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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jun 18, 2015;	2015_281542_0010 (A1)	011576-15	Other

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

JENNIFER LAURICELLA (542) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

In Order #002, the second finding was removed.

Issued on this 18 day of June 2015 (A1)

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

Original report signed by the inspector.

Ontario

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860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

JENNIFER LAURICELLA (542) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): May 30 and 31, June 1 and 5, 2015

Service Area Office Initiated Inspection

During the course of the inspection, the inspector(s) spoke with the Administrator, the Long Term Care Nursing Consultant, Registered Staff, Personal Support Workers and Residents.

Ad-hoc notes were used during this inspection.

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

- **2 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements are met with respect to the restraining of resident #006 by a physical device; 1. staff apply the physical device in accordance with any manufacturer's instructions. 2. The physical device is well maintained. 3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions.

Inspector #542 observed resident #006 in a wheel chair with an alarm seat belt device. The alarm seat belt was observed to be approximately 6-8" too loose, making it ill-fitting for this resident. The device was not secured to the wheel chair itself, instead it was wrapped around the chair and the resident. Two pieces of the alarm seat belt were tied together with a medical fabric bandage. Inspector #542 immediately retrieved the Nursing Consultant who removed the seat belt device as she agreed that it posed a risk for entrapment to the resident. The Nursing Consultant then informed the Administrator/Director of Care who also agreed with the potential risk to the resident. Both staff members agreed that this was a safety risk for resident #006 and that it should have been secured to the chair itself, not tied together and it should have properly fit the resident. [s. 110. (1)]

2. The licensee failed to ensure that where a resident is being restrained by a physical device that the resident is monitored at least every hour, released and repositioned from the physical device at least every two hours and that the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a registered nursing staff at least every eight hours.

A health care record review was completed for resident #005 on June 5, 2015, by Inspector #542. The care plan that was accessible to the direct care staff revealed that resident #005 was to have a seat belt when up in their wheel chair and that the PSW staff were to document on the restraint record. Inspector #542 observed resident #005 in their wheel chair with the seat belt secured throughout the day. Inspector reviewed the document "restraint monitoring record" for June, 2015, and noted that there was no documentation for four day shifts to indicate that the restraint was checked, removed or that resident #005 was repositioned. There was also no documentation to indicate that the registered staff were reassessing the effectiveness of the restraint every eight hours during the same four days. Inspector #542 spoke with S#100 who stated that the Personal Support Workers and the Registered Staff are to use this documentation record to document that the restrained resident has been assessed. [s. 110. (2)]

Additional Required Actions:

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

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 when a resident is being restrained by a physical device that the resident is monitored at least every hour, released and repositioned from the physical device at least every two hours and that the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a registered nursing staff at least every eight hours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004's 24-hour admission care plan identified any risks to themselves or others, including any potential behavioural triggers and safety measures to mitigate those risks.

Inspector completed a health care record review for resident #004. Resident #004 had several noted medical diagnosis. The records indicated resident #004 had multiple admissions to other facilities related to their numerous medical diagnosis. The admission records indicated that resident #004 was assessed by Senior's Mental Health (SMH) in 2014, prior to admission to the Long-Term Care home. This report identified numerous recommendations to decrease resident #004's behaviours.

Inspector #542 reviewed the resident's most current care plan that was accessible to the direct care staff and noted that none of the recommendations where indicated on the care plan.

Inspector #542 spoke with S#103 who stated that the resident doesn't participate in anything, spends time in their room.

Inspector #542 reviewed resident #004's progress notes and noted that in June 2015, the resident eloped from the long term care home. [s. 24. (2)]

2. The licensee failed to ensure that the care set out in the care plan is provided to resident #003 as specified in the plan.

On June 5, 2015, Inspector #542 completed a health care record review for resident #003. The resident was admitted to the home in May, 2015. The discharge orders from the hospital indicated that resident #003 was to have two specific nursing assessments completed weekly and a wound dressing checked every shift. This inspector was unable to locate any documentation to support that the nursing assessments were completed or that the wound dressing was being assessed every shift. The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) did not contain either of the above orders. Inspector #542 spoke with the Administrator and S#100 who confirmed that there was no documentation and that the physician's orders should have been carried to the MAR/TAR. S#101 provided this inspector with a weight record for all of the resident's that the home has completed weights on and resident #003 was not on this document as being completed. [s. 24. (6)]

3. On May 30th, 2015, Inspector #542 completed a health care record review for resident #001. Resident #001 was admitted to the home in May, 2015, with a physician's order indicating that specific wound dressings were to be completed daily on two different sites for resident #001. Inspector #542 reviewed the Medication and Treatment Administration Record for May for this resident and noted that there was no documentation over a period of three days indicating that the wound dressings were completed. Inspector #542 spoke with S#102 who indicated that the registered staff document completed medications and treatments on the Medication and Treatment Record once completed. S#102 also stated that the registered staff will also document their assessment of wounds in the nursing progress notes.
[s. 24. (6)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

Issued on this 18 day of June 2015 (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

Health System Accountability and Performance Division
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER LAURICELLA (542) - (A1)

Inspection No. / No de l'inspection : 2015_281542_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011576-15 (A1)

Type of Inspection / Genre d'inspection: Other

Report Date(s) / Date(s) du Rapport : Jun 18, 2015;(A1)

Licensee / Titulaire de permis :
AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET, SUDBURY, ON, P3C-1T6

LTC Home / Foyer de SLD :
CEDARWOOD LODGE
860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Susan Silver

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To AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that the following requirements are met for resident #006 and all other residents with respect to the restraining of a resident by a physical device;

1. staff apply the physical device in accordance with any manufacturer's instructions
2. the physical device is well maintained.
3. the physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions.

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

Grounds / Motifs :

1. The licensee failed to ensure that the following requirements are met with respect to the restraining of resident #006 by a physical device; 1. staff apply the physical device in accordance with any manufacturer's instructions. 2. The physical device is well maintained. 3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions.

Inspector #542 observed resident #006 in a wheel chair with an alarm seat belt device. The alarm seat belt was observed to be approximately 6-8" too loose, making it ill-fitting for this resident. The device was not secured to the wheel chair itself, instead it was wrapped around the chair and the resident. Two pieces of the alarm seat belt were tied together with a medical fabric bandage. Inspector #542 immediately retrieved the Nursing Consultant who removed the seat belt device as she agreed that it posed a risk for entrapment to the resident. The Nursing Consultant then informed the Administrator/Director of Care who also agreed with the potential risk to the resident. Both staff members agreed that this was a safety risk for resident #006 and that it should have been secured to the chair itself, not tied together and it should have properly fit the resident. (542)

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

Jun 23, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

O. Reg. 79/10, s. 24 (2).

Order / Ordre :

The licensee shall ensure that all 24-hour care plans identify any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Grounds / Motifs :

1. Inspector completed a health care record review for resident #004. Resident #004 had several noted medical diagnosis. The records indicated resident #004 had multiple admissions to other facilities related to their numerous medical diagnosis. The admission records indicated that resident #004 was assessed by Senior's Mental Health (SMH) in 2014, prior to admission to the Long-Term Care home. This report identified numerous recommendations to decrease resident #004's behaviours.

Inspector #542 reviewed the resident's most current care plan that was accessible to the direct care staff and noted that none of the recommendations where indicated on the care plan.

Inspector #542 spoke with S#103 who stated that the resident doesn't participate in anything, spends time in their room.

Inspector #542 reviewed resident #004's progress notes and noted that in June 2015, the resident eloped from the long term care home. (542)

(A1)
Ground #2 has been removed.

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

Jun 23, 2015

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Order / Ordre :

The licensee shall ensure that the care set out in the care plan, is provided to the resident as specified in the plan. The licensee shall ensure that resident #001 receives the specified wound interventions as indicated by the physician's orders and that resident #003's medical interventions are completed also as ordered by the physician.

Ontario

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

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to resident #001 and #003.

On May 30th, 2015, Inspector #542 completed a health care record review for resident #001. Resident #001 was admitted to the home in May, 2015, with a physician's order indicating that specific wound dressings were to be completed daily on two different sites for resident #001. Inspector #542 reviewed the Medication and Treatment Administration Record for May for this resident and noted that there was no documentation over a period of three days indicating that the wound dressings were completed. Inspector #542 spoke with S#102 who indicated that the registered staff document completed medications and treatments on the Medication and Treatment Record once completed. S#102 also stated that the registered staff will also document their assessment of wounds in the nursing progress notes.

On June 5, 2015, Inspector #542 completed a health care record review for resident #003. The resident was admitted to the home in May, 2015. The discharge orders from the hospital indicated that resident #003 was to have two specific nursing assessments completed weekly and a wound dressing checked every shift. This inspector was unable to locate any documentation to support that the nursing assessments were completed or that the wound dressing was being assessed every shift. The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) did not contain either of the above orders. Inspector #542 spoke with the Administrator and S#100 who confirmed that there was no documentation and that the physician's orders should have been carried to the MAR/TAR. S#101 provided this inspector with a weight record for all of the resident's that the home has completed weights on and resident #003 was not on this document as being completed. (542)

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

Jun 23, 2015

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

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

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
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
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
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
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 18 day of June 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

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

Service Area Office /
Bureau régional de services : Sudbury