Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
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) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2012_066107_0006
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Mar 7, 8, 12, 15, Apr 17, 18, 19, 23, 24, Jun 5, 6, 7, 8, 11, 12, 21, 25, 26, 28, Jul 11, 12, 2012
Licensee / Titulaire de permis :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ROSEMARY OKIMI

To HERITAGE GREEN NURSING HOME, 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) (b)

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 prepare, submit and implement a plan that ensures that the care set out in the plan of care for all residents of the home, in addition to the identified residents, is provided as specified in the residents' plans in relation to meal service (correct diets and preferences and interventions outlined in the residents' plans of care and in relation to hydration). The plan should include:
a) An assessment of the current method for communicating resident preferences and needs to staff in the dining rooms
b) staff education provided, including dates of the education and which staff the education is targeted to (e.g. PSW's, Dietary Aides, etc)
c) Quality management activities (including the type of activities and frequency) that will be implemented to target the identified area of non-compliance.
The plan is to be submitted by July 27, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail: Michelle.Warrener@ontario.ca or Fax: 905-546-8255.

Grounds / Motifs :

1. Previously issued as a CO on February 7-11, 2011.
The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan.
a) The resident's plan of care identified a specialized menu with specific food restrictions was required. A memo posted in the dining room and in the nursing station directed staff not to provide a certain food item, however, the resident was provided the restricted food item by staff providing care.
b) The Registered Dietitian discontinued one type of nutritional supplement and replaced the order with a different type of supplement. The previous supplement order was discontinued on the Medication Administration Record (MAR), however, the new order was not added to the MAR. The resident had not been receiving the ordered supplement for six months. The resident's wound was not healing well and was being treated with recommendations by a specialized wound care nurse. (107)
2. The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan.
a) The resident had a physician's order for a nutritional supplement several times daily with the medication pass. The order was not discontinued, however, the supplement was removed in error from the Medication Administration Records for one month in 2012, resulting in the resident not receiving the nutritional supplement. The error was not identified by staff. The resident was at high nutrition risk with poor food and fluid intake and a history of significant weight loss.
b) The resident had a physician's order for a nutritional supplement when food intake at meals was poor or refused. The supplement was not provided as required when food intake was poor/refused (as per the food intake records) for nine breakfasts meals, 14 lunch meals, and one supper meal in a 1.5 month period in 2012. The supplement was also given in a different quantity of than what was specified in the physician order (given less).
c) The resident's plan of care stated to provide specialized foods at meals. The quarterly review by the

Registered Dietitian stated Dietary was aware that those foods must be available as an alternate choice if the resident was not able to eat/refused the entree. The specialized item was not available at the lunch meal April 17, 2012, requiring nursing staff to go to the kitchen to retrieve the item. The item was then not offered to the resident as required in their plan of care.
d) The resident ate poorly at the observed lunch meal April 17, 2012, however, the ordered nutritional supplement was not offered to the resident. Staff interviewed was not aware of the order for a supplement to be offered when food intake was poor. (107)
3. The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan.
The resident's plan of care stated they required a specific consistency of thickened fluids. The resident was provided thin fluids at the supper meal March 12, 2012 and the PSW interviewed was unaware that the resident required thickened fluids. The thin fluid was removed, however, an alternative thickened beverage was not provided. The resident was also provided thin fluids at the lunch meal March 8, 2012. Registered staff removed the thin fluid when identified, however, a replacement was not provided/offered. (107)
4. The care set out in the plan of care for an identified resident was not provided to the resident as specified in their plan.
a) The resident's plan of care stated a specific consistency of thickened fluids were required, however, the resident was served a different consistency of fluids at all of their meals daily. This resulted in a mixed consistency of textures being served to the resident, creating a potential risk for choking. Staff confirmed the fluid was not thickened to the correct consistency.
b) The resident's plan of care stated to provide a specific type of milk at lunch daily and that the resident liked milk at meals, however, this was not offered to the resident at the lunch meal March 7, and supper meal March 8, 2012. The resident confirmed that milk was not offered at these meals.
c) The resident's plan of care stated that staff were to report to the Charge Nurse when the resident was consuming less than 1000ml per day. Documentation did not reflect that the charge nurse was routinely contacted when the resident's fluid intake was less than 1000ml/day. The resident consumed less than 1000ml/day 59% of the days over a two month period in 2012.
d) The resident's plan of care stated to offer water three times daily between meals. During interview the resident stated staff were not consistently offering the water between meals and the resident stated they were very thirsty. The resident was not meeting their hydration requirements 97% of the time over a two month period in 2012. (107)
5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in their plans. Some examples:
At the lunch meal March 7, 2012:
a) Three residents were not offered milk/specialized milk as per their plans of care.

2. At the supper meal March 8, 2012:
a) All thickened fluids on the beverage cart were a certain consistency, however, some residents required a different consistency of thickened fluids. Staff did not adjust the consistency of the thickened fluids and the same consistency was provided to all residents requiring thickened beverages. Three observed residents received an incorrect consistency of thickened fluids (fluids and nutritional supplements) creating a risk for choking or reduced fluid availability.
b) An identified resident received the incorrect texture of entree. The resident's plan of care stated they required a pureed texture at meals, however, the resident was provided with a minced textured entree, creating a risk for choking.
c) An identified resident required thin fluids according to their plan of care, however, staff provided a mixture of fluid consistencies at the meal.
d) An identified resident's plan of care stated to provide a minced diet but if that texture was refused, to offer a regular textured meal. The resident was not offered a minced textured diet prior to providing a regular textured entree.
e) Two residents were not offered high protein milk, as per their plans of care.

f) Three residents did not receive special dietary interventions as per their plans of care.

3. At the lunch meal March 15, 2012:
a) Three residents received the incorrect texture of their meal, creating a risk for choking or an unnecessary downgrade in texture. Staff confirmed the items were provided in error and that the residents did not request them.
b) An identified resident received an incorrect consistency of thickened fluids creating a risk for aspiration.
c) Four residents received items that were contrary to their prescribed diet orders:
i) An identified resident required a fluid restriction at meals, however, they were provided with more fluids than the restriction allowed. Food and fluid intake documentation records reflected that the resident was consuming more fluids than the required restriction on 50/59 days over a two month period in 2012.
ii) An identified resident required a restricted menu, however, was provided foods that were restricted. The resident stated they weren't supposed to get the item that was provided to them. The therapeutic extension menu stated the resident was to receive a substitution at the meal.
iii) An identified resident required a restricted diet without a specific menu item, however, the item was provided to the resident and the resident stated it was given all the time.
iv) An identified resident had a plan of care that stated a specific item was not to be on the resident's table, however, the resident had the item beside them at the table.
d) Two residents received items they were not supposed to for safety or resident preferences. The residents were unable to voice their meal needs/preferences/dislikes.
e) Four residents were not offered items identified on their plans of care:
(specialized milk, extra water)

4. At the lunch meal April 17, 2012:
a) Three identified residents were provided items that were identified as dislikes on their plans of care.
b) An identified resident was not offered their preferred menu item as specified in their plan of care. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

The licensee must prepare, submit and implement a plan that ensures the implementation of a quality improvement and utilization review system for the dietary department that monitors, analyzes, evaluations and improves the quality of care, services, programs and goods provided to residents of the long-term care home. The plan is to be submitted by July 27, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca or Fax 905-546-8255.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 84) Previously issued as a CO February 7-11, 2011.
a) A quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home had not been fully implemented for the dietary department. Management staff interviewed confirmed that quality management activities were not consistently being completed in the dietary department and data collected was not being analyzed with an action plan developed to improve quality. The licensee was unable to fully implement their corrective action plan submitted to the Ministry of Health and Long Term Care related to outstanding compliance orders for non-compliance within the home. Several compliance orders related to dietary services have been issued a consecutive time during this inspection. (107)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee must prepare, submit and implement a plan that ensures that:
a) All residents of the home have their weight taken monthly
b) All residents with significant unplanned weight changes have the significant weight changes verified through a re-weigh
c) All residents of the Home with verified unplanned weight change are identified and assessed using an interdisciplinary approach with actions taken and outcomes evaluated. The plan is to be submitted by July 27, 2012 to Long Term Care Homes Inspector: Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton Ontario, L8P 4Y7, e-mail Michelle.Warrener@ontario.ca, Fax 905-546-8255.

Grounds / Motifs :

1. Previously issued as a CO on February 7-11, 2011. This was also issued under the Program Standards Manual as B3.24 on June 10, 2010.
The licensee did not ensure that a significant weight change of 33.1% in one month was assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated for an identified resident. A re-weigh to verify the accuracy of the weight did not occur and an assessment of the significant weight change did not occur that same month. Follow up on the weight did not occur until the quarterly review scheduled the next month, however, the next months weight was not available/taken. An accurate assessment of the resident could not be completed and interventions could not be accurately evaluated for effectiveness. (107)
2. The licensee did not ensure that an identified resident had actions taken and outcomes evaluated after an undesirable 6.5% weight loss over a three month period in 2012. The weight loss was noted, however, the plan was to continue with the same interventions. The goal on the resident's plan of care was for weight maintenance within a specific target body weight range, however, the resident had not been within this weight range for several years. Outcomes were not evaluated in relation to care planning goals and the current status of the resident. (107)
3. The licensee did not ensure that action was taken and outcomes were evaluated for an identified resident after a significant weight loss. The resident's plan of care identified a goal for the prevention of weight loss or weight maintenance within a specific target body weight range. At the nutrition assessment, the Registered Dietitian noted the resident had a significant weight loss of 18% to below their target weight range, and that the resident had decreased food intake over the quarter, however, action was not taken to address the significant weight loss. Interventions identified on the resident's plan of care were not evaluated for effectiveness and outcomes were not evaluated in relation to the goal for weight maintenance/prevention of weight loss. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that all menu items are prepared and served according to the planned menu and planned recipes. The plan is to be submitted by July 15, 2012 to Long Term Care Homes Inspector Michelle Warrener, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail: Michelle.Warrener@ontario.ca, Fax: 905-546-8255.

Grounds / Motifs :

1. Previously issued as a CO February 7-11, 2011. Previously issued June 10, 2010 under the Nursing Homes Act Chapter N.7, Section 20.11 related to un-met criterion P1.14.
Not all menu items were prepared according to the planned menu. Some examples:
a) The following items were not prepared:
pureed rice pilaf, pureed Greek salad (indicated on the therapeutic extension menu, however, production sheets indicated hot pureed vegetable), pureed garlic bread, pureed whole wheat bread, 2 x boiled potatoes for the renal menu (cook stated that the renal diets could have the mashed potatoes, which was contrary to the planned menu)
b) The following item did not follow the planned menu:
The alternative vegetarian choice prepared was chicken alternative, however, the planned menu stated vegetable stew. (107)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2012

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee shall ensure that all hazardous substances, including identified chemicals, are kept inaccessible to resident at all times.

Grounds / Motifs :

1. Previously issued as a CO February 7-11, 2011.
Not all hazardous substances were kept inaccessible to residents on March 7, 2012 at 1205 hours. The door to the tub room was left ajar with no staff present in the hallway or in the tub room. The inspector was able to enter the tub room where there was an accessible bottle of disinfectant cleaner (corrosive). After 10 minutes staff came in and stated the door automatically locked, however, on this occasion, the door did not lock automatically and was significantly delayed in closing when staff left the room. (107)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2012

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Ontario

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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 :

The licensee shall ensure that all residents of the home are provided with:
a) the required level of assistance and encouragement with eating at meals and snacks
b) any assistive devices required at meals and snacks and
c) assistance with eating using proper feeding techniques to ensure the safety of residents

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)10] Previously issued as a CO February 7-11, 2011.
Proper techniques, including safe positioning of residents who required assistance with eating were not provided to residents at the observed supper meal March 8, 2012.
a) An identified resident was being fed by staff while in their room. The resident was not in an upright position and their chin was pointed towards the ceiling (not tucked for safe swallowing). The resident was coughing while being assisted with their thickened fluids. The inspector asked the staff to reposition the resident prior to continued feeding.
b) An identified resident was being fed by staff while in their room. The resident's bed was not in an upright position and the resident stated they were having difficulty swallowing. (107)
2. [O.Reg. 79/10, s. 73(1)9] Previously issued as a CO February 7-11, 2011. Previously issued as B3.32 under the Program Standards manual June 10, 2010.
Not all residents were provided with the required eating aides, assistive devices, and personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
a) An identified resident had a plan of care that required total assistance with eating if the resident was not willing to feed themselves. The resident sat with their meal in-front of them for over 1 hour without assistance or encouragement being provided. The resident was at high nutritional risk.
b) An identified resident had a plan of care requiring total assistance with eating, however, assistance was not provided to the resident until the end of the lunch meal March 7, 2012 and the resident ate poorly. Assistance with eating was also not provided at the lunch meal March 12, 2012, and the morning and afternoon snack pass April 18, 2012. At the morning snack pass the resident sat for over one hour with the beverage in-front of them. At the afternoon snack service, the resident placed the beverage in the railing beside their wheelchair and sat without consuming the beverage. The resident did not consume more than a teaspoon of the beverage at the identified snack passes. The day prior, the resident's family member fed them their morning beverage and the resident consumed the beverage.
c) An identified resident's plan of care stated staff were to return several times to provide encouragement to eat and finish the meal or the resident would leave the dining room without completing the meal. The resident did not receive encouragement with eating and the resident left the dining room without eating and before dessert was offered.
d) An identified resident did not receive assistive devices at the supper meal March 8, 2012 as per their plan of care. The resident sat for over 50 minutes at the table waiting for their meal and for feeding assistance to be provided.
e) An identified resident did not receive assistance with opening a beverage carton, as per the resident's plan of care. The container sat on the table and the resident did not consume it. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of July, 2012

Signature of Inspector / Signature de l'inspecteur : M Warrener

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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