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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2018	2017_509617_0023	028041-17	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

SHEILA CLARK (617)

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 7-8, and 11-12, 2017.

This Critical Incident (CI) System Inspection was conducted as a result of two CI reports (CI #2923-000155-17 and #2923-000157-17/log #028041-17), the home submitted to the Director, related to a resident fall during a transfer in which the home sent the resident to hospital and suspected staff neglect.

The inspector conducted a tour of the resident care areas, reviewed the resident's health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personnel records, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with Regional Director of Extendicare, Director of Care (DOC), Clinical Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument Coordinator (RAI Coord), Physiotherapist (PT), family members and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system; that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with applicable requirements under the Act.

In accordance with O. Reg. 79/10, s. 36., every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of resident #001's progress notes and safety incident report both dated on a specific date in November 2017, indicated that during a transfer to bed using a specific assistive device performed by PSW #100 and PSW #104, the resident flipped out of the device onto the floor resulting in an injury.

In interviews with PSWs #100, #104, #106, and #108, respectively, they all confirmed to the Inspector that staff used this specific assistive device for several residents including resident #001 to safely support the residents during bathing and transferring.

A review of the home's policy entitled "Minimal Lift-HR 7-221", last revised in September 2016, indicated that the applicable lifting, transferring and repositioning procedures as provided in the Healthy Back Program were to be followed once a plan of care for the resident was established or modified. A review of the Health Back Program entitled, "Guidelines for Minimal Lift", last revised in October 2017, did not indicate a procedure for the use of the specific assistive device used for resident #001 when the incident occurred in November 2017.

In interviews with both the DOC and manager #101, they both confirmed to the Inspector that the procedure for the use of the specific assistive device was not indicated in the home's policy and procedures. They both further explained that the use of these specific assistive devices throughout the home had been discontinued and were removed from further service after the incident occurred. [s. 8. (1) (a)]

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. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

The licensee has failed to ensure that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the additional area of training regarding the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that were relevant to the staff member's responsibilities was provided.

The home had submitted a Critical Incident (CI) Report to the Director regarding an incident that caused an injury to resident #001 for which the resident was taken to hospital and resulted in a significant change to the resident's health status. The CI report indicated that on a specific date in December 2017, while PSW #111 and PSW #112 were providing a mechanical lift transfer to resident #001, the resident fell, and was injured. After 7.5 hours of monitoring the resident's condition post injury, RN #114 determined that the resident required to be sent to the hospital for further assessment. The hospital report identified that resident #001 sustained a specific injury that was directly related to their fall.

During Inspection of this CI report, the Inspector discovered that seven days prior to this incident, resident #001 had another fall during a staff transfer involving a specific assistive device. Please refer to WN #1 for further details.

In interviews with PSWs #100, #104, #106, and #108, respectively, they all confirmed to the Inspector that for the past several months, staff have used the specific assistive device for bathing and transferring residents who were not able to use the bath chair. All four PSWs further clarified that they had recent training in the operation of lift equipment but training for use of this specific assistive device was not provided.

In an interview with Educator #110, they reported that staff were required to complete annual training on lifts and transfers, including the use of this specific assistive device.

The Inspector reviewed the content of training that was provided in November 2017, to PSWs #100, #104, #106, and #108. The training content did not include the use of the specific assistive device to bathe and transfer residents.

In interviews with the DOC and manager #101 they both confirmed with the Inspector that the home did not provide training for the safe use of the specific assistive device to bathe and transfer residents. Both the DOC and the manager further explained that the use of the specific assistive device throughout the entire home had been discontinued and all of the devices were removed from the units. [s. 218. 2.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Please refer to WN #1 regarding a description of the incident where resident #001 fell during a staff transfer with the use of a specific assistive device.

In interviews with PSWs #100, #104, #106, and #108, respectively, they confirmed to the Inspector that the staff had been using the specific assistive device to bathe resident #001 in the shower room and used the device to transfer the resident to bed.

A review of resident #001's care plan and kardex, in effect at the time of the incident, did not indicate that this specific assistive device was used for the resident.

Both the Inspector and PSWs #100 and #104, respectively, reviewed the care plan/kardex for resident #001. The PSWs both confirmed to the Inspector that the use of the specific assistive device was not indicated for bathing the resident in their care plan. The PSWs clarified that the use of the specific assistive device was indicated for resident #001 on the unit's bath schedule updated in September 2017.

In an interview with manager #101 they confirmed that resident #001's use of the specific assistive device was not indicated in the resident's care plan/kardex; however, it was indicated on the unit's bath schedule at the time of the incident. The manager further explained that the resident's care plan/kardex was currently updated to use a specific bath chair to safely support the resident in the tub.
[s. 6. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #001's health care record (HCR) indicated that during two staff assisted transfers the resident had fallen and sustained an injury as follows:

-A Critical Incident Report submitted by the home to the Director indicated that on a specific date in December 2017, while PSW #111 and PSW #112 were providing a mechanical lift transfer to resident #001, the resident fell, resulting in an injury. The resident was sent to hospital for further assessment and it was identified that resident #001 sustained a specific injury directly related to their fall.

-A review of resident #001's progress notes on a specific date in November 2017, indicated that during a transfer from a specific assistive device to the bed performed by PSW #100 and PSW #104, the resident flipped out of the device resulting in injury.

A review of resident #001's HCR indicated that a Physiotherapy quarterly assessment was completed in April 2014, which identified that the resident required a mechanical lift. A review of resident #001's HCR determined that there were no further physiotherapy assessments completed for the resident's transfer status over the past three years.

In an interview with RAI Coord #115 and the Physiotherapist (PT) they both confirmed to the Inspector that the last physiotherapy assessment for resident #001 was completed in April 2014, and there were no further assessments completed over the past three years.

A review of the home's policy titled, "Minimal Lift-#HR 7-221", last revised in September 2016, indicated that all residents were to be assessed within 24 hours of admission to determine proper lift/transfer/reposition and the resident's mobility was to be continually

assessed and incorporated into their plan of care. Lifting, transferring or repositioning aids were to be used as indicated in the assessment of the resident.

In an interview with the PT, they reported to the Inspector that they had not received a referral from the nursing staff regarding resident's transfer assessment over the past three years, since April 2014.

In an interview with Manager #101 they reported to the Inspector that the home's process for assessing and documenting the resident's transfer status was the PT assessment. Manager #101 further clarified that if the resident maintained their transfer status of two person mechanical lift then the registered staff would not have referred the resident to the PT for continued assessments as was required in the home's policy. Manager #101 confirmed to the Inspector that according to the home's policy, there was a gap in the home's procedure for the documentation of the resident's transfer status, on a continual basis, in keeping with that policy.

In an interview with the DOC they confirmed to the Inspector that there was a gap in the home's procedure for documenting the continual re-assessment of the resident's transfer status. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home had submitted a Critical Incident (CI) Report to the Director regarding an incident of staff to resident neglect. The CI report indicated that resident #001 sustained an injury directly related to their fall during a transfer provided by staff with a mechanical lift.

A review of resident #001's health care records indicated that the resident was totally dependent on staff for transferring with the use of a mechanical lift.

In interviews with PSWs #100, #104, #106, #108, and #112, respectively, they all confirmed to the Inspector that operation of the mechanical lift, to assist resident #001, required to be operated by two staff members in accordance with the home's policy.

A review of the home's policy entitled "Guidelines for Minimal Lift", indicated that mechanical lifting devices required two caregivers to operate. The lift devices were used for bed to wheelchair transfers. This transfer required two caregivers. One was to be the leader; the other was to be the assistant to ensure proper use of the lift and safety of the resident during the operation of the lift equipment.

A review of the home's investigation notes indicated that PSW #111 provided an unsafe transfer while operating the mechanical lift with resident #001 without a second PSW present.

A review of PSW #111's training records indicated that on a specific date in November 2017, one month prior to the time of the critical incident, they were trained in the Lifts and Transfers Super User training which included instruction and hands on demonstration for the safe operation of mechanical lifts.

In an interview with the DOC they clarified to the Inspector that PSW #111, as a super user, was trained as a mentor to staff to ensure proper operation of lift equipment.

In an interview with PSW #112 they confirmed to the Inspector that they entered resident #001's room at the time of the incident, and witnessed PSW #111 operating the mechanical lift by themselves with resident #001 attached to the lift; and being lifted. PSW #112 further explained that they heard the motor working on the mechanical lift at the time they had walked into the room to assist PSW #111 with the transfer.

In an interview with both the DOC and manager #101, they confirmed to the Inspector that the home's investigation determined that PSW #112 provided an unsafe mechanical lift during a transfer with resident #001 resulting in injury to the resident.

A Compliance Order (CO) #004 was issued in Critical Incident System Inspection #2017_509617_0017 with a compliance date of February 28, 2018, and this finding will serve as grounds to support CO #004. [s. 36.]

Issued on this 15th day of January, 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) :	SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_509617_0023
Log No. / No de registre :	028041-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 5, 2018
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	HOGARTH RIVERVIEW MANOR 300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Judy Plummer

To ST. JOSEPH'S CARE GROUP, 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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the procedure for the safe operation of all lift and transfer device equipment used in the home for the assessed needs of residents, is clearly defined in the home's policy and procedures.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system; that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with applicable requirements under the Act.

In accordance with O. Reg. 79/10, s. 36., every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of resident #001's progress notes and safety incident report both dated on a specific date in November 2017, indicated that during a transfer to bed using a specific assistive device performed by PSW #100 and PSW #104, the resident flipped out of the device onto the floor resulting in an injury.

In interviews with PSWs #100, #104, #106, and #108, respectively, they all confirmed to the Inspector that staff used this specific assistive device for several residents including resident #001 to safely support the residents during

bathing and transferring.

A review of the home's policy entitled "Minimal Lift-HR 7-221", last revised on in September 2016, indicated that the applicable lifting, transferring and repositioning procedures as provided in the Healthy Back Program were to be followed once a plan of care for the resident was established or modified. A review of the Health Back Program entitled, "Guidelines for Minimal Lift", last revised in October 2017, did not indicate a procedure for the use of the specific assistive device used for resident #001 when the incident occurred in November 2017.

In interviews with both the DOC and manager #101, they both confirmed to the Inspector that the procedure for the use of the specific assistive device was not indicated in the home's policy and procedures. They both further explained that the use of these specific assistive devices throughout the home had been discontinued and were removed from further service after the incident occurred.

The decision to issue this Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, although the scope was isolated, the severity of actual harm to the resident who had fallen, was determined. The home has a history of non-compliance in this area of the legislation as follows:

-a Voluntary Plan of Correction (VPC) during the Critical Incident System Inspection #2017_509617_0017 issued on August 14, 2017,
-a VPC during a Resident Quality Inspection #2016_435621_0012 issued on July 7, 2016, and
-a Written Notice (WN) during the Complaint Inspection #2016_264609_0006 issued on February 11, 2016. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 218. For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Order / Ordre :

The licensee shall:

a) ensure all direct care staff who are required to perform resident transfers are trained in the use of all lift and transfer devices,

b) ensure that annual training includes hands on return demonstration, and

c) ensure that the home maintains a record of the dates and content of the training provided, and signed documentation by the staff who successfully complete the training.

Grounds / Motifs :

1. The licensee has failed to ensure that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the additional area of training regarding the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that were relevant to the staff member's responsibilities was provided.

The home had submitted a Critical Incident (CI) Report to the Director regarding an incident that caused an injury to resident #001 for which the resident was

taken to hospital and resulted in a significant change to the resident's health status. The CI report indicated that on a specific date in December 2017, while PSW #111 and PSW #112 were providing a mechanical lift transfer to resident #001, the resident fell, and was injured. After 7.5 hours of monitoring the resident's condition post injury, RN #114 determined that the resident required to be sent to the hospital for further assessment. The hospital report identified that resident #001 sustained a specific injury that was directly related to their fall.

During Inspection of this CI report, the Inspector discovered that seven days prior to this incident, resident #001 had another fall during a staff transfer involving a specific assistive device. Please refer to WN #1 for further details.

In interviews with PSWs #100, #104, #106, and #108, respectively, they all confirmed to the Inspector that for the past several months, staff have used the specific assistive device for bathing and transferring residents who were not able to use the bath chair. All four PSWs further clarified that they had recent training in the operation of lift equipment but training for use of this specific assistive device was not provided.

In an interview with Educator #110, they reported that staff were required to complete annual training on lifts and transfers, including the use of this specific assistive device.

The Inspector reviewed the content of training that was provided in November 2017, to PSWs #100, #104, #106, and #108. The training content did not include the use of the specific assistive device to bathe and transfer residents.

In interviews with the DOC and manager #101 they both confirmed with the Inspector that the home did not provide training for the safe use of the specific assistive device to bathe and transfer residents. Both the DOC and the manager further explained that the use of the specific assistive device throughout the entire home had been discontinued and all of the devices were removed from the units.

The decision to issue this Compliance Order (CO) was based on the home's ongoing non-compliance unrelated to this section of the legislation, although the scope was isolated, the severity of actual harm to to the resident who had fallen as a result of staff neglect, was determined. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 5th day of January, 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 : Sheila Clark

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