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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2015	2015_205129_0007	H-002260-15	Critical Incident System

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ALEXANDER PLACE
329 Parkside Drive P. O. Box 50 Waterdown ON L0R 2H0

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 21, 22 and 23, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co Director of Care, the Resident Assessment Instrument-Minimum Data Set/Staff Education Coordinator and the Restorative Care Coordinator.
The Inspector also reviewed clinical records, the licensee's policies related to falls management, bed rail and head injury routine as well as reviewed documents created by the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 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. (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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other, in relation to the following: [6(4)(a)]
The RAI Coordinator/Staff Educator and the Restorative Care Coordinator did not collaborate with nursing in the assessment of resident #001 in relation to the use of bed rails. The resident's plan of care included two care focuses both initiated September 2012 and both with goal target dates of December 30, 2014. One care focus was related to a high risk of falling and included a care intervention for the use of padded bed rails in order to reach the identified goal that the resident would have no falls over the next quarter. The second care focus was related to bed mobility that included a care intervention that the resident was to be instructed to use the bed rails as an assistive device to turn and reposition themselves in bed with the assistance of one staff in order to reach the identified goal that resident would be able to preposition themselves in bed over the next quarter.
The RAI Coordinator/Staff Educator and Restorative Care Coordinator completed a bed rail assessment for resident #001 as part of the home's bed rail reduction program on an identified date in 2015. Following this assessment staff were directed not to use bed rail for this resident and the resident's plan of care was updated. During an interview on

April 21, 2015 both staff who completed the bed rail assessment they were unaware of the reasons this resident was using bed rails and they did not speak to nursing staff about the use of bed rails for this resident prior to directing staff not to use bed rails for this resident. On an identified date following removal the bed rails the resident fell from bed and staff documented that the fall was likely the result of the resident attempting to shift in the bed and slid off the bed due to lowered bed rails. The following day staff documented the resident had received a head injury as a result of the fall. The resident fell from bed again a month later and was found with vital signs absent two and a half hours after the fall. [s. 6. (4) (a)]

2. The licensee failed to ensure that resident #001's plan of care was reviewed and revised when the care set out in the plan of care related to the falls was not effective, in relation to the following: [6(10)(c)]
a)The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and the Resident Assessment Protocol (RAP) completed for resident #001 on July 15, 2014 indicated the resident had fallen in the past 30 days and the past 31 to 180 days. The care plan decision documented on the RAP at that time was that staff would care plan with the goal to decrease the number of falls. Clinical documentation reviewed indicated the resident had fallen twice prior to this reassessment.
Care interventions initiated in 2012 included a clutter free environment, the falling star program, reinforce with the resident the need to call for assistance, to wear footwear to bed at night, wear proper fitting foot wear and staff was to transfer the resident and change position slowly. Care interventions initiated in 2013 included; the falling star program, a personal alarm on at all times and assist the resident to the toilet before and after meals as well as before bed. Care interventions in place without initiation dates, included; check resident every 30 minutes, use of padded bed rails and the bed to be in the lowest position, staff to make frequent checks on the resident and staff are to attempt to de-escalate responsive behaviours. The resident's plan of care was not revised following the RAI-MDS assessment of July 15, 2014 when the clinical record indicated the resident had fallen twice prior to this assessment which indicated the care being provided to the resident to manage the risk of falling had not been effective and the resident continued to fall.

b) The following RAI-MDS and RAP completed September 30, 2014 indicated the resident fell in the past 30 days and the past 180 days. The care plan decision documented on the RAP at that time was that staff would care plan to prevent or improve the resident's number of falls. Clinical documentation reviewed indicated the resident fell six times over the three months prior to the completion of this assessment.

Care interventions identified following the July 15, 2014 reassessment remained in place following this reassessment and the resident's plan of care was not revised when it was identified that the care being provided to the resident to manage the risk of falling had not been effective and the resident continued to fall.
c) The following RAI-MDS and RAP completed on December 23, 2014 indicated the resident fell in the past 31 to 180 days. The care plan decision documented on the RAP at the time was that staff would care plan to maintain current level of functioning and to have no further falls in the next 90 days. Clinical documentation reviewed indicated the resident fell three times over the three month period prior to this assessment.
The care interventions removed from the resident's plan of care following the above noted reassessment, included; checking the resident every 30 minutes, the use of padded bed rails with the bed in the lowest position, the use of crash mats on the floor by the bed, staff to make frequent checks on the resident and staff were to attempt to de-escalate the resident's responsive behaviours. The remainder of the interventions documented following the July 15, 2014 reassessment remained in place following this reassessment. The Co DOC and documents created by the home confirmed that resident #001 fell 24 times over a 12 month period of time. The resident's plan of care was not revised when reassessments indicated that the care being provided to the resident was not effective in moving towards the identified goals of care. The resident the fell on two identified dates in 2015 and was found with vital signs absent two and a half hours after a last fall. [s. 6. (10) (c)]

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. 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 failed to ensure that staff complied with the directions contained in the policies related to the prevention and management of falls, the use of bed rails and the policy related to completion of head injury routine. [8(1)(b)]
a) Staff did not comply with the following directions included in the "Falls Prevention and Management " policy, identified as version two and revised on March 18, 2015:
-The policy directed that "registered staff will ensure that a Resident Assessment Protocol (RAP) is completed that reflects critical thinking and an evaluation of the previous interventions and underlying causes of the falls risk". Staff did not comply with this direction when the RAP tool completed for resident #001 on July, 15, 2014, September 30, 2014 and December 2014 did not contain an evaluation of the effectiveness of the previous interventions related to the management of falls. The RAP completed for this resident on March 17, 2015 did not contain and evaluation of the effectiveness of the previous interventions or the underlying causes of the falls risk.
b) Staff did not comply with the following direction included in the "Bedside Rails" policy revised on December 30, 2014:
- The policy directed that "where bed rails are used the resident is assessed in accordance with evidenced based practices and where there are none in accordance with prevailing practices". Staff did not comply with this direction when staff and the clinical record confirmed resident #001's plan of care indicated that bed rails were implemented in November 2012 as an intervention for both bed mobility and falls management care focuses. The Administrator and the Co-Director of Care (Co DOC) confirmed that an assessment of the resident, that incorporated the evidenced based practices contained in the document "Clinical Guidance For the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities and Home Care Settings (April 2003), had not been completed.
c) Staff did not comply with the following direction included in the "Head Injury Routine"

policy, identified as version two and revised on March 20, 2015:
-The policy directed that "registered staff will complete head injury routine assessment using the “Head Injury Routine” form every 30 minutes for two hours, every hour for four hours, every two hours for six hours, every four hours for the next 12 hours and daily for one week". Staff did not comply with this direction when clinical documentation confirmed that head injury routine initiated on:
- An identified date in 2014 –was not completed every 30 minutes for two hours or every hour for four hours.
- An identified date in 2014 –was not completed every two hours for six hours or every four hours for the next 12 hours.
- An identified date in 2014– was not completed every hour for four hours or every four hours for the next 12 hours.
- An identified date in 2014– was not completed every hour for four hours or every four hours for 12 hours.
- –was not completed every hour for four hours, every two hours for six hours, every four hours for the next 12 hours or daily for seven days.
- An identified date in 2014 –was not completed every four hours for the next 12 hours.
- An identified date in 2014–was not completed every four hours for 12 hours or daily for seven days.
- An identified date in 2014–was not completed every four hours for 12 hours.
- An identified date in 2014–was not completed every four hours for 12 hours or daily for seven days.
- An identified date in 2014 –was not completed every hour for four hours, every four hours for 12 hours or daily for 7 days.
- An identified date in 2015 –was not completed every 30 minutes for two hours, every hour for four hours or daily for seven days.
- An identified date in 2015 –was not completed every 30 minutes for two hours, every hour for four hours, every four hours for 12 hours or daily for seven days.
-An identified date in 2015 –was not completed every 30 minutes for two hours. [s. 8. (1) (b)]

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 ensuring that staff comply with directions contained in the licensee's policies, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when bed rails are use the resident is assessed and their bed system is evaluated in accordance with evidence-based practices to minimize the risk to the resident, when bed rails were used, in relation to the following: [15(1)(a)]
a) The licensee completed an assessment of resident #001's bed system on February 19, 2015, determined the mattress and bed rail combination presented an entrapment risk to this resident and directed staff to not use bed rails for this resident. Staff performing this assessment confirmed that the assessment was completed as part of the homes bed rail reduction program, a specific tool for completing this assessment was not used and they had not incorporated the US Food and Drug Guidelines titled "Clinical Guidance For the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities and Home Care Settings (April 2003) as a guide for this assessment. The guideline has been endorsed by Heath Canada and is currently the only document with comprehensive information regarding bed safety and bed rail use. The specific entrapment risks that resulted in staff being directed to stop using bed rails for this resident were not documented in the resident's plan of care and during an interview on April 22, 2015 the staff who completed the assessment were unable to identify the specific risks. The guideline refers to the "automatic use of bed rails" may pose unwarranted hazards to patient safety and then goes on to identify a number of things that should be considered when planning care, none of which were incorporated into the assessment of this resident's plan of care related to the use of bed rail.
b) Resident #001's plan of care indicated that bed rails were implemented as an intervention to assist with bed mobility and to manage a risk of falls in November 2012 and remained as interventions for both of these care focuses until February 19, 2015 when staff were directed to stop using bed rails for this resident. During an interview on April 23, 2015 the Administrator and the Co-Director of Care (Co DOC) confirmed that an assessment of the resident, that incorporated the evidenced based practices contained in the document "Clinical Guidance For the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities and Home Care Settings (April 2003), had not been completed prior to the use of bed rails for this resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that when bed rails are use the resident is assessed and their bed system is evaluated in accordance with evidence-based practices to minimize the risk to the resident, when bed rails were used, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Falls Prevention and Management program included the development and implementation of a clinically appropriate reassessment instrument, in relation to the following: [48(2)(b)]
The licensee's Falls Prevention and Management program did not include a clinically appropriate assessment instrument to be used when the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) tool, the Resident Assessment Protocol (RAP) tool and subsequent care set out in the plan was not effective to manage a clinical concern related to falls. Staff and investigative notes compiled by the home confirmed that resident #001 fell 24 times over a period of 12 months. During this 12 month period of time staff continued to use the RAI-MDS and the RAP tool to reassess the resident. The goal of care identified on the July 15, 2014 RIA-MDS and RAP tool was to "decrease the number of falls" for this resident, the goal identified on the September 30, 2014 RIA-MDS and RAP tool was to "improve the number of falls" for the resident and the goal identified on the December 23, 2014 RAI-MDS and RAP tool was that the resident "would have no further falls in the next 90 days". These assessments and subsequent care set out in the plan of care had not been effective in managing the resident's falls and throughout this period of time and staff continued to use the RAI-MDS and RAP tool to reassess the resident.
The licensee's "Falls Prevention and Management" policy identified as version two and revised on March 18, 2015 indicated that the tools staff were to use to assess and reassess a resident who has fallen was the combination of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) tool and the Resident Assessment Protocol (RAP) tool and did not include a clinically appropriate assessment instrument for staff to use when it was determined that the RAI-MDS and RAP tool was not effective in managing the clinical concern. The Administrator and nursing leaders confirmed that the only tool used in the home to reassess the resident was the RAI-MDS and RAP tool. [s. 48. (2) (b)]

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

Issued on this 23rd day of July, 2015

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2015_205129_0007
Log No. / Registre no:	H-002260-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 10, 2015
Licensee / Titulaire de permis :	WATERDOWN LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ALEXANDER PLACE 329 Parkside Drive, P. O. Box 50, Waterdown, ON, L0R-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	[redacted] Helen Jovicich

To WATERDOWN LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee is to prepare, submit and implement a plan to ensure that the resident's plan of care is reviewed and revised when the care being provided has not been effective in managing the care need. The plan is to include, but is not limited to the following:
1 The development and implementation of a training program to ensure that staff are able to recognize factors that would indicate the care being provided to residents has not been effective. This training program is to include what specific actions staff are to take when it is determined that the care being provided has not been effective.
2. The development and implementation of a schedule for the reassessment of all residents who fall to determine if the care provided to the resident has been effective in managing the risks related to falling.
3 The development and implementation a schedule of ongoing monitoring of staff's performance in determining when the care for a resident has not been effective and the actions taken if it is determined that the care provided to the resident has not been effective.
The plan is to be submitted on or before July 24, 2015 to Phyllis Hiltz-Bontje by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified non-compliant as a WN on October 24, 2012, May10, 2013, April 8, 2014 and as a VPC on February 19, 2015.

2. Resident #001 fell 24 times over a 12 month period of time and was found with vital signs absent two and a half hours after a fall from bed on an identified date in 2015.
3. A review of the care provided to resident #001 indicated that the care being provided to the resident in order to manage a risk of falling was not effective and the resident's plan of care was not revised.
a)The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and the Resident Assessment Protocol (RAP) completed for resident #001 on July 15, 2014 indicated the resident had fallen in the past 30 days and the past 31 to 180 days. The care plan decision documented on the RAP at that time was that staff would care plan with the goal to decrease the number of falls. Clinical documentation reviewed indicated the resident had fallen two times prior to this assessment begin completed.
Care interventions initiated in 2012 included a clutter free environment, the falling star program, reinforce with the resident the need to call for assistance, to wear specialized footwear to bed, wear proper fitting footwear and staff was to transfer the resident and change position slowly. Care interventions initiated in 2013 included; the falling star program, a personal alarm on at all times and staff were to assist the resident to the toilet before and after meals as well as before bed. Care interventions in place without initiation dates, included; check resident every 30 minutes, use of padded bed rails and the bed to be in the lowest position, staff to make frequent checks on the resident and staff are to attempt to de-escalate responsive behaviours. The resident's plan of care was not revised following the RAI-MDS assessment of July 15, 2014 when it was identified that the care being provided to the resident to manage the risk of falling had not been effective in reaching the care goals identified and the resident continued to fall.

b) The following RAI-MDS and RAP completed September 30, 2014 indicated the resident fell in the past 30 days and the past 180 days. The care plan decision documented on the RAP at that time was that staff would care plan to prevent or improve the resident's number of falls. Clinical documentation reviewed since the previous RAI-MDS indicated that the resident fell six times in the three months prior to this assessment.
Care interventions identified following the July 15, 2014 reassessment remained in place following this reassessment and the resident's plan of care was not revised when it was identified that the care being provided to the resident to manage the risk of falling had not been effective and the resident continued to fall.

c) The following RAI-MDS and RAP completed on December 23, 2014 indicated the resident fell in the past 31 to 180 days. The care plan decision documented on the RAP at the time was that staff would care plan to maintain current level of functioning and to have no further falls in the next 90 days. Clinical documentation reviewed since the previous RAI-MDS indicated that the resident fell three times prior to this assessment.
The care interventions removed from the resident's plan of care following the reassessment completed on September 30, 2014, included; checking the resident every 30 minutes, the use of padded bed rails with the bed in the lowest position, the use of crash mats on the floor by the bed, staff to make frequent checks on the resident and staff were to attempt to de-escalate the resident's responsive behaviours. The remainder of the interventions documented following the July 15, 2014 reassessment remained in place following this reassessment. The Co DOC and documents created by the home confirmed that resident #001 fell 24 times over a 12 month period of time.. The resident's plan of care was not revised when reassessments indicated that the care being provided to the resident was not effective in moving towards the identified goals of care. The resident fell two more times and was found with vital signs absent two and a half hours after the last fall. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 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 10th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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