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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2014	2014_331595_0004	S-232-14, 296-14	Critical Incident System

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0

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

MARINA MOFFATT (595)

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): July 29, 30, 2014 related to Ministry of Health and Long-Term Care logs S-000232-14, S-000296-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Staff, Non-Registered Staff and Residents.

During the course of the inspection, the inspector(s) observed resident care areas, reviewed health care records, employee personnel file, and various policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. A Critical Incident (CI) reported to the Director identified that resident #002 had their legs up in the air kicking while in a chair and resident #001 held an ashtray in the air and then proceeded to hit resident #002 in the forehead. Resident #001 was removed from the situation. The incident resulted in an injury whereby resident #002 was sent to hospital.

Another CI reported to the Director identified that resident #001 was hitting resident #003's wheelchair with their walker from behind. The altercation then led to the residents "fighting with hands in the hallway". Both residents were removed from the area. It was noted that resident #003 sustained injury as a result, however resident #001 did not sustain any injuries.

Inspector #595 reviewed resident #001's health care record. Upon review of resident # 001's kardex, Inspector #595 identified that the kardex did not provide clear direction to staff related to the care of resident #001. In contrast to the kardex, resident #001's care plan identified goals and interventions for care, however Personal Support Worker (PSW) staff do not have access to this care plan.

Inspector #595 interviewed staff members #102 and #107 who both confirmed that PSWs have access to the kardex on the mounted unit computers for resident care information. Both staff members also confirmed that PSWs only use the computers and do not have access to the health care binders or care plans.

Inspector #595 interviewed staff members #101, #102, and #106 who identified a trigger for resident #001 which was not included in resident #001's kardex.

Inspector #595 reviewed the home's policy 'Abuse and Neglect Prevention Program' which identified all of the following:
- That abuse of residents will not be tolerated and requires immediate reporting to the Supervisor or Manager, and that any abusive acts will be documented, reported and monitored by the health care team.
- At the time the Supervisor or Manager is made aware of the alleged abuse, an investigation must be conducted immediately.
- Each resident involved in the alleged abusive act will be assessed for the need for a referral to a specialist or external consultants and counseling services.
- A plan of action to prevent further abuse is to be implemented for the alleged abuser, in addition to a review of the care plan and interventions that deal with aggressive or abusive behaviour, monitoring, updating and adapting as necessary.

- Should interventions not control the disruptive behaviour of the abusive resident, consideration will be given to relocating the resident.

2. Inspector #595 reviewed staff member #109's personnel file. An incident of resident neglect was confirmed by staff member #108 through the home's own investigation. Staff member #109 covered a resident's urine-soaked bed with a clean linen without changing the soiled sheets. Disciplinary action included a one-day suspension. No interventions or procedures were implemented to manage and/or monitor this staff member.

Eight days later another incident of resident neglect was confirmed by the home when staff member #109 provided inadequate care to a resident and did not comply with resident wishes. Disciplinary action included a three-day suspension. No interventions or procedures were implemented to manage and/or monitor this staff member.

A CI reported to the Director identified that resident #004 alleged being treated roughly by staff member #109. Inspector reviewed the progress notes related to resident #004 and the alleged abuse. Staff member #108 informed Inspector that there was only one progress note completed. The note identified that the resident reported that the PSW was rough during care, and that staff member #108 was made aware. That same day, the home confirmed the incident of staff-to-resident physical abuse. It was identified that staff member #109 treated resident #004 roughly during the delivery of care. Disciplinary action included termination the same day.

Inspector #595 reviewed the home's policy 'Abuse and Neglect Prevention Program' which identified that abuse of residents will not be tolerated and requires immediate reporting to the Supervisor or Manager, an investigation shall be commenced immediately with the alleged employee suspended for its duration with pay, and staff who have committed abusive acts will be subject to disciplinary action up to and including dismissal for cause.

Inspector #595 reviewed the home's abuse policy 'Abuse and Neglect Prevention Program'. The policy did not contain procedures and interventions to deal with staff who have abused, neglected or allegedly abused or neglected residents. The policy outlined that "staff members found to have committed abusive acts will be subject to disciplinary action up to and including dismissal for cause" and "the Manager must clearly communicate the possible outcomes (disciplinary action up to and including termination)". Additionally, the policy does not reference the home's policy 'Employee

Discipline' which outlines a formal process for disciplinary action.

Despite the home's progressive disciplinary actions, staff member #109 continued to subject residents to abuse and neglect. Additionally, resident #001 has continued to subject fellow residents to abuse.

The licensee failed to ensure that residents are protected from abuse by anyone and free from neglect by staff in the home. [s. 19. (1)]

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. (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).

Findings/Faits saillants :

1. Inspector #595 reviewed resident #001's health care record. Upon review of resident # 001's kardex, Inspector #595 identified that the kardex did not provide clear direction to staff related to the care of resident #001. In contrast to the kardex, resident #001's care plan identified goals and interventions for care, however Personal Support Workers (PSW) staff do not have access to this care plan.

Inspector #595 interviewed staff members #101, #102, and #106 who identifed a trigger for resident #001 which was not included in resident #001's kardex.

Inspector #595 interviewed staff members #102 and #107 who both confirmed that PSWs have access to the kardex on the mounted unit computers for resident care information. Both staff members also confirmed that PSWs only use the computers and do not have access to the health care binders or care plans.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001 related to the management of responsive behaviours. [s. 6. (1) (c)]

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 written plan of care for resident #001 sets out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #595 reviewed the home's policy 'Abuse and Neglect Prevention Program' related to investigation of alleged abuse. It was identified in the policy that the home's investigation into resident-to-resident abuse must include the following:

- All witnesses must be interviewed and the facts documented;
- A detailed description of the incident is to be documented on the resident's record that clearly describes the incident. The documentation is to outline the physical findings and the care and treatment provided to all involved.

Inspector #595 spoke with staff member #108 and requested the investigation documentation for two CIs both pertaining to resident-to-resident abuse. Inspector received the information and confirmed with staff member that the documentation included everything from both of the investigations of resident-to-resident abuse. The following were provided to Inspector #595:

- Progress note for resident #001 and #003 (which mirrored the statements in the CI report)
- Physical assessments for resident #001 and #003

The information provided to Inspector #595 did not include anything pertaining to the abuse of resident #002. There was no documentation of the facts and witness interviews provided to Inspector #595.

Inspector #595 reviewed the progress notes regarding resident #004 and the physical abuse by staff member #109. Staff member #108 informed Inspector that there was only one progress note completed. The note identified that the resident reported that the PSW was rough during the delivery of care. Administrator and DOC were made aware.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated.[s. 23. (1) (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 every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

1. Inspector #595 reviewed a CI report which identified that staff member #109 was physically abusive towards resident #004. According to the CI, the staff member treated the resident roughly during the delivery of care. The incident occurred and staff member #108 made aware on the same day, however the home did not report the incident to the Director until 13 days later.

Inspector #595 reviewed the home's policy 'Abuse and Neglect Prevention Program' which identified that the home is to immediately notify the Ministry of Health and Long-Term Care (MOHLTC) via Critical Incident Reporting System or via pager once aware of the alleged abuse. It further identifies that the Administrator/Designate is responsible to complete all required reporting to the MOHLTC within legislated time frames.

Inspector #595 asked staff member #108 to comment on the date of the CI and the date the home reported the incident. The staff member confirmed that they did not know the incident was considered a CI and that it needed to be reported, even though they were aware of the incident on the day it occurred.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 person who has reasonable grounds to suspect that any abuse of a resident has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Two CIs reported to the Director identified that resident #001 was physically aggressive towards residents #002 and #003 on two separate occasions. Both resident #002 and #003 sustained injuries as a result of the incidents.

Inspector #595 reviewed resident #001's health care record. Upon review of resident # 001's kardex, Inspector #595 identified that the kardex did not provide clear direction to staff related to the care of resident #001. In contrast to the kardex, resident #001's care plan identified goals and interventions for the care of resident #001, however Personal Support Worker (PSW) staff do not have access to this care plan.

Inspector #595 interviewed staff members #101, #102, and #106 who identified a trigger for resident #001 which was not included in resident #001's kardex.

Inspector #595 interviewed staff members #102 and #107 who both confirmed that PSWs have access to the kardex on the mounted unit computers for resident care information. Both staff members also confirmed that PSWs only use the computers and do not have access to the health care binders or care plans.

The licensee has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours. [s. 53. (4) (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 the behavioural triggers for resident #001 are identified, to be implemented voluntarily.

WN #6: 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. Inspector #595 interviewed staff member #101 and requested the home's most recent policy to promote zero tolerance of abuse.

Inspector #595 reviewed the home's abuse policy 'Abuse and Neglect Prevention Program'. The policy did not contain procedures and interventions to deal with staff who have abused, neglected or allegedly abused or neglected residents. The policy outlined that "staff members found to have committed abusive acts will be subject to disciplinary action up to and including dismissal for cause" and "the Manager must clearly communicate the possible outcomes (disciplinary action up to and including termination)". Additionally, the policy does not reference the home's policy 'Employee Discipline' which outlines a formal process for disciplinary action.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. [s. 96. (b)]

Issued on this 3rd day of October, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARINA MOFFATT (595)
Inspection No. / No de l'inspection :	2014_331595_0004
Log No. / Registre no:	S-232-14, 296-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 3, 2014
Licensee / Titulaire de permis :	WIKWEMIKONG NURSING HOME LIMITED 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	WIKWEMIKONG NURSING HOME 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

To WIKWEMIKONG NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. A Critical Incident (CI) reported to the Director identified that resident #002 had their legs up in the air kicking while in a chair and resident #001 held an ashtray in the air and then proceeded to hit resident #002 in the forehead. Resident #001 was removed from the situation. The incident resulted in an injury whereby resident #002 was sent to hospital.

Another CI reported to the Director identified that resident #001 was hitting resident #003's wheelchair with their walker from behind. The altercation then led to the residents "fighting with hands in the hallway". Both residents were removed from the area. It was noted that resident #003 sustained injury as a result, however resident #001 did not sustain any injuries.

Inspector #595 reviewed resident #001's health care record. Upon review of resident # 001's kardex, Inspector #595 identified that the kardex did not provide clear direction to staff related to the care of resident #001. In contrast to the kardex, resident #001's care plan identified goals and interventions for care, however Personal Support Worker (PSW) staff do not have access to this care plan.

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plans.

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- That abuse of residents will not be tolerated and requires immediate reporting to the Supervisor or Manager, and that any abusive acts will be documented, reported and monitored by the health care team.
- At the time the Supervisor or Manager is made aware of the alleged abuse, an investigation must be conducted immediately.
- Each resident involved in the alleged abusive act will be assessed for the need for a referral to a specialist or external consultants and counseling services.
- A plan of action to prevent further abuse is to be implemented for the alleged abuser, in addition to a review of the care plan and interventions that deal with aggressive or abusive behaviour, monitoring, updating and adapting as necessary.
- Should interventions not control the disruptive behaviour of the abusive resident, consideration will be given to relocating the resident.

2. Inspector #595 reviewed staff member #109's personnel file. An incident of resident neglect was confirmed by staff member #108 through the home's own investigation. Staff member #109 covered a resident's urine-soaked bed with a clean linen without changing the soiled sheets. Disciplinary action included a one-day suspension. No interventions or procedures were implemented to manage and/or monitor this staff member.

Eight days later another incident of resident neglect was confirmed by the home when staff member #109 provided inadequate care to a resident and did not comply with resident wishes. Disciplinary action included a three-day suspension. No interventions or procedures were implemented to manage and/or monitor this staff member.

A CI reported to the Director identified that resident #004 alleged being treated roughly by staff member #109. Inspector reviewed the progress notes related to resident #004 and the alleged abuse. Staff member #108 informed Inspector that there was only one progress note completed. The note identified that the resident reported that the PSW was rough during care, and that staff member

#108 was made aware. That same day, the home confirmed the incident of staff-to-resident physical abuse. It was identified that staff member #109 treated resident #004 roughly during the delivery of care. Disciplinary action included termination the same day.

Inspector #595 reviewed the home's policy 'Abuse and Neglect Prevention Program' which identified that abuse of residents will not be tolerated and requires immediate reporting to the Supervisor or Manager, an investigation shall be commenced immediately with the alleged employee suspended for its duration with pay, and staff who have committed abusive acts will be subject to disciplinary action up to and including dismissal for cause.

Inspector #595 reviewed the home's abuse policy 'Abuse and Neglect Prevention Program'. The policy did not contain procedures and interventions to deal with staff who have abused, neglected or allegedly abused or neglected residents. The policy outlined that "staff members found to have committed abusive acts will be subject to disciplinary action up to and including dismissal for cause" and "the Manager must clearly communicate the possible outcomes (disciplinary action up to and including termination)". Additionally, the policy does not reference the home's policy 'Employee Discipline' which outlines a formal process for disciplinary action.

Despite the home's progressive disciplinary actions, staff member #109 continued to subject residents to abuse and neglect. Additionally, resident #001 has continued to subject fellow residents to abuse.

The licensee failed to ensure that residents are protected from abuse by anyone and free from neglect by staff in the home. [s. 19. (1)] (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 3rd day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Marina Moffatt

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