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 # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2016	2016_326569_0010	010580-16	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

KENSINGTON VILLAGE
1340 HURON STREET LONDON ON N5V 3R3

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

DONNA TIERNEY (569), INA REYNOLDS (524), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 25, 26, 27, 28, May 2, 3, 4, 5, 6, 2016

Complaint inspections log #030683-15, and #005814-16 were conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Nursing Care (ADNOC), Director of Environmental Services (DES), Resident Assessment Instrument (RAI) Coordinator, the Physiotherapist, the Physiotherapy Assistant (PTA), the Director of Recreation, the Director of Food Services, a Physician, a Laundry Aide, 2 Recreation Aides, 2 Dietary Aides, 8 Registered Nursing staff, 10 Personal Support Workers (PSW), the Family Council Vice-Chair, several family members, and over 40 residents.

The Inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports, and the general maintenance, cleaning, and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Resident Council meeting minutes revealed the following:

-concerns with some residents wandering in and out of other resident rooms identified on August 31, 2015, November 30, 2015, December 28, 2015, and January 25, 2016
-missing clothing concerns identified on December 28, 2015, and January 25, and March 28, 2016
-request for grace to be said before meals identified on January 25, February 29, March 28, and April 25, 2016
-a variety of food related concerns identified on January 25, February 29, and April 25, 2016

There was no documented evidence of a written response from the licensee to these identified concerns.

Interviews with the the Director of Recreation on May 3, 2016, and with an identified resident on May 4, 2016, verified the home had not responded in writing within 10 days of receiving these concerns from Residents' Council.

Interview with the Administrator on May 3, 2016, confirmed the home did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, and that it was the expectation of the licensee to do so. [s. 57. (2)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review on April 28, 2016, of the current plan of care for an identified resident indicated that they required a specific safety intervention to be in place. During an observation on May 2, 2016, of the identified resident, the specific safety intervention was noted not to be in place which was verified by a Personal Support Worker and a registered staff member at the time.

In an interview on May 2, 2016, the Administrator verified the expectation that the care provided to the resident should be as specified in the plan of care. [s. 6. (7)]

2. Record review of the current plan of care for an identified resident under the physiotherapy focus indicated that the resident was to receive a specified intervention.

Record review of the Physiotherapy Attendance Chart for a specified month in 2016, revealed there was no documentation regarding the specified intervention for the resident as identified in the care plan.

In a staff interview with the Physiotherapist Assistant on April 28, 2016, it was shared that they had not provided the specified intervention for the identified resident due to the fact that the required equipment to facilitate the intervention was on order and had not yet arrived at the home.

In an interview with the Physiotherapist on May 2, 2016, they agreed that the care had not been provided to the identified resident as set out in the resident's plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Observation on April 26, 2016, revealed an identified resident had several areas of compromised skin integrity.

Record review on April 28, 2016, of the current care plan and the treatment assessment record (TAR) revealed the identified resident had a specified area of compromised skin integrity since admission. Review of the progress notes revealed no written documentation that the specified area of compromised skin was healed. Further review identified no documented evidence of weekly assessments and treatment as ordered.

In a staff interview on May 2, 2016, with a registered staff member, they verified that weekly assessments for the identified resident were not completed for three weeks because the specified area of compromised skin was healed. They also verified that the care plan was not revised to reflect the change.

Record review on May 2, 2016, of a specific home's policy stated "The resident's plan of care will be reviewed and revised by the interdisciplinary team members within 92 days of the previous assessment, when there is a change in the resident's care needs, when the care set out is no longer necessary, or when the care set out was not effective."

In an interview on May 2, 2016, the Administrator agreed that the home's expectation is the care plan should be reviewed and revised when the residents' care needs change, or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and is reviewed and revised when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 :

1. The licensee failed to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place was complied with.

Observations of eight identified residents' bed systems over the course of the Resident Quality Inspection revealed one and/or both one-quarter side rails were in use.

Review of the home's policy titled "Bed Rails – Application - NS-III-480" last revised January 2011, stated that "a physician order must be obtained and clearly indicate if one or both bed rails are required."

Record review of the current plan of care under the bed mobility focus for the eight residents revealed the daily application of one and/or both one-quarter side rails as an intervention. Record review of the physician orders on PointClickCare (PCC) for these identified residents revealed the absence of a physician order indicating the use of one or both bed rails.

In an interview with the Administrator on May 2, 2016, the Administrator agreed there were no physician orders for the identified residents' bed rails, and that it was the home's expectation that the policy related to bed rails application should have been complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Observation of an identified resident on May 6, 2016 revealed the resident was in a mobility device with a PASD in use. Interview with a Personal Support Worker (PSW) confirmed the observation.

Record review of the identified resident's most recent plan of care on the electronic charting system revealed the absence of goals and interventions related to the use of the mobility device and PASD. Further review of the Kardex showed there were no interventions related to the use of the identified devices in place.

The Resident Assessment Instrument (RAI) Coordinator and a PSW confirmed that the devices were required daily by the resident as a PASD. The RAI Coordinator confirmed the use of the mobility device and the PASD were not included in the resident's plan of care and should have been. [s. 33. (3)]

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 a Personal Assistance Services Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Record review revealed that weekly wound assessments for an identified with a specified area of altered skin integrity were not completed for four weeks in 2016.

Staff interview on May 5, 2016, with a registered staff confirmed that the weekly skin assessments for the identified resident were not completed.

During an interview on May 5, 2016, the Administrator agreed that it is the home's expectation that registered staff complete weekly wound assessments for all residents exhibiting altered skin integrity. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

The licensee failed to ensure that all food and fluids were prepared, stored, and served using methods which preserved nutritive value.

Observation of the dinner meal service on May 3, 2016, on the second floor dining room revealed the following: diced carrots were served using a #12 scoop instead of a #8 scoop (equivalent to receiving a one third cup instead of a one half cup serving) and the herb roast potatoes were served with a tong instead of a measured portion scoop as indicated on the planned menu. This resulted in the nutritive value of the meal to be altered.

A Dietary Aide confirmed that the posted therapeutic menu serving sizes should have been followed. Interview with Director of Food Services on May 4, 2016, confirmed the home's expectation that all food is to be served according to the posted serving sizes to ensure nutritive value was maintained. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are prepared, stored and served using methods which preserve nutritive value, appearance and food quality, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's meal and snack times were reviewed by Residents' Council.

Record review on May 3, 2016, of the minutes from the Residents' Council meetings for the period of January 2015 to April 2016, revealed no documented evidence that snack service times were discussed with the residents.

Staff interview on May 3, 2016, with the Director of Recreation and the Director of Food Services verified that snack times were not discussed with Residents' Council.

Staff interview on May 3, 2016, with the Administrator confirmed the expectation that snack service times are to be reviewed with the Residents' Council. [s. 73. (1) 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 home's meal and snack times are reviewed by Residents' Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible, in the circumstances of a resident who was missing for three hours or more.

Record review of the progress notes for an identified resident indicated that on a specified date, the resident was not seen by staff in the home for more than three hours. A code yellow was initiated and the police were notified by the Registered Nurse on duty. As documented, the resident returned to the home approximately three and a half hours later.

Review of "Missing Resident Search Policy #ADM-RR-II-160" dated March 2011 stated that the "Administrator or Director of Care/Assistant Director of Care will notify POA/responsible party, Board member(s) and Ministry of Health."

In an interview with the Administrator on May 4, 2016, they verified that no Critical Incident was filed to report the missing resident to the Director, and that it was the expectation of the licensee to immediately report when a resident has gone missing for three hours or more. [s. 107. (1) 3.]

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 Director is immediately informed, in as much detail as is possible in the circumstances of a resident who is missing for three hours or more, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning the home, including resident bedrooms and common areas.

Observation of the home during the inspection by Inspectors #525 and #569 revealed numerous dead bugs in the ceiling light fixtures in the first floor hallway, and numerous dead bugs in the ceiling lights in residents rooms on the first and second floor.

This was confirmed by the Director of Environmental Services (DES) on May 5, 2016. The DES further confirmed the expectation that housekeeping aides were to monitor ceiling lights and document on the daily task housekeeping log in order to plan a scheduled cleaning of ceiling lights and this had not occurred. [s. 87. (2) (a)]

Issued on this 24th day of June, 2016

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) :	DONNA TIERNEY (569), INA REYNOLDS (524), NANCY JOHNSON (538)
Inspection No. / No de l'inspection :	2016_326569_0010
Log No. / Registre no:	010580-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 16, 2016
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	KENSINGTON VILLAGE 1340 HURON STREET, LONDON, ON, N5V-3R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Ducharme

To SHARON FARMS & ENTERPRISES LIMITED, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Order / Ordre :

The licensee must achieve compliance by responding in writing to all concerns brought forward by Residents' Council since January 1, 2016, and ongoing within 10 days of receiving future concerns or recommendations from Residents' Council.

Grounds / Motifs :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Resident Council meeting minutes revealed the following:

-concerns with some residents wandering in and out of other resident rooms identified on August 31, 2015, November 30, 2015, December 28, 2015, and January 25, 2016
-missing clothing concerns identified on December 28, 2015, and January 25, and March 28, 2016
-request for grace to be said before meals identified on January 25, February 29, March 28, and April 25, 2016
-a variety of food related concerns identified on January 25, February 29, and April 25, 2016

There was no documented evidence of a written response from the licensee to these identified concerns.

Interviews with the Director of Recreation on May 3, 2016, and with an identified resident on May 4, 2016, verified the home had not responded in writing within 10 days of receiving these concerns from Residents' Council.

Interview with the Administrator on May 3, 2016, confirmed the home did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, and that it was the expectation of the licensee to do so.

The severity is determined to be a level 1 being minimum risk. The scope of this issue is widespread. The home did have a history of non-compliance with this regulation being issued in the home on October 7, 2015, as a Written Notification (WN) inspection #2015_303563_0040, and on May 25, 2015, as a Voluntary Plan of Correction (VPC) inspection #2015_303563_0018.

(538)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 16th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Donna Tierney

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