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

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

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
Mar 7, 2016	2016_264609_0006	004038-16	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

CHAD CAMPS (609)

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): February 11, 12, 13, 2016.

This inspection was completed related to three complaints concerning care of residents and staffing levels.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner (NP), two Clinical Managers, the Pharmacist, the Food Services Supervisor, the Infection Control Lead (ICL), eight Personal Support Workers (PSW), one Registered Nurse (RN), one Registered Practical Nurse (RPN), and three resident family members.

The inspector(s) toured the resident care areas of the home as well as resident and staff interactions. Policies and procedures, clinical records and schedules were also reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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. The licensee has failed to ensure that that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was submitted to the Director which alleged improper care of an identified resident.

A review of the clinical record revealed that during a specified time frame staff

implemented nursing and dietary interventions for the identified resident which was not communicated to the medical staff responsible for the care of the resident.

During an interview with dietary staff they stated that they confirmed a dietary intervention had occurred for an identified resident for a specified time frame but that these changes were not communicated to dietary staff.

Dietary staff confirmed that it was the expectation of the home that any diet changes were to be communicated to the dietary department and revised in the plan of care and that this did not occur for the identified resident.

The medical staff also confirmed to the inspector that the identified resident had a worsening health condition that was brought to their attention by a visitor to the home and that the worsening health condition should have been reported to medical staff and that this did not occur.

During an interview with management staff they confirmed that it was the expectation of the home that staff and others involved in the different aspects of care of the resident collaborated with each other.

Management staff confirmed that in the case of medical staff unaware of dietary and nursing interventions implemented by staff of the home as well as not reporting the worsening health condition for the identified resident to medical staff, the home was not in compliance with the Act and should have been. [s. 6. (4)]

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

A complaint was submitted to the Director which alleged identified residents of the home were not provided care on a specified day.

During an interview with an identified resident they confirmed that care was not provided on a specified day as they required in their plan of care.

During an interview with personal support staff working during the specified time frame stated that a specified number of residents did not receive care as required during a specified time frame.

Documentation during the specified time frame was incomplete.

During an interview with management staff they confirmed that it was the expectation of the home that care set out in the plan of care was provided.

Management staff confirmed that in the case of the residents cited above, the home was not in compliance with the Act and should have been. [s. 6. (7)]

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

A complaint was submitted to the Director which alleged that an identified resident received improper care by staff of the home.

A review of the plan of care for the identified resident identified specific dietary interventions.

A review of the progress notes for the identified resident revealed for a specified time frame the identified resident was not provided the specific dietary interventions outlined in the plan of care until medical staff intervened to stop staff from altering the dietary plan of care.

During an interview with management staff they confirmed that it was the expectation of the home that care provided to the resident was to have been as specified in the plan of care.

Management staff confirmed that in the case of the cited interventions implemented for the identified resident, the home was not in compliance with the Act and should have been. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director which alleged that identified residents of the home were not provided a specified dietary intervention on a specified day.

An audit of the dietary intakes of an identified number of residents was completed by the inspector for a specified time frame which revealed staff did not document dietary

interventions or that the dietary interventions that were recorded were incorrect.

During an interview with personal support staff, they confirmed the incorrect documentation as a result of not enough time to document during their shift and that they must have entered the information incorrectly in their haste.

During an interview with nursing staff, they confirmed that it was the expectation of the home that the provision of care set out in the plan of care was to be documented.

Nursing staff confirmed that in the case of the no documentation of dietary interventions and incorrect inputting of dietary interventions, the home was not in compliance with the Act and should have been.

During an interview with management staff, they further stated that if staff do not have time to complete documentation during their shift then they were to contact them and arrange for overtime.

The management staff was unable to provide any documentation to support in policy or training that staff were made aware to alert management for overtime if unable to complete documentation during the course of their shift.

Interviews were conducted with personal support staff of the home which revealed that none were aware that when documentation could not be completed during their shift, they were to alert their manager to obtain permission for overtime. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

A complaint was submitted to the Director which alleged that an identified resident was cared for improperly.

During an interview with registered staff they stated that an assessment completed on a specified day for the identified resident identified a specified health condition and that a specified intervention was being provided to the resident by staff.

A review of the most recent plan of care for the identified resident revealed no mention of the specified intervention cited by registered staff.

During an interview with registered staff, they confirmed that it was the expectation of the home that the plan of care was revised when the resident's care needs changed.

Registered staff confirmed that in the case of the treatment for a specified health condition being provided to the identified resident not outlined in the plan of care, the home was not in compliance with the Act and should have been. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

a) A complaint was submitted to the Director which alleged residents were cared for improperly during a specified time frame.

During interviews with personal support staff who were present during the specified time frame stated that they were required to share a specified piece of equipment between residents that was not to have been shared because there were not enough of the equipment on the units to meet the needs of each resident.

An audit was conducted of a specified area of the home that revealed an identified number of residents required the identified piece of equipment for use in care and that the number available to staff did not meet the care needs of each of residents.

Staff were unable to tell the inspector how they could get more pieces of the equipment when they required them.

During an interview with management staff for the home, they confirmed the results of the audit that an identified number of residents did not did not have an identified piece of equipment required for care. They also confirmed that they were aware of the infection control and safety concerns of sharing the identified piece of equipment between residents.

The management staff confirmed that it was the expectation of the home that each resident who required the identified piece of equipment would each have their own, that for the identified number of residents who did not have the identified piece of equipment, the home was not in compliance with the Regulation and should have been.

During an interview with management staff they confirmed that additional pieces of the identified equipment were ordered and the home was awaiting delivery.

b) During interviews with personal support staff they stated that since the new unit opened, they were advised not to provide a specific bathing intervention as the shower drains did not function correctly and would result in water running into the hallways.

During an interview with an identified resident they stated that since transferring to the new home, they have not been permitted a specific bathing intervention.

A review of the plan of care for the identified resident outlined the specific bathing intervention cited.

During interviews with personal support staff they confirmed that it was the expectation of the home that the care needs of residents were to have been met as specified in the plan of care.

Personal support staff confirmed that in the case of no available shower in order to provide a specified bathing intervention for the identified resident, the home was not in compliance with the Regulation and should have been. [s. 44.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, the licensee was required to ensure that the plan was in compliance with and was implemented in accordance with applicable requirements under the Act.

A complaint was submitted to the Director which alleged care of residents was being impacted by shortages of staff.

A review of the home's RN back-up plan revealed that when an RN was unable to be replaced by the home, an RN from A-Supreme Nursing agency was to be called to fill the absent shift.

The home's RN staffing back-up plan did not indicate the restrictions to the use of agency RN staff as set forth in the Regulation, whereby the home was not permitted to use agency RNs to fill absent RN shifts if it resulted in the agency RNs being the only RNs in the building.

A review of the Regulation was conducted with the Administrator who confirmed that it was the expectation of the home to be in compliance, that for a home of its size the current back-up plan for replacement of absent RN shifts did not correctly outline when agency RNs could be utilized and should have been updated. [s. 8. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily.

A complaint was submitted to the Director which alleged identified residents of the home did not receive a specific dietary intervention during a specified time frame.

During a previous inspection a voluntary plan of correction was issued to the home related to this Regulation.

During an interview with one of the identified residents they confirmed that on a specified day a specified dietary intervention was not provided during a specified time frame.

During interviews with personal support staff they confirmed that they were present and working short during a specified time frame and acknowledged they were working far behind schedule and as a result a specified number of residents in a specified location of the home were not provided a specified dietary intervention.

A review of the clinical records for the identified residents was incomplete during the specified time frame.

During an interview with the management staff they confirmed that it was the expectation of the home that every resident was to have been offered a minimum of three meals daily.

Management staff confirmed that in the case of the identified number of residents during a specified time frame who did not receive a specified dietary intervention, the home was not in compliance with the Regulation and should have been. [s. 71. (3) (a)]

Issued on this 9th day of March, 2016

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2016_264609_0006
Log No. / Registre no:	004038-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 7, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, 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 :	Meaghan Sharp

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. 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).

Order / Ordre :

The licensee shall:

a) Perform training and retraining of all staff involved in caring for residents on the home's policies and procedures related to isolation precautions. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed.

b) Identify all residents of the home who are at high risk of dehydration and audit each resident's fluid record to ensure adequate fluid intake is provided and that it is correctly documented in the resident clinical records.

c) Provide training and retraining to all direct care staff of the home to ensure that they provide care as specified in each resident's plan of care and that any revisions to the plan of care are communicated to the appropriate members of the care team, especially related to nursing care measures. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed.

d) Provide training and retraining to all direct care staff related to the home's policies, procedures and contingency plans when working with less staff than the regular deployment especially related to filling vacant shifts and redeployment of staff to meet the needs of the residents of the home. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was

provided to the resident as specified in the plan.

A complaint was submitted to the Director which alleged that an identified resident received improper care by staff of the home.

A review of the plan of care for the identified resident identified specific dietary interventions.

A review of the progress notes for the identified resident revealed for a specified time frame the identified resident was not provided the specific dietary interventions outlined in the plan of care until medical staff intervened to stop staff from altering the dietary plan of care.

During an interview with management staff they confirmed that it was the expectation of the home that care provided to the resident was to have been as specified in the plan of care.

Management staff confirmed that in the case of the cited interventions implemented for the identified resident, the home was not in compliance with the Act and should have been. [s. 6. (7)] (609)

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

A complaint was submitted to the Director which alleged identified residents of the home were not provided care on a specified day.

During an interview with an identified resident they confirmed that care was not provided on a specified day as they required in their plan of care.

During an interview with personal support staff working during the specified time frame stated that a specified number of residents did not receive care as required during a specified time frame.

Documentation during the specified time frame was incomplete.

During an interview with management staff they confirmed that it was the expectation of the home that care set out in the plan of care was provided.

Management staff confirmed that in the case of the residents cited above, the home was not in compliance with the Act and should have been.

The scope of this issue was a pattern of non-compliance related to resident plans of care and a history of non-compliance related to this section of the Act. The severity was determined to have been level three or actual harm to a resident occurred related to dietary, hydration and skin integrity concerns which negatively affected their health, safety and wellbeing. [s. 6. (7)] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

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. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Order / Ordre :

The licensee shall:

a) Provide training and retraining to all direct care staff on the home's policies and procedures when there is not sufficient equipment available to meet the needs of residents, especially related to transfer equipment. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed.

b) Perform an audit of every resident of the home and identify which residents require transfer slings in order to provide care. Ensure that each resident identified in the audit has a dedicated, properly sized transfer sling available for use during care. Maintain a record of the audit, when it was completed, by who and what actions occurred as a result of the audit.

c) Provide training and retraining to all direct care and laundry staff on the home's policies and procedures when transfer slings or other equipment become soiled and how to have the equipment replaced promptly. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed.

d) Audit to ensure that every shower room drain is working properly so that staff are able to use the shower rooms for resident care. Maintain a record of when the audit was completed, what the results of the audit revealed and when the repairs were completed.

Grounds / Motifs :

1. The licensee has failed to ensure that equipment and devices were readily

available at the home to meet the nursing and personal care needs of residents.

a) A complaint was submitted to the Director which alleged residents were cared for improperly during a specified time frame.

During interviews with personal support staff who were present during the specified time frame stated that they were required to share a specified piece of equipment between residents that was not to have been shared because there were not enough of the equipment on the units to meet the needs of each resident.

An audit was conducted of a specified area of the home that revealed an identified number of residents required the identified piece of equipment for use in care and that the number available to staff did not meet the care needs of each of residents.

Staff were unable to tell the inspector how they could get more pieces of the equipment when they required them.

During an interview with management staff for the home, they confirmed the results of the audit that an identified number of residents did not did not have an identified piece of equipment required for care. They also confirmed that they were aware of the infection control and safety concerns of sharing the identified piece of equipment between residents.

The management staff confirmed that it was the expectation of the home that each resident who required the identified piece of equipment would each have their own, that for the identified number of residents who did not have the identified piece of equipment, the home was not in compliance with the Regulation and should have been.

During an interview with management staff they confirmed that additional pieces of the identified equipment were ordered and the home was awaiting delivery.

b) During interviews with personal support staff they stated that since the new unit opened, they were advised not to provide a specific bathing intervention as the shower drains did not function correctly and would result in water running into the hallways.

During an interview with an identified resident they stated that since transferring to the new home, they have not been permitted a specific bathing intervention.

A review of the plan of care for the identified resident outlined the specific bathing intervention cited.

During interviews with personal support staff they confirmed that it was the expectation of the home that the care needs of residents were to have been met as specified in the plan of care.

Personal support staff confirmed that in the case of no available shower in order to provide a specified bathing intervention for the identified resident, the home was not in compliance with the Regulation and should have been.

The scope of this issue was widespread non-compliance related to staff not having the equipment needed to perform care with residents especially related to transfer slings and showers. There was no history of non-compliance related to this section of the Regulation. The severity was determined to have been level two or potential harm to the health, safety and wellbeing of residents who could have been negatively affected by the lack of equipment needed to provide safe transfer and shower care. [s. 44.] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

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 7th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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