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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 21, 2014 | 2014_293554_0032 | O-000785-14 | Complaint |

### Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

LAKEVIEW MANOR
133 Main Street P.O. Box 514 Beaverton ON L0K 1A0

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

KELLY BURNS (554)

### 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): September 02, through to September 05, 2014**

**Inspection report relates to Log(s): #O-000826-14 and #O-000785-14**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Resident Care Manager(s), Manager of Nursing Practice, Social Worker, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Resident and Family**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

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

**Findings/Faits saillants :**

1. Related to Log #O-000785-14, for Resident #01:

The licensee failed to comply with s. 6 (1), by ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, relating to sharing of personal health information.

Family Member(s) #100 and #101 indicated a care conference was held on a specific date, in which the Director of Care, Registered Nursing Staff, Social Worker and Physician were present; Resident #01 gave permission during this conference, for family members (#100 and #101) to receive health care information. Family indicated that despite resident giving permission, no health information has been shared with the family.

Progress notes dated on a specific date confirm that Resident #01 granted permission for information sharing with specific family members; notes indicated that permission was received by Director of Care, Registered Nurse, Social Worker and Physician who were

present at the care conference held on the above date.

A review of the written care plan, failed to provide any supporting evidence specific to planned care, goals of care or clear direction to staff surrounding communicating with identified Family #100 or #101 as indicated by Resident #01 wishes.

Resident #01, during an interview, confirmed giving permission to the management team to share health information with family.

The Director of Care and Administrator, both agreed that representatives of the home would meet with Resident #01 and Family #101 to develop a communication plan, which would be included in the written plan of care, to enable information sharing with designated family member on a go forward basis. [s. 6. (1)]

2. Related to Log #O-000785-14, for Resident #01:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, related to safety concerns.

Admission interview notes, written by a Registered Nurse indicated resident is to have specific interventions in place to ensure safety. According to the family of Resident #01, the home was notified on admission that resident will engage in unsafe practices if not monitored.

The Director of Care indicated that Resident #01 has been caught performing unsafe practices despite knowing of the home's policy and despite being spoken to on more than one occasion. Director of Care indicated ongoing concern as to the safety of not only Resident #01 but other residents when resident was not abiding by the homes policy.

The written care plan indicates Resident #01 has a history of unsafe practices. The goal of care is resident safety. The plan of care included specific interventions to ensure safety.

Physicians Medication Review, for a specific time directs that resident's safety is to be monitored and documented on the required form.

Documentation on the above form failed to provide supporting evidence that staff were consistently completing the required documentation and or following interventions as described in the plan of care specific to the safety concern.

RN #114, who is a charge nurse within the home, communicated that resident, has specific interventions in place to ensure resident's safety; interventions listed are to be followed. Staff indicated that despite interventions in place resident has been observed engaging in unsafe practices on several occasions.

Staff #112, also a registered nurse in a charge role, indicated not following the safety interventions listed in the plan of care, as resident was not considered at risk to self or others; this is contrary to the care plan.

Director of Care confirmed that Resident #01 is expected to follow the planned care to ensure safety. DOC indicated that if the plan of care indicated assessments were to be completed quarterly then such would be an expectation. DOC further indicated that staff are to be monitoring resident's unsafe practices as resident poses a safety risk to self and others.

The home's policy, #ADM-01-03-37, directs that resident specific supplies are to be stored in a designated locked area for resident's deemed at risk. [s. 6. (7)]

3. Related to Log #O-000826-14, for Resident #02:

The licensee failed to comply with LTCHA, 2007, s. 6 (10) (b), by ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary related to falls risk.

A Critical Incident Report was submitted by the home on a specific date, relating to an injuring requiring transfer to hospital, after Resident #02 sustained a fall.

Progress notes, written by registered nursing staff, detail Resident #02 suffering a falls incident on a specific date. Resident #02 sustained injuries as a result of the fall and was subsequently transferred to the hospital.

Resident was discharged, from hospital three days later and was re-admitted to the home. Progress notes indicate Resident #02's health declined after return from hospital.

The written care plan, in place at that time, indicated the following care needs for Resident #02:
Dressing:
- staff to dress each morning and undress at bedtime

Eating:
- limited assistance; one person to provide oversight and supervision, encouragement, cueing or task segmentation throughout the meal
- Sits in the dining room with co-residents

Toileting:
- resident will toilet self; staff to check and ensure resident is clean and dry; provide assistance as required. Toilet routinely upon rising, before and after meals, bedtime and as needed.

Transferring:
- limited assistance. Use of sit to stand lift or other lift as needed

Daily Cleaning of Teeth:
- total assistance of one staff

Bowel and Bladder Incontinence:
- frequently incontinent

Mobility:
-independent walking in corridors

Rest and Sleep:
- sleeps in occasionally; naps in armchair of choice. Settles around a specific time or when tired

Staff #111 indicated resident's care needs changed significantly upon return to the home; Staff commented that Resident #02 required the following care, post admission:
- total dependence for all aspects of care; two to three staff were required for all activities of daily living
- was no longer toileted; had a catheter and was totally incontinent of bowel functions
- was unable to eat due to injuries; refused food, would occasionally take sips of fluids

initially on return from hospital but then refused
- staff were unable to perform mouth care due to resident's resistance; staff indicated resident seemed to have a lot of discomfort
- was no longer walking
- was on bed rest upon return from hospital; resident was not transferred from bed; was totally dependent on two to three staff for repositioning when in bed

The written care plan for Resident #02 failed to reflect the care needs of this resident post fall, specific to eating, dressing, toileting and or catheter use, mouth care, mobility and sleep/wake patterns.

Resident Care Coordinator (#104) indicated Resident #02's plan of care should have been reviewed and revised following resident's return to the home, especially noting the significant change in resident's care needs.

The Director of Care indicated the expectation is that the plan of care is reviewed quarterly and whenever a residents needs change. [s. 6.(10)(b)]

***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 there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, specific communication based on resident's wishes and or request, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. Related to Log #O-000826-14, for Resident #02:

The licensee failed to comply with O. Reg. 79/10, s. 49 (2), by ensuring when a resident has fallen , the resident has been assessed and, if required a post falls assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #02 has a cognition impairment.

A review of progress notes for a specific period indicated resident as having had numerous falls and a few near misses during this period.

Resident #02 fell, on an indicated date, while ambulating; according to interviews with staff, resident was walking, lost balance and fell. Resident #02 sustained injuries as a result of the fall requiring the need for transfer to hospital and admission. Notes indicate resident was discharged from hospital on a specific date and returned to the home.

According to progress notes, written by both the registered nursing staff and physician, resident's health and care needs significantly changed as a result of the fall. Post admission progress notes, indicate resident being dependent on staff for all care needs, was no longer ambulating and cognition had declined. Progress notes indicated family voiced concern relating to resident's risk for falls.

The home's policy, Falls Prevention and Management Program (INTERD-03-08-01), directs that staff will complete a screening fall risk assessment (RAI-MDS) in conjunction with evidence based practice fall risk assessment on admission, quarterly and when a change in health status puts a resident at increased risk for falls.

The policy directs that the care plan will be updated incorporating interventions and strategies specific to the resident's needs.

There is no indication that a falls risk assessment was completed following Resident #02's fall and noting resident's change in health status and physical limitations.

Resident Care Coordinator indicted that Resident #02 should have had a falls risk assessment completed following the fall and or post hospitalization. [s. 49. (2)]

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. Related to Log #O-000785-14, for Resident #01:

The licensee failed to comply with LTCHA, 2007, s. 76 (4), by ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

Staff #109 was alleged of verbally/emotionally abusing Resident #01 on specific date. The incident was investigated by the home, reported to police and reported to the Ministry of Health and Long Term Care via the after-hours contact number.

According to the Director of Care and the Manager of Nursing Practice, this was not the first incident of Staff to Resident Abuse (verbal/emotional) involving Staff #109; the first incident occurred approximately a month earlier.

The Director of Care indicated Staff #109 was last provided education specific to zero tolerance of abuse and resident bill of rights during the previous year. DOC indicated training is completed annually for all staff.

Director of Care indicated that Staff #109 was booked to attend re-training, specific to Prevention of Abuse, Resident Bill of Rights, and Duty to Report (under Section 24) following the first incident, but failed to attend.

Director of Care commented that Staff #109 is scheduled for annual re-training specific to zero tolerance and resident bill of rights at a later date this year. [s. 76. (4)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. Related to Log #O-000826-14, for Resident #02:

The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4. , by ensuring the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital (subject to r. 107 (3.1).

A Critical Incident Report was submitted, by the home's Manager of Nursing Practice, indicating Resident #02 was walking in the home, on a specific date, when resident lost balance and fell. Resident sustained injuries as a result of the fall and was transferred and admitted to hospital.

The Critical Incident Report was not submitted by the home until three days later. Manager of Nursing Practice confirmed that no attempts were made to contact MOHLTC by any other means (e.g. telephone call to after-hours pager). [s. 107. (3) 4.]

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**Issued on this 5th day of December, 2014**

**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

**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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KELLY BURNS (554) |
| **Inspection No. / No de l'inspection :** | 2014_293554_0032 |
| **Log No. / Registre no:** | O-000785-14 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Nov 21, 2014 |
| **Licensee / Titulaire de permis :** | REGIONAL MUNICIPALITY OF DURHAM<br>605 Rossland Road East, WHITBY, ON, L1N-6A3 |
| **LTC Home / Foyer de SLD :** | LAKEVIEW MANOR<br>133 Main Street, P.O. Box 514, Beaverton, ON, L0K-1A0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Allan Latter |

To REGIONAL MUNICIPALITY OF DURHAM, 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) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 6 - Plan of Care, specific to, s. 6 (7) and s. 6 (10) (b);

The homes plan shall include:

1) Specific to, LTCHA, 2007, s. 6 (7):
- review the home's smoking policy with all staff to ensure awareness and agreement to comply with provisions in the document
- review and revise Resident #01's plan of care to ensure there are safety measures, specific to smoking, in place to reduce the potential or actual risk of harm for Resident #01 and other resident's residing in the home
- to ensure there is a process in place to monitor that care set out in the plan of care is provided to each resident as specified in the plan, specific to smoking

2) Specific to LTCHA, 2007, s. 6 (10) (b):
- review and revise resident's care plans to ensure such are reflective of resident care needs, specific to falls prevention and management, decline in functional status relating to changes post-hospitalization or following a serious injury
- to ensure there is a process in place to monitor that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, the resident's care needs change

The plan shall be submitted in writing and emailed to LTC Homes Inspector, Kelly Burns at kelly.burns@ontario.ca on or before December 05, 2014. The plan shall identify who will be responsible for each of the corrective action listed.

**Grounds / Motifs :**

1. Related to Log #O-000785-14, for Resident #01:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, related to safety concerns.

Admission interview notes, written by a Registered Nurse indicated resident is to have specific interventions in place to ensure safety. According to the family of Resident #01, the home was notified on admission that resident will engage in unsafe practices if not monitored.

The Director of Care indicated that Resident #01 has been caught performing unsafe practices despite knowing of the home's policy and despite being spoken to on more than one occasion. Director of Care indicated ongoing concern as to the safety of not only Resident #01 but other residents when resident was not abiding by the homes policy.

The written care plan indicates Resident #01 has a history of unsafe practices. The goal of care is resident safety. The plan of care included specific interventions to ensure safety.

Physicians Medication Review, for a specific time directs that resident's safety is to be monitored and documented on the required form.

Documentation on the above form failed to provide supporting evidence that staff were consistently completing the required documentation and or following interventions as described in the plan of care specific to the safety concern.

RN #114, who is a charge nurse within the home, communicated that resident, has specific interventions in place to ensure resident's safety; interventions listed are to be followed. Staff indicated that despite interventions in place resident has been observed engaging in unsafe practices on several occasions.

Staff #112, also a registered nurse in a charge role, indicated not following the safety interventions listed in the plan of care, as resident was not considered at risk to self or others; this is contrary to the care plan.

Director of Care confirmed that Resident #01 is expected to follow the planned care to ensure safety. DOC indicated that if the plan of care indicated assessments were to be completed quarterly then such would be an

expectation. DOC further indicated that staff are to be monitoring resident's unsafe practices as resident poses a safety risk to self and others.

The home's policy, #ADM-01-03-37, directs that resident specific supplies are to be stored in a designated locked area for resident's deemed at risk. [s. 6. (7)] (554)

2. Related to Log #O-000826-14, for Resident #02:

The licensee failed to comply with LTCHA, 2007, s. 6 (10) (b), by ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary related to falls risk.

A Critical Incident Report was submitted by the home on a specific date, relating to an injuring requiring transfer to hospital, after Resident #02 sustained a fall.

Progress notes, written by registered nursing staff, detail Resident #02 suffering a falls incident on a specific date. Resident #02 sustained injuries as a result of the fall and was subsequently transferred to the hospital.

Resident was discharged, from hospital three days later and was re-admitted to the home. Progress notes indicate Resident #02's health declined after return from hospital.

The written care plan, in place at that time, indicated the following care needs for Resident #02:

Dressing:
- staff to dress each morning and undress at bedtime

Eating:
- limited assistance; one person to provide oversight and supervision, encouragement, cueing or task segmentation throughout the meal
- Sits in the dining room with co-residents

Toileting:
- resident will toilet self; staff to check and ensure resident is clean and dry; provide assistance as required. Toilet routinely upon rising, before and after

meals, bedtime and as needed.

Transferring:
- limited assistance. Use of sit to stand lift or other lift as needed

Daily Cleaning of Teeth:
- total assistance of one staff

Bowel and Bladder Incontinence:
- frequently incontinent

Mobility:
-independent walking in corridors

Rest and Sleep:
- sleeps in occasionally; naps in armchair of choice. Settles around a specific time or when tired

Staff #111 indicated resident's care needs changed significantly upon return to the home; Staff commented that Resident #02 required the following care, post admission:
- total dependence for all aspects of care; two to three staff were required for all activities of daily living
- was no longer toileted; had a catheter and was totally incontinent of bowel functions
- was unable to eat due to injuries; refused food, would occasionally take sips of fluids initially on return from hospital but then refused
- staff were unable to perform mouth care due to resident's resistance; staff indicated resident seemed to have a lot of discomfort
- was no longer walking
- was on bed rest upon return from hospital; resident was not transferred from bed; was totally dependent on two to three staff for repositioning when in bed

The written care plan for Resident #02 failed to reflect the care needs of this resident post fall, specific to eating, dressing, toileting and or catheter use, mouth care, mobility and sleep/wake patterns.

Resident Care Coordinator (#104) indicated Resident #02's plan of care should have been reviewed and revised following resident's return to the home,

especially noting the significant change in resident's care needs.

The Director of Care indicated the expectation is that the plan of care is reviewed quarterly and whenever a residents needs change. [s. 6. (10) (b)] (554)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 16, 2015

## 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 21st day of November, 2014**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Kelly Burns

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office