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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 22, 2014	2014_250511_0006	H-000183-14	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

ROBIN MACKIE (511)

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): February 13, 14, 18, 19, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Director of Care (ADOC), registered staff, personal support workers (PSW), physiotherapist and environmental manager.

During the course of the inspection, the inspector(s) observed provision of resident care, reviewed home's applicable policy, programs and procedures, manufacturer's instructions, maintenance documents, employee educational files and resident clinical records.

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

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure the residents were not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Resident #01 was a resident that had resided in the home when they fell from a bath chair during the provision of personal care sustaining an injury that resulted in a

transfer to hospital. Soon after the incident resident #01 succumbed to their injuries and deceased in hospital.

Clinical records identified resident #01 required extensive assistance with activity of daily living and had a high risk for falls, specifically for sliding from their chair, due to balance problems and weakness. Resident #01's plan of care identified previous falls from sliding out of the wheelchair since admission and required interventions for repositioning in the wheelchair to prevent further falls.

An interview with the PSW confirmed that resident #01 was in the bath chair, elevated approximately 75 centimeters from the floor, when the PSW unbuckled the safety belt and raised the hand rest bar during the provision of care. The PSW stated the resident was shivering when they turned away from the resident to obtain another bath towel. Unwitnessed and unsecured in the bath chair, the resident fell out striking their head on the floor as they landed on their left side.

A review of the home's incident documents and interview with the PSW confirmed the staff member removed the safety belt during bath care contrary to the manufacturer's instructions.

Interviews with five PSW's indicated that four of the five believed it was common practice in the home to remove the safety belt and hand rest bar, to assist in drying the resident, near the end of the bath despite the resident remaining in the bath chair. Five of the five staff members interviewed confirmed there had been no training on safe, lift and transfer using the bath chair in greater than five years and stated confusion on what constituted 'safe use' of the bath chair and if the bath chair was considered a 'mechanical lift' under the home's policy.

The licensee did not provide the staff with the annual training required under the home's Lifts and Transfer-Resident Care program. This was confirmed through the examination of the training and education records and interviews with staff members.

A review of the home's Fall committee minutes, prior to the fall of resident #01, identified the need to provide more education to front line staff on fall prevention. Interviews with the Administrator and with the DOC confirmed the home was aware of the need for safe lift and transfer training however had not offered training and education in a "long time" but that it was on their list of upcoming education. The Administrator and DOC confirmed the home had manufacturer education scheduled

for Tuesday February 18, 2014.

The Administrator confirmed that after the incident the staff continued to use the bath chair for the provision of resident baths within the home without training and without the implementation of interventions to mitigate the risk to residents due to the misconception and misuse of the safety belt on the mechanical bath lift. The Administrator further confirmed, the PSW involved in the incident of resident #01, was called back in to work by the home to provide resident care after the incident and prior to the training on February 18, 2014.

The ADOC confirmed approximately 341 baths were provided to the residents of the home between the date of the accident and the date of the training on February 18, 2014.

Having knowledge of the home's need for safe lift and transfer training and the statement from the employee indicating she did not use the lift according to the manufacturer's instructions for the care provided to resident #01; the home continued to allow the use of the bath lifts between the dates of the accident and February 18, 2014 without providing immediate interventions to staff to reduce further resident risk. This pattern of inaction constituted neglect under the act as it jeopardized the health and/or safety of resident #01 and one or more residents during the time the home had knowledge of the risk and the time the manufacturer training was implemented to staff on February 18, 2014.

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 did not ensure that the policies and procedures for the Falls Prevention program required by s. 48 and 30 of this Regulation were complied with. O. Reg. 79/10, s. 8 (1)

Review of clinical records confirmed resident #01 was a high risk for falls, sustaining several falls since their admission. More than half of the falls were documented to be from sliding from the wheelchair.

A review of the home's Fall Prevention policy and procedure detailed that the required falls committee will, at a minimum of quarterly, review and analyze the falls that have occurred and look for trends. An interview with the DOC confirmed the falls committee did not meet and review resident #01's frequent falls despite documentation in the clinical records suggesting a trend of sliding from their wheelchair.

Further, the home's Fall Prevention policy and procedure identified the post fall huddle assessment would identify contributing factors, trends and identify interventions that would mitigate future risk. Documentation outlined on the post huddle fall form, section H, was either not completed or did not identify nursing interventions for many of the falls in an effort to mitigate future risk as per the home's Fall Prevention program. An interview with the Administrator and DOC confirmed the home had not fully implemented the home's Fall Prevention policy and procedure. [s. 8. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee did not ensure that the staff and others who provided direct care to resident #01 were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Resident #01 sustained an injury that required a transfer to hospital when they fell from a bath chair during the provision of personal care.

Clinical records identified resident #01 had a high risk for falls, specifically for sliding from their chair, due to balance problems and weakness. Resident #01's plan of care focus stated that they were a high risk for falls related to balance problems and required repositioning in the wheelchair to prevent further falls from the chair.

The electronic care record (kardex) available to the direct care staff through Point Of Care(POC)did not identify the high risk for falls as contained in the electronic record available to registered staff through Point Click Care(PCC).

An interview with a PSW confirmed they used the POC kardex for resident #01's plan of care and stated they did not know resident #01 had a fall history of sliding from the chair.

Interview with the DOC and Administrator confirmed resident #01's plan of care, was not conveniently and immediately accessible to the front line staff. [s. 6. (8)]

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 staff and others who provide direct care will be kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Resident #01 was sitting in a mechanical bath chair, when they slid from the chair and sustained an injury that resulted in a transfer to hospital.

The manufacturer's instruction says that the safety belt must be used at all times to ensure the resident remained in an upright position, in the middle of the seat, and the safety belt was to be secured throughout the bathing cycle. An interview with the PSW confirmed the safety belt was not secured on resident #01 during the provision of personal care throughout the bathing cycle.

The manufacturer's instruction further says that the bath chair was to be lowered immediately after removing the resident from the bath and that care was to be provided when the bath chair was in a lowered position. An interview with the PSW confirmed the resident was not lowered immediately and that the resident continued to receive personal care in the bath chair, elevated approximately 75 centimeters from the floor, when they fell sustaining an injury.

The manufacturer's instruction recommended the equipment only be used by appropriately trained caregivers in accordance with the directions outlined in the operating and product care instructions. An interview with the PSW indicated the PSW was unaware of the need to keep the safety belt on at all times and the bath chair in the lowest position immediately after removing the resident from the bath. The PSW stated their training was provided by another PSW as part of a mentoring orientation and she was not taught the above manufacturer's instructions. The Administrator and DOC were unable to confirm the training, to this psw, was provided as outlined in the operating and product care instructions. [s. 23.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that staff used safe transferring and positioning devices or techniques when assisting residents in particular resident #01.

Resident #01 fell from a mechanical bath chair while receiving personal care from a PSW resulting in an injury that required a transfer to hospital.

An interview with the PSW confirmed that resident #01 was in the bath chair, elevated approximately 75 centimeters from the floor, when the PSW unbuckled the safety belt and raised the hand rest bar during the provision of care. The PSW stated the resident was shivering when she turned away from the resident to obtain another bath towel. The resident slid from the bath chair and landed on their left side.

Clinical documentation confirmed resident #01 was a high risk for falls and had slid from a wheelchair on previous occasions.

Interview with the Administrator and DOC confirmed that removing the safety belt, and keeping the chair in an elevated position while the PSW turned away from the resident was not ensuring safe positioning devices or techniques were used when assisting resident #01. [s. 36.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation
For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee did not ensure for the purposes of paragraph 11 of subsection 76 (2) of the Act, the following were additional areas in which training was provided: Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

A PSW, employed by the home, provided a bath to resident #01 which required the use of a mechanical bath chair as directed in resident #01 clinical records. During the provision of care the resident fell from the bath chair and sustained an injury resulting in transfer to hospital.

An interview with the PSW, who had provided care at the time of the fall, indicated she did not know how the resident had fallen as she believed the care was provided using a safe and correct use of the equipment. The PSW stated she had not received training on the use of the mechanical bath chair but had learned by watching other staff use the equipment. Interview with four other PSW's confirmed the practice of unbuckling the safety belt prior to completing resident care contrary to the manufacturer's instructions for use of the chair.

A review of the PSW's personnel file, educational records and home's orientation documents indicated the employee did not receive training in the safe and correct use of the mechanical bath chair prior to performing her responsibilities.

An interview with the DOC and Administrator confirmed the PSW had not received training on the safe and correct use of the mechanical bath lift as per the home's Safe, Lift and transfer program, relevant to the staff member's responsibilities. [s. 218. 2.]

Issued on this 24th day of April, 2014

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

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

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) :	ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2014_250511_0006
Log No. / Registre no:	H-000183-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 22, 2014
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - BRANTFORD 389 WEST STREET, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~Shelly Desgagne~~ Susan Hastings

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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement an action plan that includes the education, training, evaluation and ongoing monitoring for all staff on Falls prevention and the safe, lift and transfer use of mechanical lifts used in the home, specifically the bath chair, to ensure that the residents are not neglected by the licensee or staff. The plan is to be submitted on or before March 14, 2014 to Robin.Mackie@ontario.ca

Grounds / Motifs :

1. The licensee of the long-term care home did not ensure the residents were not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Resident #01 was a resident that had resided in the home when they fell from a bath chair during the provision of personal care sustaining an injury that resulted in a transfer to hospital. Soon after the incident resident #01 succumbed to their injuries and deceased in hospital.

Clinical records identified resident #01 required extensive assistance with activity of daily living and had a high risk for falls, specifically for sliding from their chair, due to balance problems and weakness. Resident #01's plan of care identified previous falls from sliding out of the wheelchair since admission and required interventions for repositioning in the wheelchair to prevent further falls.

An interview with the PSW confirmed that resident #01 was in the bath chair, elevated approximately 75 centimeters from the floor, when the PSW unbuckled the safety belt and raised the hand rest bar during the provision of care. The PSW stated the resident was shivering when they turned away from the resident to obtain another bath towel. Unwitnessed and unsecured in the bath chair, the

resident fell out striking their head on the floor as they landed on their left side.

A review of the home's incident documents and interview with the PSW confirmed the staff member removed the safety belt during bath care contrary to the manufacturer's instructions.

Interviews with five PSW's indicated that four of the five believed it was common practice in the home to remove the safety belt and hand rest bar, to assist in drying the resident, near the end of the bath despite the resident remaining in the bath chair. Five of the five staff members interviewed confirmed there had been no training on safe, lift and transfer using the bath chair in greater than five years and stated confusion on what constituted 'safe use' of the bath chair and if the bath chair was considered a 'mechanical lift' under the home's policy.

The licensee did not provide the staff with the annual training required under the home's Lifts and Transfer-Resident Care program. This was confirmed through the examination of the training and education records and interviews with staff members.

A review of the home's Fall committee minutes, prior to the fall of resident #01, identified the need to provide more education to front line staff on fall prevention. Interviews with the Administrator and with the DOC confirmed the home was aware of the need for safe lift and transfer training however had not offered training and education in a "long time" but that it was on their list of upcoming education. The Administrator and DOC confirmed the home had manufacturer education scheduled for Tuesday February 18, 2014.

The Administrator confirmed that after the incident the staff continued to use the bath chair for the provision of resident baths within the home without training and without the implementation of interventions to mitigate the risk to residents due to the misconception and misuse of the safety belt on the mechanical bath lift. The Administrator further confirmed, the PSW involved in the incident of resident #01, was called back in to work by the home to provide resident care after the incident and prior to the training on February 18, 2014.

The ADOC confirmed approximately 341 baths were provided to the residents of the home between the date of the accident and the date of the training on February 18, 2014.

Having knowledge of the home's need for safe lift and transfer training and the statement from the employee indicating she did not use the lift according to the manufacturer's instructions for the care provided to resident #01; the home continued to allow the use of the bath lifts between the dates of the accident and February 18, 2014 without providing immediate interventions to staff to reduce further resident risk. This pattern of inaction constituted neglect under the act as it jeopardized the health and/or safety of resident #01 and one or more residents during the time the home had knowledge of the risk and the time the manufacturer training was implemented to staff on February 18, 2014. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 28, 2014

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_122156_0024, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure the home's Fall Prevention policy and procedure is fully implemented, specifically:
1. that the falls committee will, at a minimum of quarterly, review and analyze the falls that have occurred, including the falls of resident #01, and look for trends; and,
2. that the home will ensure the post fall huddle assessments are completed in their entirety and implemented according to the policy.

Grounds / Motifs :

1. The licensee did not ensure that the policies and procedures for the Falls Prevention program required by s. 48 and 30 of this Regulation were complied with. O. Reg. 79/10, s. 8 (1)

Review of clinical records confirmed resident #01 was a high risk for falls, sustaining several falls since their admission. More than half of the falls were documented to be from sliding from the wheelchair.

A review of the home's Fall Prevention policy and procedure detailed that the required falls committee will, at a minimum of quarterly, review and analyze the falls that have occurred and look for trends. An interview with the DOC confirmed the falls committee did not meet and review resident #01's frequent falls despite documentation in the clinical records suggesting a trend of sliding from their wheelchair.

Further, the home's Fall Prevention policy and procedure identified the post fall huddle assessment would identify contributing factors, trends and identify interventions that would mitigate future risk. Documentation outlined on the post huddle fall form, section H, was either not completed or did not identify nursing interventions for many of the falls in an effort to mitigate future risk as per the home's Fall Prevention program. An interview with the Administrator and DOC confirmed the home had not fully implemented the home's Fall Prevention policy and procedure. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 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.

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

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 22nd day of April, 2014

Signature of Inspector / Signature de l'inspecteur : R Mackie

Name of Inspector / Nom de l'inspecteur : Robin Mackie

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