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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 12, 2014	2014_241502_0003	T-618-13	Critical Incident System

Licensee/Titulaire de permis

THE KENSINGTON HEALTH CENTRE
25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9

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

THE KENSINGTON GARDENS
25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9

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

JULIENNE NGONLOGA (502), DIANE BROWN (110)

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): January 27 and January 30, 2014.

During the course of the inspection, the inspector(s) spoke with personal care assistant (PCA), Food Service Manager (FSM), Team Lead (TL), registered nurses (RN), registered dietitian (RD), Nurse Manager (NM), Director of Care (DOC), Executive Director, resident's Power of Attorney (POA).

During the course of the inspection, the inspector(s) reviewed health records and observed dining services.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure resident #1's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #1 was dysphagic, at high risk of choking, and required a modified diet. He/she needs to be monitored closely at meals, at an assisted table, and eats meals in the resident home area dining room.

Staff interview confirmed that resident #'1's usual routine was having lunch with a friend twice weekly, whereby the friend would bring in restaurant food such as lasagna, chicken wings, chicken legs, and roasted potatoes of regular texture. According to staff, the friend would like to dine alone with the resident in the unit's activity room. Interviews with staff, including the Director of Care and registered dietitian, revealed that the resident's friend did not accept the change in resident's diet, and continued to provide unsafe textured food and fluids to the resident despite being advised of the risks.

Record review revealed that on an identified day, the RD was approached by the charge nurse who was concerned that resident #1 may choke on unsafe texture of

food brought in by the friend. The RD approached the resident's friend asking if he could cut up food smaller and left message for POA to discuss the friend's behaviour and the risk he/she is causing resident #1. An interview with the RD revealed that one of the substitute-decision makers contacted the resident's friend and advised him/her to bring in safe food. Record review of team conference held on an identified day, with resident's substitute decision maker/POA revealed that he/she wanted to know if the resident's friend is being cooperative with staff and if no, to ask him/her (friend) to leave and they (POA/family) would support the staff.

Resident #1's written plan of care states if his/her friend wants to continue feeding the resident regular foods he/she should sign a waiver taking responsibility for any unwanted consequences.

In an interview the resident's substitute decision-maker/POA stated that the home was informed that he/she did not want resident #1 in the craft room eating with his/her friend; the home should move resident #1 in the dining room and have staff feed him/her. He/she could allow staff to let resident's friend to be present and observe but he/she was not to feed resident.

Resident's substitute decision-maker/POA was not given an opportunity to participate fully in the development and implementation of the resident's plan of care as he/she had no knowledge of a waiver allowing the friend to continue to provide regular food and did not support the friend continuing to feed resident #1. The POA stated during an interview that he/she was "upset" when she found out that, on the day of the choking incident, resident #1 was being fed by his/her friend in the activity room.

2. The licensee failed to ensure that the care set out in the plan of care is provided to resident #1 as specified in the plan.

Record review of the resident's written plan of care revealed that resident #1 was dysphagic, at high risk of choking, and required a modified diet. He/she needs to be monitored closely at meals, at an assisted table, and eats meals in the resident home area dining room.

An interview with the Team Lead revealed that close monitoring would require a staff member to be with the resident while the resident is eating.

Record review on an identified period of time, revealed that a speech language

pathologist (SPL) identified resident #1 as being at high risk of choking / aspiration and recommended downgrading diet texture and supervision at mealtimes. A registered dietitian (RD) ordered the resident's diet to be modified and identified that the resident would benefit from sitting at a feeder table where he/she can receive encouragement to eat slowly. The registered nurse was aware that the resident was to be placed at the feeding table to remind him/her to eat slowly and required close supervision and reminding to put smaller amounts of food in his/her mouth to prevent aspiration.

An interview with the RD confirmed that she was aware that resident #1 was at risk for choking. An interview with resident #1's primary personal care assistant (PCA) revealed that he/she was aware that resident #1 was at risk for choking, and had a modified diet, with food cut-up in pieces. The PCA revealed that resident #1 would hoard bread in his/her mouth and the PCA would sit with resident #1 at breakfast even though he/she was able to feed herself. Staff interview confirmed that resident #'1's usual routine was having lunch with a friend twice weekly, whereby the friend would bring in restaurant food such as lasagna, chicken wings, chicken legs, and roasted potatoes of regular texture. The resident and his/her friend would dine alone in the unit's activity room without staff supervision. Interviews with staff, including the Director of Care and registered dietitian revealed that the resident's friend did not accept the change in the resident's diet, and continued to provide unsafe textured food and fluid to the resident despite being advised of the risks.

Staff interview and record review revealed that on an identified day, the resident was in the activity room, alone with his/her friend. The activity room is across a corridor, parallel to the unit dining room with glass wall panels where staff was attending to meal service. Resident #1 did not receive texture modified food, instead was provided and ate 4 – 5 pieces of roasted potato and lasagna. The resident's friend was feeding him/her food brought from outside of the home without close monitoring by staff. During the meal, when resident #1 stopped chewing and swallowing, his/her friend called staff. Record review revealed resident's condition changed. He/she was pale, unconscious, had bluish lips and nails, and had laboured breathing. The resident's PCA and the registered nurse confirmed through interview that they had not been in the activity room during resident #1's meal and were unaware what foods had been offered until after the incident of choking/aspiration.

Resident #1 was transferred to hospital and died six days later. Record review identified aspiration pneumonia as the primary cause of death.

3. The licensee failed to ensure that if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

Resident #1's plan of care identified resident to be at high risk for choking/ aspiration. A speech language pathologist's swallowing assessment on an identified day, recommended a diet change from regular to a modified texture, no mixed consistencies and mealtime supervision. These interventions were identified in the resident care plan on an identified day. Five months later, resident #1's diet was further downgraded from regular fluids to thickened fluids to minimize choking.

Staff interview confirmed that resident #'1s usual routine was having lunch with a friend twice weekly, whereby the friend would bring in restaurant food such as lasagna, chicken wings, chicken legs, and roasted potatoes of regular texture. The resident and his/her friend would dine alone in the unit's activity room. Interviews with staff, including the Director of Care and registered dietitian, revealed that the resident's friend did not accept the change in resident diet, and continued to provide unsafe textured food and fluid to the resident despite being advised of the risks.

Record review revealed the following:
On an identified day, the RD observed the friend feeding resident regular food and advised him/her to cut food up. The resident's friend was not happy and called the dietitian "idiot".
Two days later, the friend was observed providing regular food again to resident.
Six days later , resident #1's POA called the home and informed staff that resident's friend was informed to bring appropriate food for resident #1.
Seventeen days later, the RD observed resident #1 coughing on his/her lunch when his/her friend was providing food for the resident. The RD's plan was to continue with the current plan of care and continue to encourage friend to bring more appropriate foods for the resident.
Two months later, the RD recommended the resident move to a table with constant supervision to help minimize further choking risk.
Three months later, the RD indicated resident #1 needs constant encouragement to eat slowly.
On an identified day, care conference documentation revealed that the resident's POA stated that if the resident's friend is not listening to staff they should ask him to leave and that they (POA/family) will support staff.

Resident's written care plan stated "modified texture, thickened fluids, is high risk for choking; he/she bites and swallows her foods. He/she needs to be monitored closely and needs to be at an assisted table. Wednesday and Fridays eats Italian lunch, provided by his/her friend".

In an interview the POA stated that he/she told the home, approximately one year ago, that he/she did not want resident #1 eating in the activity room with the friend and that staff should move the resident in the dining room and have staff feed resident. The POA stated that she allowed staff to let friend be present and observe but not to feed the resident.

An interview with resident #1's regular personal care assistant (PCA) revealed that the usual routine was when she observed the friend arriving on unit he/she would place a tray of thickened beverages and a protective clothing cover in the activity room while the friend went to resident #1's room to porter him/her to the activity room for lunch together. The PCA stated that he/she allowed them to have this time alone together, as the friend wanted to dine alone with resident so PCA did not stay in the activity room while resident #1 ate.

Record review and staff interview revealed that on an identified day, resident #1 was being fed by his/her friend in the activity room alone. The resident was provided roasted potato and lasagna. During the meal the resident stopped chewing and swallowing, and the resident's friend called staff. Record review revealed the resident condition changed, he/she was pale, unconscious, had bluish lips and nails, and had laboured breathing. Resident #1 was transferred to hospital and died six days later. Record review identified aspiration pneumonia as the primary cause of death.

The resident's PCA and registered nurse confirmed through interview that they had not been in the activity room during resident #1's meal and were unaware what foods had been offered until after the incident. In an interview the DOC stated that the incident was not unexpected, "we knew he/she might aspirate at some point, because his/her friend was not compliant".

The POA stated during an interview that he/she was "upset" when he/she found out that on the day of the incident resident #1 was being fed by his/her friend in the activity room.

The licensee failed to ensure that different approaches were considered in the revision of the plan of care when resident #1's friend continued to be non-compliant when providing lunch to the resident.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the home's policy titled "Tray Service" and revised on May 2007 revealed a resident request for specific occasion e.g. eating with visitors may be approved for tray service. A resident receiving tray service and eating in their room will be supervised by personal care staff.

Record review of the resident's written plan of care revealed that resident #1 was dysphagic, at high risk of choking, and required a modified diet. He/she needs to be monitored closely at meals, at an assisted table, and eats meals in the resident home area dining room.

An interview with the Team Lead revealed that close monitoring would require a staff member to be with the resident while the resident is eating.

Record review on an identified period of time revealed that a speech language pathologist (SPL) identified resident #1 as being at high risk of choking / aspiration and recommended downgrading diet texture and supervision at mealtimes. A registered dietitian (RD) ordered the resident's diet to be modified and identified that the resident would benefit from sitting at a feeder table where he/she can receive encouragement to eat slowly. The registered nurse was aware that the resident was to be placed at the feeding table to remind him/her to eat slowly and required close supervision and reminding to put smaller amounts of food in his/her mouth to prevent aspiration.

An interview with the RD confirmed that she was aware that resident #1 was at risk for choking. An interview with resident #1's primary personal care assistant (PCA) revealed that he/she was aware that resident #1 was at risk for choking, and had a modified diet, with food cut-up in pieces. The PCA revealed that resident #1 would hoard bread in his/her mouth and the PCA would sit with resident #1 at breakfast even though he/she was able to feed herself. Staff interview confirmed that resident #'1's usual routine was having lunch with a friend twice weekly, whereby the friend would bring in restaurant food such as lasagna, chicken wings, chicken legs, and roasted potatoes of regular texture. The resident and his/her friend would dine alone in the unit's activity room without staff supervision. Interviews with staff, including the Director of Care and registered dietitian revealed that the resident's friend did not accept the change in resident's diet, and continued to provide unsafe textured food and fluid to the resident despite being advised of the risks.

Staff interview and record review revealed that on an identified day, the resident was in the activity room, alone with his/her friend. The activity room is across a corridor, parallel to the unit dining room with glass wall panels where staff was attending to meal service. Resident #1 did not receive texture modified food, but instead was provided and ate 4 – 5 pieces of roasted potato and lasagna. The resident's friend was feeding him/her food brought from outside of the home without close monitoring by staff. During the meal, when resident #1 stopped chewing and swallowing, his/her friend called staff. Record review revealed resident's condition changed. He/she was pale, unconscious, had bluish lips and nails, and had laboured breathing. The resident's PCA and the registered nurse confirmed through interview that they had not been in the activity room during resident #1's meal and were unaware what foods had been offered until after the incident of choking/aspiration.

Resident #1 was transferred to hospital and died six days later. Record review

identified aspiration.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident.

Record review and staff interview revealed that on an identified day, resident #1 was fed unsafe regular textured food by his/her friend, contrary to his/her required modified texture diet. The resident aspirated, was transferred to the hospital, and died in the hospital six days later, with a primary diagnosis of aspiration pneumonia.

The home did not inform the Director under the Long Term Care Home Act in as much detail as possible of an incident that caused an injury to resident #1 for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident, to be implemented voluntarily.

Issued on this 13th day of March, 2014

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

Ministry of Health and Long-Term Care

Ministère 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) :	JULIENNE NGONLOGA (502), DIANE BROWN (110)
Inspection No. / No de l'inspection :	2014_241502_0003
Log No. / Registre no:	T-618-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 12, 2014
Licensee / Titulaire de permis :	THE KENSINGTON HEALTH CENTRE 25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9
LTC Home / Foyer de SLD :	THE KENSINGTON GARDENS 25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jim Eagleton

To THE KENSINGTON HEALTH CENTRE, 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. (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 must prepare, submit and implement a plan for achieving compliance to ensure that the care set out in the plan of care is provided to residents assessed at high nutritional risk as specified in the plan of care.

The compliance plan must include the following:
1. Develop an ongoing process to monitor the care provided to residents at high nutritional risk during meal times.
2. Identify who will be responsible for completing all tasks identified in the plan.

The plan must be submitted to juliene.ngonloga@ontario.ca by April 4, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident #1 as specified in the plan.

Record review of the resident's written plan of care revealed that resident #1 was dysphagic, at high risk of choking, and required a modified diet. He/she needs to be monitored closely at meals, at an assisted table, and eats meals in the resident home area dining room.

An interview with the Team Lead revealed that close monitoring would require a staff member to be with the resident while the resident is eating.

Record review on an identified period of time, revealed that a speech language pathologist (SPL) identified resident #1 as being at high risk of choking / aspiration and recommended downgrading diet texture and supervision at mealtimes. A registered dietitian (RD) ordered the resident's diet to be modified

and identified that the resident would benefit from sitting at a feeder table where he/she can receive encouragement to eat slowly. The registered nurse was aware that the resident was to be placed at the feeding table to remind him/her to eat slowly and required close supervision and reminding to put smaller amounts of food in his/her mouth to prevent aspiration.

An interview with the RD confirmed that she was aware that resident #1 was at risk for choking. An interview with resident #1's primary personal care assistant (PCA) revealed that he/she was aware that resident #1 was at risk for choking, and had a modified diet, with food cut-up in pieces. The PCA revealed that resident #1 would hoard bread in his/her mouth and the PCA would sit with resident #1 at breakfast even though he/she was able to feed herself. Staff interview confirmed that resident #'1's usual routine was having lunch with a friend twice weekly, whereby the friend would bring in restaurant food such as lasagna, chicken wings, chicken legs, and roasted potatoes of regular texture. The resident and his/her friend would dine alone in the unit's activity room without staff supervision. Interviews with staff, including the Director of Care and registered dietitian revealed that the resident's friend did not accept the change in the resident's diet, and continued to provide unsafe textured food and fluid to the resident despite being advised of the risks.

Staff interview and record review revealed that on an identified day, the resident was in the activity room, alone with his/her friend. The activity room is across a corridor, parallel to the unit dining room with glass wall panels where staff was attending to meal service. Resident #1 did not receive texture modified food, instead was provided and ate 4 – 5 pieces of roasted potato and lasagna. The resident's friend was feeding him/her food brought from outside of the home without close monitoring by staff. During the meal, when resident #1 stopped chewing and swallowing, his/her friend called staff. Record review revealed resident's condition changed. He/she was pale, unconscious, had bluish lips and nails, and had laboured breathing. The resident's PCA and the registered nurse confirmed through interview that they had not been in the activity room during resident #1's meal and were unaware what foods had been offered until after the incident of choking/aspiration.

Resident #1 was transferred to hospital and died six days later. Record review identified aspiration pneumonia as the primary cause of death. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 12, 2014

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 12th day of March, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

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