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 11, 2014	2014_163109_0011	T-347-14	Complaint

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

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

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 20, 21, 2014.

This inspection includes areas of non-compliance related to skin and wound care from inspection # 2014_163109_0006 which corresponds with Log #: T-552-13, and from inspection # 2014_163109_0010 which corresponds with Log #: T-195-14.

During the course of the inspection, the inspector(s) spoke with Administrator, director of care, personal support workers(PSW), registered staff, substitute decision maker (SDM), registered dietitian (RD), resident assessment instrument (RAI) Coordinator, wound care coordinator.

During the course of the inspection, the inspector(s) reviewed the health care record for identified residents, reviewed skin care policy and procedure, conducted walk through of care areas.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Skin and Wound Care

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #6 received a skin assessment by a member of the registered nursing staff upon return from hospital.

Record review revealed that resident #6 was at a high risk for skin breakdown. On an identified date, the resident was sent to the hospital. Prior to being sent to the hospital the nurse assessed the resident's skin and indicated that the resident had a dressing on the left hand and another one on right arm. There was bruising noted.

Resident #6 returned from the hospital on a specified date. At this time a skin assessment was not completed for the resident.

Staff interview indicated that the skin assessment is expected to be completed for residents returning from the hospital and should be documented in the progress notes as well as on the homes skin assessment form. There was no documented

assessment on the resident's health record. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #12 was noted to have multiple deteriorating areas of skin breakdown ranging from rashes to decubitus ulcers over a 4 month period of time.

Photographs from SDM show that the resident has dressings on several of the wounds.
The home has a weekly wound assessment tool which is used for all wounds. The home's weekly wound assessments for resident #12 were only completed on three specified dates over the four month period of time. There were no other assessments completed for the wounds. [s. 50. (2) (b) (i)]

3. Record review of the progress notes revealed that resident # 6 was identified to be at a high risk for skin breakdown and was not assessed using the home's clinically appropriate assessment instrument.
Resident #6 had multiple different areas of skin breakdown over a 4 month period of time.
Staff interview confirmed that there were no weekly skin assessments completed for this resident's multiple areas of skin breakdown. [s. 50. (2) (b) (i)]

4. Record review and staff interview revealed on an identified date, resident #11 sustained a skin tear. There is no indication which area of the body was injured. There is no indication what the treatment was for the skin tear and there is no indication as to when the skin healed. The resident was not assessed using the home's clinically appropriate assessment instrument.

The home has a clinically appropriate assessment tool which is in place to complete weekly assessments on residents with skin breakdown. This assessment tool was not completed for resident #11 for the skin tear. [s. 50. (2) (b) (i)]

5. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent

infection.

Record review revealed that resident #12 developed multiple pressure ulcers over a four month period of time.

On an identified date, the enterostomal therapy (ET) nurse assessed the resident's wounds and recommended a treatment. The treatment was not endorsed to the physician and therefore not implemented.
On a later identified date the ET nurse re-assessed the resident and made new recommendations.
These recommendations were not implemented until more than 3 weeks after the ET assessment.
On another identified date the ET nurse re-assessed 2 of the wounds and made recommendations. These recommendations were not implemented.

On an identified date resident was found to be in a seriously compromised physical state. The resident was transferred to the hospital for assessment. The resident deceased days later in the hospital. [s. 50. (2) (b) (ii)]

6. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain.

Resident #6 developed a pressure ulcer on an identified date. Staff interview revealed that the resident experiences significant pain when staff touches the wound to clean and change the dressing.

There were no pain interventions have implemented even though the resident experienced significant pain when the wound was touched. Resident #6 has a standing order for analgesic to be given as needed. A review of the medication administration records and staff interview indicates that this medication was not administered for pain control prior to dressing changes.

The home ordered and administered a narcotic analgesic prior to dressing changes after inspector inquired about pain management strategies. [s. 50. (2) (b) (ii)]

7. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a

registered dietitian who is a member of the staff of the home.

Record review revealed that resident #12 developed decubitus ulcers on an identified date. Staff interview revealed that a referral was not sent to the RD until a month later. The nutritional plan of care was not revised to promote wound healing until after the resident was seen by the RD resulting in delayed nutritional care. [s. 50. (2) (b) (iii)]

8. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

Resident #6 was found to have a pressure ulcer on an identified date. The RD did not become aware of the ulcer until over a month later when she was alerted to the result of decreased weight.

Staff interview with the registered dietitian (RD) indicated that a referral was not sent when the nursing staff discovered the resident's pressure ulcer, she was not aware that the resident had a skin problem and therefore the resident was not assessed. [s. 50. (2) (b) (iii)]

9. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff if clinically indicated.
Record review revealed that resident #12 developed multiple pressure ulcers over a four month period of time.
ET assessments on two identified dates indicate that there was another ulcer present. According to staff interview and record review, there were no weekly assessments completed on any of the wounds between over the 4 month period of time. [s. 50. (2) (b) (iv)]

10. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

Record review revealed that resident # 6 was identified to be at a high risk for skin breakdown did not receive weekly assessments by a member of the registered nursing staff for multiple skin breakdowns.

Staff interview and record review confirmed that there were no weekly skin assessments completed for this resident's skin. [s. 50. (2) (b) (iv)]

11. Record review and staff interview revealed resident #11 is at risk for skin breakdown.
On an identified date resident #11 sustained a skin tear. There is no indication which area of the body was injured. There is no indication what the treatment was for the skin tear and there is no indication as to when the skin tear healed.

There were no weekly assessments completed for the skin tear.

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 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #12 at risk of altered nutritional status was losing weight over a period of five months.

The RD changed the residents diet from regular texture to pureed texture because the resident was having difficulty in chewing food.

The SDM was not contacted by the RD and given an opportunity to participate in the development and implementation of the plan of care. [s. 6. (5)]

2. Record review revealed that resident #12 developed decubitus ulcers which progressed over a four month period of time.
Record review and staff interview revealed that the resident's substitute decision maker (SDM) was not informed of the wounds and their progression and eventual treatment plan so as to be given an opportunity to participate in the development and implementation of the plan of care. The SDM was distressed to find out that resident #12's wounds had progressed to a catastrophic state in which the resident was sent to the hospital on an identified date and died in the hospital a few days later. [s. 6. (5)]

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

Record review and staff interview revealed that resident #12 had multiple skin breakdowns. The home arranged for the ET nurse to assess the resident and recommend a treatment plan.
On an identified date the ET nurse assessed the resident's wounds and recommended a treatment. This treatment recommendation was not implemented.
On another identified date the ET nurse re-assessed the resident and made recommendations. These recommendations were not implemented until 3 weeks later.
On another identified date the ET nurse re-assessed two of the wounds and made recommendations. These recommendations were not implemented.
Staff interview confirmed that the implementations were not implemented. [s. 6. (7)]

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 SDM was provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff are provided training in skin and wound care.

Review of the 2013 education records for skin and wound care revealed that only 72 out of 176 direct care staff were provided with training in skin and wound care. The wound care nurse confirmed that she had not been provided with any training by the licensee to assume the role of the wound care coordinator for the home. [s. 221. (1) 2.]

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 direct care staff are provided training in skin and wound care, to be implemented voluntarily.

Issued on this 30th day of April, 2014

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2014_163109_0011
Log No. / Registre no:	T-347-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 11, 2014
Licensee / Titulaire de permis :	WEST PARK HEALTHCARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	WEST PARK LONG TERM CARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TRISH TALABIS

To WEST PARK HEALTHCARE 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 :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that the following areas of non-compliance are corrected:

The licensee shall ensure that resident #6 and #11 exhibiting altered skin integrity, including skin tears, receive a skin assessment by a member of the registered nursing staff, using the homes clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The licensee shall ensure that resident #6 who is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The licensee shall ensure that resident #6 who is exhibiting altered skin integrity is assessed by the registered dietitian (RD).

The licensee shall ensure that resident #6 and #11 who are exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff.

Please submit compliance plan to susan.squires@ontario.ca on or before April 18, 2014

Grounds / Motifs :

1. The licensee has failed to ensure that resident #6 received a skin assessment by a member of the registered nursing staff upon return from hospital.

Record review revealed that resident #6 was at a high risk for skin breakdown. On an identified date, the resident was sent to the hospital. Prior to being sent to the hospital the nurse assessed the resident's skin and indicated that the resident had a dressing on the left hand and another one on right arm. There was bruising noted.

Resident #6 returned from the hospital on a specified date. At this time a skin assessment was not completed for the resident.

Staff interview indicated that the skin assessment is expected to be completed for residents returning from the hospital and should be documented in the progress notes as well as on the homes skin assessment form. There was no

documented assessment on the resident's health record.
(109)

2. Record review and staff interview revealed on an identified date, resident #11 sustained a skin tear. There is no indication which area of the body was injured. There is no indication what the treatment was for the skin tear and there is no indication as to when the skin healed. The resident was not assessed using the home's clinically appropriate assessment instrument.

The home has a clinically appropriate assessment tool which is in place to complete weekly assessments on residents with skin breakdown. This assessment tool was not completed for resident #11 for the skin tear.
(109)

3. Record review of the progress notes revealed that resident # 6 was identified to be at a high risk for skin breakdown and was not assessed using the home's clinically appropriate assessment instrument.

Resident #6 had multiple different areas of skin breakdown over a 4 month period of time.

Staff interview confirmed that there were no weekly skin assessments completed for this resident's multiple areas of skin breakdown
(109)

4. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
Resident #12 was noted to have multiple deteriorating areas of skin breakdown ranging from rashes to decubitus ulcers over a 4 month period of time.

Photographs from SDM show that the resident has dressings on several of the wounds.

The home has a weekly wound assessment tool which is used for all wounds. The home's weekly wound assessments for resident #12 were only completed on three specified dates over the four month period of time. There were no other

assessments completed for the wounds.
(109)

5. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain. Resident #6 developed a pressure ulcer on an identified date. Staff interview revealed that the resident experiences significant pain when staff touches the wound to clean and change the dressing.

There were no pain interventions have implemented even though the resident experienced significant pain when the wound was touched. Resident #6 has a standing order for analgesic to be given as needed. A review of the medication administration records and staff interview indicates that this medication was not administered for pain control prior to dressing changes.

The home ordered and administered a narcotic analgesic prior to dressing changes after inspector inquired about pain management strategies
(109)

6. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Record review revealed that resident #12 developed multiple pressure ulcers over a four month period of time.
On an identified date, the enterostomal therapy (ET) nurse assessed the resident's wounds and recommended a treatment. The treatment was not endorsed to the physician and therefore not implemented.

On a later identified date the ET nurse re-assessed the resident and made new recommendations.
These recommendations were not implemented until more than 3 weeks after the ET assessment.

On another identified date the ET nurse re-assessed 2 of the wounds and made recommendations. These recommendations were not implemented.

On an identified date resident was found to be in a seriously compromised physical state. The resident was transferred to the hospital for assessment. The resident deceased days later in the hospital. (109)

7. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

Resident #6 was found to have a pressure ulcer on an identified date. The RD did not become aware of the ulcer until over a month later when she was alerted to the result of the decreased weight.

Staff interview with the registered dietitian (RD) indicated that a referral was not sent when the nursing staff discovered the resident's pressure ulcer, she was not aware that the resident had a skin problem and therefore the resident was not assessed.
(109)

8. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

Record review revealed that resident #12 developed decubitus ulcers on an identified date. Staff interview revealed that a referral was not sent to the RD until a month later. The nutritional plan of care was not revised to promote wound healing until after the resident was seen by the RD resulting in delayed nutritional care.
(109)

9. Record review and staff interview revealed resident #11 is at risk for skin breakdown.

On an identified date resident #11 sustained a skin tear. There is no indication which area of the body was injured. There is no indication what the treatment was for the skin tear and there is no indication as to when the skin tear healed.

There were no weekly assessments completed for the skin tear.
(109)

10. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

Record review revealed that resident # 6 was identified to be at a high risk for skin breakdown did not receive weekly assessments by a member of the registered nursing staff for multiple skin breakdowns.

Staff interview and record review confirmed that there were no weekly skin assessments completed for this resident's skin
(109)

11. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

Record review revealed that resident #12 developed multiple pressure ulcers over a four month period of time.
ET assessments on two identified dates indicate that there was another ulcer present.

According to staff interview and record review, there were no weekly assessments completed on any of the wounds between over the 4 month period of time.
(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 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
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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 11th day of April, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SUSAN SQUIRES

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