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 prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2016;	2016_463616_0016 (A1)	011644-16	Resident Quality Inspection

Licensee/Titulaire de permis

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT MANITOUWADGE ON P0T 2C0

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

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT MANITOUWADGE ON P0T 2C0

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

JENNIFER KOSS (616) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendments have been made to the Manitouwadge General Hospital Resident Quality Inspection #2016_463616_0016 Licensee and Orders Reports (attached) related to:

1) dates the inspection was conducted
2) WN#1, CO#001, s. 24 Reporting certain matter to Director
3) WN#7, s. 79 (3), posting copies of the inspection reports from the past two years

Issued on this 27 day of September 2016 (A1)

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

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

JENNIFER KOSS (616) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 30, 31, June 1, and 2, 2016

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), the Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator, Acting Recreation Therapist/Physiotherapy Aide, Maintenance staff, Housekeeping staff (HSK), family members, and residents.

Observations were made of the home areas, and the provision of care and services to residents during the inspection. Many of the home's policies and procedures, and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #617 reviewed resident #005's progress notes. Within the progress notes it was identified that, in March 2016, co-resident #009's safety alarm was sounding and staff had responded to the alarm. According to the documentation, when the staff reached resident #009's room, they found resident #005 leaving the room and resident #009 was on the floor.

A review of the home's Internal Incident Report indicated that resident #005 had pulled resident #009 resulting in resident #009's injury.

Inspector #617 reviewed resident #005's consultation note from an external provider that described the reason for referral being an incident which occurred when resident #005 pulled a resident causing injury.

Inspector #617 interviewed RN #105, the Nurse Manager, and the Chief Nursing

Officer (CNO). They stated that a Critical Incident (CI) had occurred when resident #005 had pulled on resident #009 which resulted in an injury to resident #009.

Inspector #617 reviewed the Ministry of Health Critical Incident System website and was not able to find a CI report submitted by the home for the incident that occurred in March 2016, involving resident #005 causing injury to resident #009.

A review of the home's policy titled, "Abuse Directive-B-1", revised on April 2016, indicated that a person who had reasonable grounds to suspect abuse of a resident by anyone had occurred, that resulted in harm to the resident, must report it immediately to the Charge Nurse who would inform the Director.

Inspector #617 interviewed RN #105, who stated that CIs were documented by the registered nursing staff in the resident's progress notes and on an internal incident report. They stated that the registered nursing staff were responsible to immediately report the incident to the Nurse Manager or CNO, who then reported to the Director. RN #105 confirmed to the Inspector that this CI was documented internally and reported to management immediately.

Inspector #617 interviewed the Nurse Manager and the CNO. They stated that this CI report was not submitted to the Director and should have been. [s. 24. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the pain management program must, at a minimum, provide for the following: monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Resident #007 was identified through the Resident Assessment Instrument Minimum Data Set (RAI MDS) to have had pain.

During Inspector #616's interview with the resident, they stated that they received as needed (prn) analgesic, which was ineffective at times.

The Inspector reviewed the resident's Medication Administration Record (MAR) over a 21 day period related to the administration of prn pain medication. During this period, prn medications were administered 13 times. The effectiveness of the prn medication was not documented on seven of the 13 times that the analgesic was administered.

2. Resident #001 was identified through the RAI MDS to have had pain.

During Inspector #616's interview with the resident, they stated that they received prn analgesic.

The Inspector reviewed the resident's MAR over a 22 day period related to the administration of prn pain medication. During this period, prn medications were

administered twice. The effectiveness of the prn medication was not documented for either dates that the analgesic was administered.

3. Resident #006 was identified through the RAI MDS to have had pain.

During Inspector #616's interview with the resident, they stated that they received prn analgesic.

The Inspector reviewed the resident's MAR related to the administration of prn pain medication. On two occasions, prn medications were administered however, the effectiveness of the prn medication was not documented for either of the dates.

According to the current care plans for resident #007, #001, and #006, staff were to have monitored and recorded the effectiveness of administered prn pain medications.

The home's policy titled "Pain Management", #237, last reviewed April 2016, stated that pain treatments and interventions would be monitored. Further, the policy stated that an individualized plan of care would be determined and implemented.

During interviews with the Nurse Manager and the RAI Coordinator #102, they stated to the Inspector that staff should have documented the effectiveness of prn pain medication in the designated section of the residents' Daily Resident Care Record. [s. 52. (1) 4.]

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 pain management program must, at a minimum, provide for the following: monitoring of residents' responses to, and the effectiveness of, the pain management strategies, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirement for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

Inspector #617 reviewed the home's policy titled, "Abuse-Prevention-B-2", revised on April 2016, identified that staff and volunteers would be educated on types of abuse, recognizing abuse, and reporting abuse.

The training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, were not identified in the policies.

The Inspector interviewed the Nurse Manager who stated that zero tolerance of abuse, mandatory reporting and whistle-blowing training was provided to staff at orientation, when hired and annually thereafter.

The Nurse Manager was unable to provide the Inspector with records of staff training related to abuse.

The Inspector interviewed PSW #107, HSK #108, and HSK #109, who stated that they had not received training in zero tolerance of abuse, and described examples of resident abuse as residents hurting staff. PSW #107 stated to the Inspector that they had only been working in the facility for the last month and had not received training during orientation. [s. 96. (e)]

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 that ensures that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies the training and retraining requirements for all staff, including, training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1.The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During a family interview, it was reported to Inspector #616 that resident #005 had a preference for the frequency of an activity of daily living, and required this care to be provided by staff. In the interview, it was reported that staff did not perform this daily task as per the resident's preference.

The Inspector reviewed the kardex and the care plan related to this activity and found no reference to this activity preference.

The Inspector reviewed the Daily Resident Care Record. On 25 of 31 days in the

first month, and five of seven days in the second month, this activity had not been documented by staff.

During an interview with RPN #101, they stated to the Inspector that this activity was provided to the resident by staff, which staff documented in the resident's flow sheet. However, they stated they were unsure whether this information would be found in the resident's plan of care.

During an interview with the Nurse Manager, they reported to the Inspector that staff documented this activity as an itemized care task in the resident's Daily Resident Care Record. They stated that the plan of care may not have included a specific task such this resident's preference for the activity.

2. Inspector #616 observed resident #005 lying in their bed without the bed rails raised. The "nurse call" button was the communication and response system within the bed rails. In the down position, the button on the bed rail was inaccessible to the resident when they were lying in bed.

During an interview with RPN #101, they stated to the Inspector that this resident was unable to use the call bell, and as per family's request, no bed rails were to be used while the resident was in bed. They added staff do hourly checks when the resident was in bed.

The Inspector reviewed the resident’s current kardex, and the care plan. There was no reference to the resident’s inability to use the call bell, nor the reported hourly checks by staff.

During an interview with the RAI Coordinator #102, they stated to the Inspector that the resident’s plan of care should have included their ability, or inability, to use the call bell, and should have included interventions such as hourly checks by staff. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During an interview with Inspector #616, resident #007 self-reported to have a condition. They stated that they were independent with their own care related to this condition, and that the nursing staff were aware of the condition but did not provide any assistance with this task. They stated the staff did not assess their

condition daily.

The Inspector reviewed the resident's current care plan and an assessment. Both records identified the resident's condition, and that the resident was at high risk related to their assessment. The resident's care plan included an intervention where staff were to assess the resident daily.

During interviews with RPN #101 and RPN #103, they stated to the Inspector that the resident was independent with this specific care and that staff did not perform daily assessments. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During a tour of the home on June 6, 2016, Inspector #617 observed wall damage in the dining room. The circular area of damaged dry wall measured approximately 10 centimetres in diameter with a small hole observed underneath the area. The damaged area was located under the emergency pull call bell above the railing where the sofa was positioned against the wall.

Inspector #617 interviewed Maintenance staff #106, who stated the wall damage in the dining room needed to be repaired and that the maintenance department had not been notified of the damage. They stated that the nursing staff should have notified the department that there was a hole in the wall by submitting a requisition to the department.

Inspector #617 interviewed Ward Clerk #110 who confirmed to the Inspector, after reviewing the online submitted maintenance requests for 2016, that the damaged wall had not been reported to the Maintenance Department for repair. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they convened semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council.

The Chief Nursing Officer (CNO) stated to Inspector #616 there was not currently an active Family Council in the home.

The Inspector reviewed Family Council records with a focus on communication from the home to families of the right to establish a council. The most recent record was minutes from a meeting held on May 26, 2015, and before then on January 23, 2013. There was no record found of any Family Council activity or correspondence in 2014. After the scheduled meeting in May 2015, a meeting was scheduled for July 21, 2015, however there was no record to verify whether this meeting took place. There was no record found of semi-annual meetings to promote the establishment of Family Council since 2013.

During an interview with the CNO, they stated they were unable to provide verification that semi-annual meetings were held to advise families or persons of importance of the right to establish a Family Council. [s. 59. (7) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted.

During a tour of the home on June 6, 2016, Inspector #617 noted three Ministry of Health and Long Term Care (MOHLTC) inspection reports posted on the wall in the dining room. The Inspector identified the following previously issued reports were missing from the posting:

-2015_380593_0017 Resident Quality Inspection
-2014_332575_0013 Complaint Inspection
-2013_246196_0016 Follow Up Inspection

On June 08, 2016, the Inspector interviewed the CNO. They stated that they were responsible to post all issued public inspection reports on the dining room wall. The CNO confirmed to the Inspector that Resident Quality Inspection #2015_380593_0017, Complaint Inspection #2014_332575_0013, and Follow Up Inspection #2013_246196_0016 had been received by the home and were not posted on the dining room wall. [s. 79. (3) (k)]

Issued on this 27 day of September 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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
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Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER KOSS (616) - (A1)

Inspection No. / No de l'inspection : 2016_463616_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011644-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 26, 2016;(A1)

Licensee / Titulaire de permis : MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

LTC Home / Foyer de SLD : MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jocelyn Bourgoin

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To MANITOUWADGE GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 27 day of September 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JENNIFER KOSS - (A1)

Service Area Office /
Bureau régional de services : Sudbury