Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2017	2017_509617_0020	023413-17	Complaint

Licensee/Titulaire de permis

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

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

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

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

SHEILA CLARK (617) Ryan Goodmurphy (638) - (A1)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 5-6, 2017.

This Complaint Inspection was conducted as a result of a complaint related to inappropriate restraining of residents, and detailed in the related Critical Incident System report #2923-000104-17, that were submitted to the Director.

The Inspector conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, various staffing schedules, observed resident common areas, and observed the delivery of resident care and services, including staff to resident interactions.

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

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no device provided for in the regulations was used on resident #001, to assist the resident with a routine activity of living, if the device would have had the effect of limiting or inhibiting the resident's freedom of movement.

In accordance with O. Reg. 79/10, s. 112, for the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the the following devices are not used in the home:
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Inspector reviewed a complaint received by the Director on October 5, 2017, reporting that the home was using two types of inappropriate restraint devices for residents.

On October 6, 2017, in an interview with the complainant (an advocate for PSW #100) they reported that PSW #100 was wrongfully dismissed from the home for applying inappropriate restraints. The complainant further explained that all staff practiced the application of different kinds of inappropriate restraints to the residents because there weren't enough staff to monitor their safety.

The home submitted Critical Incident (CI) report to the Director on a particular date in September 2017, regarding an incident of staff to resident abuse. The CI report indicated that on a particular day in September 2017, resident #001 was found by PSW #105 and PSW #106 with an inappropriate restraint which caused an injury to the resident.

In interviews with PSW #105 and PSW #106 respectively, they confirmed to Inspector #617 that at the beginning of their day shift on a particular date in September 2017, they described how they had found resident #001 restrained with an inappropriate device which had prevented resident #001 from changing their position in their bed and as the resident attempted to turn over, caused an injury. PSW#106 further described that resident #001 had been positioned for a prolonged period of time which resulted in parts of their body being affected and their clothes, brief, and bedding were saturated in urine.

A review of the home's investigation notes regarding the critical incident identified that PSW #100 was responsible for providing resident #001 with a prohibitive restraint that caused injury to resident #001. The home's investigation concluded that PSW #100 did not follow the home's policies in accordance with Least Restraints, acted alone and were not remorseful for their actions.

In an interview with PSW #100, they confirmed to the Inspector that they had provided the prohibitive restraint to resident #001 on their night shift on a particular date in September 2017. PSW #100 further described another type of restraint device they had used to prevent resident #001 from falling out of bed. PSW #100 confirmed to the Inspector that these interventions did not comply with the home's restraint policy nor were they indicated in the resident's plan of care.

PSW #100 stated to the Inspector in the same interview that both of the prohibitive restraint devices they had used for resident #001, were common practices of the staff on a specific unit withing the home, and that the practice had been going on for the last year. PSW #100 was not able to identify the names of staff members who also performed these common practices in the interview with the Inspector.

A review of the home's policy titled, "Least Restraint Use-#LTC 3-100", last revised January 2017, indicated that the use of sheets, wraps, tensors or other types of strips or bandages as a physical restraint device and any device that could not be immediately released by staff were prohibited.

A review of resident #001's health care record did not indicate the use of these two prohibitive restraint devices related to their continence care and falls prevention.

Interviews with PSW #103, PSW #105, PSW #104, and PSW #106, all confirmed to the Inspector that they had never used the prohibitive restraint device for resident #001 or any other resident that prevented the resident from freely moving in bed,as this type of device was not part of their care plan and did not follow the home's restraint policy.

During the interviews with PSWs #103, #105, #104 and #106, they confirmed to the Inspector that over the last six months they had placed and/or witnessed a prohibitive restraint device used to prevent resident #001 from falling out of bed. PSW #103, #105 and #106 further clarified to the Inspector that they were familiar with resident #001's care plan; they confirmed that the use of this prohibitive restraint device did not follow the home's restraint policy.

The Inspector interviewed CM #102 who confirmed that the home's investigation in relation to the reported critical incident did conclude that PSW #100 provided a prohibited restraint device to resident #001 that prevented the resident from freely moving in their bed.

In that same interview with CM #102, they confirmed to the Inspector that staff on the specific home unit including PSW #100 were providing a prohibited restraint device to resident #001's bed to prevent them from falling out of bed. CM #102 further clarified that this prohibited restraint was applied only to resident #001 and that since the investigation when this information was brought forward, its use had been discontinued. [s. 35. (a)]

Additional Required Actions: (A1) The following order(s) have been amended: CO #001

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for residents #003, #004, and #005 were provided to the residents as specified in the plan.

Inspector reviewed a complaint received by the Director on a particular date in October 2017, reporting that the home was using inappropriate bed restraints for certain residents.

In an interview with the complainant (an advocate for PSW #100) they reported that PSW #100 was wrongfully dismissed from the home for applying inappropriate restraints to residents. The complainant further explained that all staff practiced and continued to practice the application of inappropriate restraint devices to residents because there wasn't enough staff to monitor their safety.

In an interview with PSW #100, they confirmed to the Inspector that it was common practice amongst the staff on unit four south to provide a particular incontinent intervention to certain residents. PSW #100 confirmed to the Inspector that they had provided this intervention to three residents (#003, #004, and #005) on the night shift on

a particular date in September 2017. PSW #100 confirmed to the Inspector that this intervention was not part of resident #001's, #003's, #004's or #005's care plan. PSW #100 was not able to disclose the names of the staff who had practiced this type of intervention.

A review of resident #003's current care plan, indicated particular incontinent interventions specific to that resident. The resident's care plan did not indicate the intervention described and provided by PSW #100.

A review of resident #004's current care plan, indicated particular incontinent interventions specific to that resident. The resident's care plan indicated that they were resistive to care and did not indicate the intervention described and provided by PSW #100.

A review of resident #005's current care plan, indicated particular continent interventions specific to that resident. The resident's care plan indicated that they were resistive to care and did not indicate the intervention described and provided by PSW #100.

During an interview with PSW #104, they confirmed to the inspector that while working on a specific unit within the home, over the past year, they had witnessed on several occasions the particular incontinent interventions described by PSW #100. PSW #104 further clarified that this was a common practice amongst the staff on this unit; however, they themselves did not participate in the practice because it was not part of the residents care plan or the policy of the home. During this interview PSW #104 was not able to identify to the Inspector the names of the staff and residents involved with this practice.

In an interview with CM #102, they reported to the Inspector that they were aware that staff had been providing this particular incontinent interventions to certain residents on the specific home unit. CM #102 further clarified with the Inspector that staff had continued to provide this practice to certain residents; however, staff did not follow the residents' care plan in providing this intervention.

A Compliance Order (CO) #001 was issued in Complaint Inspection #2017_509617_0018 with a compliance date of December 1, 2017, and this finding will serve as grounds to support CO #001. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for residents #003, #004, and #005 is provided to the residents as specified in the plan with regards to their incontinence care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure without in any way restricting the generality of the duty provided for in section 19, that the home's written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

In accordance with the Long Term Care Homes Act, 2007, c. 8, s. 20 (1), without any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home submitted Critical Incident (CI) report to the Director on a particular date in September 2017, regarding an incident of staff to resident abuse. The CI report indicated that on that particular date in September 2017, resident #001 was found by PSW #105 and PSW #106 with an inappropriate restraint device applied which caused an injury.

On October 5, and 6, 2017, in interviews with PSW #105 and PSW #106 respectively, they confirmed to Inspector #617 that at the beginning of their day shift on that particular date in September 2017, they found resident #001 with an inappropriate restraint device

and described how this device prevented resident #001 from changing their position in their bed and as the resident attempted to turn over, the device caused injury. PSW #106 further described that resident #001 was positioned for a prolonged period of time which affected parts of their body, their clothes, brief, and bedding were saturated in urine, and the resident had a look of fear on their face.

In accordance with the Long Term Care Homes Act, 2017, O. Reg. 79/10, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain, and emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that is performed by anyone other than a resident.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents-#LTC 5-50" last revised February 2016, identified the use of physical force by anyone other than a resident that caused physical injury or pain was defined as physical abuse, and any threatening, insulting or humiliating gestures, actions, behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident was defined as emotional abuse. Residents living in the home had the right to be treated with courtesy and respect and in a way that fully recognized the resident's dignity and individuality and were to be free from emotional and physical abuse. All employees were expected to protect the rights of each and every resident entrusted in their care.

A review of the home's policy titled, "Least Restraint Use-#LTC 3-100", last revised January 2017, indicated that the use of sheets, wraps, tensors or other types of strips or bandages as a physical restraint device was prohibited. Any use of a prohibited physical restraint, restraining for staff convenience or as a method of discipline, was considered a form of resident abuse.

A review of the home's investigation notes regarding the critical incident identified that PSW #100 was responsible for providing resident #001 with a prohibitive restraint device that caused an injury. The home's investigation concluded that PSW #100 abused resident #001 by providing a prohibitive restraint device. The investigation determined that PSW #100 did not follow the home's policy in accordance with Zero Tolerance of Abuse.

On October 6, 2017, in an interview with PSW #100, they confirmed to the Inspector that

they had provided the prohibitive restraint device to resident #001 on their night shift on a particular date in September 2017. PSW #100 clarified to the Inspector that at a certain time during their shift they had checked on the resident, provided incontinence care and left the resident in the same position, restrained for the rest of their shift.

Both the review of the home's investigation notes and the interviews with PSWs #100, #105 and #106 identified that resident #001 was left in the same position for a total of 4.5 hours. During the 4.5 hours, the inappropriate restraint device forced resident #001 to remain in the same position which caused anxiety and physical injury.

During the interviews with PSW #103, PSW #105, PSW #104 and PSW #106, they all confirmed to the Inspector that they had never used this particular inappropriate restraint device for resident #001 or any other resident which prevented them from moving as it was not following the home's policy and was considered a form of abuse.

The Inspector interviewed CM #102 who confirmed that the home's investigation in relation to the reported critical incident did conclude that PSW #100 provided a prohibited restraint device to resident #001, that their actions were abusive, and they did not follow the home's Zero Tolerance of Abuse policy. [s.20. (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 without in any way restricting the generality of the duty provided for in section 19, that the home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

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

[redacted] Issued on this 27 day of Dec. 2017 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHEILA CLARK (617) Ryan Goodmurphy (638) – (A1)
Inspection No. / No de l'inspection :	2017_509617_0020 2017_509617_0020 (A1)
Log No. / No de registre :	023413-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 14, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	HOGARTH RIVERVIEW MANOR 300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lina Johnson

To ST. JOSEPH'S CARE GROUP, 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. 35. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Order / Ordre :

A) The home shall refrain from the use of the following prohibited restraint devices for resident #001 and all other residents in the home to achieve compliance with the requirements under O. Reg. 79/10, s. 112:

6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

B) Provide training to all registered and direct care staff regarding the home's written policy "Least Restraint Use-#LTC 3-100" and the use of prohibited physical restraint devices. The home is to keep a record of who provided the training, the content and dates of the training and the names of the attendees.

C) Implement a process to ensure that prohibitive restraints are not used for any resident in the home in accordance with the LTCH Act, and ensure that there is a mechanism to audit the process and its efficacy.

Grounds / Motifs :

1. The licensee has failed to ensure that no device provided for in the regulations was used on resident #001, to assist the resident with a routine activity of living, if the device would have had the effect of limiting or inhibiting the resident's freedom of movement.

In accordance with O. Reg. 79/10, s. 112, for the purposes of section 35 of the

Act, every licensee of a long-term care home shall ensure that the the following devices are not used in the home:
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Inspector reviewed a complaint received by the Director on October 5, 2017, reporting that the home was using two types of inappropriate restraint devices for residents.

On October 6, 2017, in an interview with the complainant (an advocate for PSW #100) they reported that PSW #100 was wrongfully dismissed from the home for applying inappropriate restraints. The complainant further explained that all staff practiced the application of different kinds of inappropriate restraints to the residents because there weren't enough staff to monitor their safety.

The home submitted Critical Incident (CI) report to the Director on a particular date in September 2017, regarding an incident of staff to resident abuse. The CI report indicated that on a particular day in September 2017, resident #001 was found by PSW #105 and PSW #106 with an inappropriate restraint which caused an injury to the resident.

In interviews with PSW #105 and PSW #106 respectively, they confirmed to Inspector #617 that at the beginning of their day shift on a particular date in September 2017, they described how they had found resident #001 restrained with an inappropriate device which had prevented resident #001 from changing their position in their bed and as the resident attempted to turn over, caused an injury. PSW #106 further described that resident #001 had been positioned for a prolonged period of time which resulted in parts of their body being affected and their clothes, brief, and bedding were saturated in urine.

A review of the home's investigation notes regarding the critical incident identified that PSW #100 was responsible for providing resident #001 with a prohibitive restraint that caused injury to resident #001. The home's investigation concluded that PSW #100 did not follow the home's policies in accordance with Least Restraints, acted alone and were not remorseful for their actions.

In an interview with PSW #100, they confirmed to the Inspector that they had provided the prohibitive restraint to resident #001 on their night shift on a

particular date in September 2017. PSW #100 further described another type of restraint device they had used to prevent resident #001 from falling out of bed. PSW #100 confirmed to the Inspector that these interventions did not comply with the home's restraint policy nor were they indicated in the resident's plan of care.

PSW #100 stated to the Inspector in the same interview that both of the prohibitive restraint devices they had used for resident #001, were common practices of the staff on a specific unit withing the home, and that the practice had been going on for the last year. PSW #100 was not able to identify the names of staff members who also performed these common practices in the interview with the Inspector.

A review of the home's policy titled, "Least Restraint Use-#LTC 3-100", last revised January 2017, indicated that the use of sheets, wraps, tensors or other types of strips or bandages as a physical restraint device and any device that could not be immediately released by staff were prohibited.

A review of resident #001's health care record did not indicate the use of these two prohibitive restraint devices related to their continence care and falls prevention.

Interviews with PSW #103, PSW #105, PSW #104, and PSW #106, all confirmed to the Inspector that they had never used the prohibitive restraint device for resident #001 or any other resident that prevented the resident from freely moving in bed,as this type of device was not part of their care plan and did not follow the home's restraint policy.

During the interviews with PSWs #103, #105, #104 and #106, they confirmed to the Inspector that over the last six months they had placed and/or witnessed a prohibitive restraint device used to prevent resident #001 from falling out of bed. PSW #103, #105 and #106 further clarified to the Inspector that they were familiar with resident #001's care plan; they confirmed that the use of this prohibitive restraint device did not follow the home's restraint policy.

The Inspector interviewed CM #102 who confirmed that the home's investigation in relation to the reported critical incident did conclude that PSW #100 provided a prohibited restraint device to resident #001 that prevented the resident from freely moving in their bed.

In that same interview with CM #102, they confirmed to the Inspector that staff on the specific home unit including PSW #100 were providing a prohibited restraint device to resident #001's bed to prevent them from falling out of bed. CM #102 further clarified that this prohibited restraint was applied only to resident #001 and that since the investigation when this information was brought forward, its use had been discontinued

The decision to issue this Compliance Order (CO) was based on the home's ongoing non-compliance unrelated to this section of the legislation, although the scope was isolated, the severity of harm to residents who had been unlawfully restrained, was determined. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : [redacted] Dec 28, 2017
feb. 28, 2018 (A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : [redacted] Ryan Goodmurphy – (A1)

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