic specimen for a suspected infection as follows:

- Resident #003 refused personal care and diagnostic specimen was not possible during the day shift on a specified date due to the resident being physically aggressive towards nursing staff. Personal care and hygiene was provided to the resident on the evening shift, however the nursing staff were unable to obtain any diagnostic specimen related to the resident's ongoing aggressive behaviours.

- Resident #003 cooperated during the day shift however no diagnostic specimen was obtained the next day. Resident #003 refused personal care and hygiene in the evening

shift, whereby the nursing staff and the resident's SDM noted an increase in verbal and physical aggressive behaviours. No diagnostic specimen was obtained due to the resident's resistance for personal care.

- Resident #003 refused personal care and hygiene, and the resident's SDM consented for nursing staff to restrain the resident's hands in order to provide personal care and hygiene to the resident two days later. The resident was physically aggressive during the provision of care, and nursing staff were unable to obtain a diagnostic specimen. Resident #003 then refused personal care and hygiene on the evening shift, complained of pain and resisted having vital signs taken with physical aggression, and refused medication provision by registered nursing staff or the resident's SDM. A specified medication was then ordered until a diagnostic specimen could be obtained in order to treat the resident's suspected infection.

- The registered nursing staff were able to provide the resident's personal care and hygiene, and obtain a diagnostic specimen three days later. The evening shift documented that the resident's diagnostic specimen was contaminated when providing the resident personal care and hygiene. As the resident continued to have physically aggressive behaviours during the provision of care, they were unable to re-obtain a diagnostic specimen that evening.

- Resident #003 demonstrated increased resistance to personal care and hygiene, refused to have personal care since the evening shift of the day before, as the resident refused to get out of bed. The resident further refused both meals, and medications. Resident #003 refused personal care and hygiene on the evening shift with physically aggressive behaviours and the registered nursing staff were unable to obtain the diagnostic specimen. The registered nursing staff continued to experience difficulty in implementing these strategies for obtaining the required specimen the physician was requesting in order to treat the infection symptoms in the resident.

- Resident #003 continued to be drowsy on the day shift five days later, refused meals or to get out of bed. A diagnostic specimen was obtained after the lunch meal by the unit charge RN, and then an order for a specified medication was prescribed by the treating physician.

Upon review of the resident's health care records to identify when the resident presented with symptoms of infection, it was noted that the registered nursing staff suspected resident #003 may have an infection based on his/her increased behaviours on a

specified date, 27 days earlier. The resident's health and well being condition deteriorated as result. The resident's unit Charge RN indicated they kept informing the physician that the nursing staff were unable to obtain any diagnostic specimen over the 27 days, and the physician indicated that without a urine specimen, they did not find the resident symptomatic of a specified infection.

Regarding hearing issues:

Resident #003 has had ongoing issues for responsive behaviours since admission to the home on a specified date. Communication with the resident related to his/her hearing deficit has been identified as a trigger for the resident's responsive behaviours. The resident was admitted to the home with a plan of care that identified the resident had increased wax build up in both ears, that caused decreased hearing ability. The written strategies developed to manage this wax build-up were identified to have a specified treatment for a prescribed amount of time and then the resident is to have his/her ears cleaned every six months and as required. The resident has prevented physicians in the home to assess his/her ears and the resident has prevented the registered nursing staff to apply the prescribed ear treatment. The resident was seen by an audiologist in the home, a year after the resident was admitted to the home. The audiologist report identified the resident had a large build up of wax in both ears and suggested to the home's physician a course of treatment would be required for the resident followed by a cleaning procedure. This was ordered by the home's physician, however the treatment or procedure to de-wax the resident's ears was unsuccessful related to the resident's responsive behaviours. The resident's SDM has identified to the home on several occasions, this need for the resident for implementation of the plan of care related to wax build up in the resident's ears, however the strategies have not been reassessed to develop interventions to treat the resident's wax build-up.

As such, the Licensee has failed to ensure that actions were taken to meet resident #003's needs related to reassessments and interventions related to resident #003's responsive behaviours for obtaining diagnostic specimens in order to prevent delay in treatment of infections or for de-waxing of resident #003's ears to promote hearing ability to improve communication. [s. 53. (4) (c)]

Additional Required Actions:

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

Issued on this 5th day of February, 2018

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) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2017_621547_0019
Log No. / No de registre :	027263-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 2, 2018
Licensee / Titulaire de permis :	CITY OF OTTAWA Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	CENTRE D'ACCUEIL CHAMPLAIN 275 PERRIER STREET, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Roy

To CITY OF OTTAWA, 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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The Licensee shall ensure that for resident #003:

1. All nursing staff monitor resident #003's responsive behaviours and health condition, to ensure that assessments and reassessments are conducted promptly if significant changes are noted,

2. Registered nursing staff implement effective strategies in obtaining timely diagnostic specimens from resident #003 if and when such specimens are required,

3. Interventions are implemented to address resident #003's ongoing needs related to hearing and ear care.

The Licensee shall ensure that for resident #005:

4. Strategies are developed related to the resident's responsive behaviours of grabbing out while in wheelchair and in bed to prevent injuries, and that these strategies are implemented and reassessed regularly to ensure effectiveness.

The Licensee shall ensure that for resident #003 and resident #005:

5. Registered nursing staff and other nursing leaders provide on-going supervision and directions to staff providing care to these residents in order to ensure the effectiveness of the planned care,

6. Registered nursing staff in consultation with subject matter experts and the residents SDMs review weekly, resident #003 and resident #005's plan of care and documented evaluations with the home's nursing management team, until these resident's behaviours have stabilized.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to resident #005 demonstrating responsive behaviours for resident safety.

The home reported a critical incident on a specified date regarding improper/incompetent treatment of resident #005 that resulted in an injury. (Log#025999-17)

Resident#005 was admitted to the home on a specified date with several medical diagnoses. Resident #005's plan of care indicated the resident required total assistance for all Activities of Daily Living (ADL's) with two person staff assistance. The resident's care plan identified aggressive behaviours related to cognitive losses with specified interventions.

Inspector #547 observed resident #005 seated in a wheelchair on two specified dates in the lounge as well as in the dining room demonstrating these responsive behaviours.

On December 13, 2017 RPN #117 indicated to inspector #547 that she is the regular staff on the resident's unit, and indicated the resident likely was injured from the actions done during his/her responsive behaviours.

On December 13, 2017 PSW #119 indicated to Inspector #547 that resident #005 is known for these specified actions while seated in a wheelchair or while in bed. PSW #119 indicated that she did not require another staff member to assist with personal care when caring for the resident, as she can manage the resident on her own.

On December 18, 2017 PSW #121 indicated to inspector #547 that he provided the resident care regularly during the day shifts. He was aware of the interventions in resident #005's plan of care regarding two staff members required when care is being provided to resident #005, but that this was rarely required as the resident has not had aggressive behaviours with staff during care.

On December 20, 2017 PSW #118 indicated to inspector #547 that the resident demonstrated responsive behaviours of aggression during personal care with her. PSW #118 indicated on a specified date, she assisted RPN #132 with personal care for resident #005 when the resident suddenly demonstrated aggressive responsive behaviours as specified. The resident was not upset or anything, but simply agitated with personal care. PSW #118 indicated that interventions identified for the resident's aggressive behaviour were not always necessary. That night, RPN #132 was her partner while caring for the resident and was doing something else at the time and that was why the resident was able to be aggressive with PSW #118. Resident #005 was noted on a specified date to have an injury for unknown reasons.

The resident health care records had no documented incidents in which the resident may have sustained this injury. The PMPC's investigation package into this incident indicated that the interviewed staff members had no recollection as to when this resident may have injured the specified area. Resident #005's X-Ray report documented a specified fracture.

The resident's current plan of care documented a need to have two staff members during personal care for hygiene and dressing. It was noted that the specified spontaneous responsive behaviours were not identified nor approaches on how to manage these behaviours for staff direction. The resident's plan of care further does not direct personal support staff to be cautious when mobilizing or repositioning the resident due to this spontaneous behaviour for the resident's safety.

RN #101 indicated on December 20, 2017 to inspector #547 that resident #005's specified responsive behaviours are spontaneous and unpredictable, which needed to be identified in the resident's plan of care for safety that required strategies to be developed. (547)

2. The Licensee has failed to ensure that resident #003 demonstrating responsive behaviours, has actions taken to respond to the needs of the resident, including assessment, reassessments and interventions and that resident #003's responses to interventions are documented.

Resident #003 was evaluated related to a follow-up to order (Log #027263-17), for CO #001 from Inspection #2017_621547_0016 regarding duty to protect resident #003 from abuse and neglect.

Resident #003 was admitted to the home on a specified date with several medical diagnoses. Resident #003 was identified in the resident's plan of care to have responsive behaviour triggers related to resistance of receiving personal care by nursing staff. Despite these intervention strategies in place, behaviours were documented in the resident's progress notes and the resident care flow sheets almost daily during a specified period of time, as the resident was not manageable and personal care was refused. Resident #003's plan of care also identified a hearing deficit as one of the resident's responsive behaviour triggers however interventions and treatment were not implemented due to the resident's responsive behaviours.

Regarding diagnostic specimens:

Resident #003 had a previous infection on a specified date identified in report #2017_621547_0016 whereby the home took over a month to treat the resident whereby the same symptoms were identified as an end result.

On December 11, 2017 Inspector #547 reviewed resident #003's health care records and observed the documentation in the resident's progress notes during this specified period of time related to responsive behaviours preventing the nursing staff from obtaining a diagnostic specimen for a suspected infection as follows:

- Resident #003 refused personal care and diagnostic specimen was not possible during the day shift on a specified date due to the resident being physically aggressive towards nursing staff. Personal care and hygiene was provided to the resident on the evening shift, however the nursing staff were unable to obtain any diagnostic specimen related to the resident's ongoing aggressive behaviours.

- Resident #003 cooperated during the day shift however no diagnostic specimen was obtained the next day. Resident #003 refused personal care and hygiene in the evening shift, whereby the nursing staff and the resident's SDM noted an increase in verbal and physical aggressive behaviours. No diagnostic specimen was obtained due to the resident's resistance for personal care.

- Resident #003 refused personal care and hygiene, and the resident's SDM consented for nursing staff to restrain the resident's hands in order to provide personal care and hygiene to the resident two days later. The resident was physically aggressive during the provision of care, and nursing staff were unable to obtain a diagnostic specimen. Resident #003 then refused personal care and hygiene on the evening shift, complained of pain and resisted having vital signs taken with physical aggression, and refused medication provision by registered nursing staff or the resident's SDM. A specified medication was then ordered until a diagnostic specimen could be obtained in order to treat the resident's suspected infection.

- The registered nursing staff were able to provide the resident's personal care and hygiene, and obtain a diagnostic specimen three days later. The evening shift documented that the resident's diagnostic specimen was contaminated

when providing the resident personal care and hygiene. As the resident continued to have physically aggressive behaviours during the provision of care, they were unable to re-obtain a diagnostic specimen that evening.

- Resident #003 demonstrated increased resistance to personal care and hygiene, refused to have personal care since the evening shift of the day before, as the resident refused to get out of bed. The resident further refused both meals, and medications. Resident #003 refused personal care and hygiene on the evening shift with physically aggressive behaviours and the registered nursing staff were unable to obtain the diagnostic specimen. The registered nursing staff continued to experience difficulty in implementing these strategies for obtaining the required specimen the physician was requesting in order to treat the infection symptoms in the resident.

- Resident #003 continued to be drowsy on the day shift five days later, refused meals or to get out of bed. A diagnostic specimen was obtained after the lunch meal by the unit charge RN, and then an order for a specified medication was prescribed by the treating physician.

Upon review of the resident's health care records to identify when the resident presented with symptoms of infection, it was noted that the registered nursing staff suspected resident #003 may have an infection based on his/her increased behaviours on a specified date, 27 days earlier. The resident's health and well being condition deteriorated as result. The resident's unit Charge RN indicated they kept informing the physician that the nursing staff were unable to obtain any diagnostic specimen over the 27 days, and the physician indicated that without a urine specimen, they did not find the resident symptomatic of a specified infection.

Regarding hearing issues:

Resident #003 has had ongoing issues for responsive behaviours since admission to the home on a specified date. Communication with the resident related to his/her hearing deficit has been identified as a trigger for the resident's responsive behaviours. The resident was admitted to the home with a plan of care that identified the resident had increased wax build up in both ears, that caused decreased hearing ability. The written strategies developed to manage this wax build-up were identified to have a specified treatment for a prescribed amount of time and then the resident is to have his/her ears cleaned every six

months and as required. The resident has prevented physicians in the home to assess his/her ears and the resident has prevented the registered nursing staff to apply the prescribed ear treatment. The resident was seen by an audiologist in the home, a year after the resident was admitted to the home. The audiologist report identified the resident had a large build up of wax in both ears and suggested to the home's physician a course of treatment would be required for the resident followed by a cleaning procedure. This was ordered by the home's physician, however the treatment or procedure to de-wax the resident's ears was unsuccessful related to the resident's responsive behaviours. The resident's SDM has identified to the home on several occasions, this need for the resident for implementation of the plan of care related to wax build up in the resident's ears, however the strategies have not been reassessed to develop interventions to treat the resident's wax build-up.

As such, the Licensee has failed to ensure that actions were taken to meet resident #003's needs related to reassessments and interventions related to resident #003's responsive behaviours for obtaining diagnostic specimens in order to prevent delay in treatment of infections or for de-waxing of resident #003's ears to promote hearing ability to improve communication. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Lisa Kluke

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