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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2016	2016_210169_0001	019295-15	Resident Quality Inspection

Licensee/Titulaire de permis

1245556 ONTARIO INC.
200 Ronson Drive Suite 305 TORONTO ON M9W 5Z9

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

BURTON MANOR
5 Sterritt Drive BRAMPTON ON L6Y 5P3

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

YVONNE WALTON (169), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 14, 15, 18, 19, 20, 21, 22, 26, 2016

The following inspections were completed with this Resident Quality Inspection:

Critical Incident #001653-15, 029347-15 and #031369-15 related to allegations of resident abuse.
Critical incident #005284-15 related to an improper transfer resulting in an injury.
Critical incident #009581-15 and #027236-15 related to a fall resulting in an injury.
Critical incident #012617-15 related to responsive behaviouthrs.
Complaint #009733-14 related to responsive behaviours and residents rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Nurse Managers (NM), Director of Behavioural Support (BSO), Resident Support Services Manager (RSS), MDS/RAI coordinator, Physiotherapist (PT), Dietician (RD), Food and Nutrition Manager (FNM), Registered Nursing staff, Personal Support Workers (PSW), laundry and housekeeping staff. The inspectors also spoke with residents and their families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, no resident in the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A) Observation of resident #010 on January 14, 2016, revealed the resident was tilted back in their wheelchair. Review of the resident's plan of care did not include the use of a tilt wheelchair. Interview with the Administrator, DOC, ADOC, PT and NRRC confirmed that according to the home's policy, the tilt chair would be considered a restraint, and would need to meet the requirements under section 31 (3) of the Act, as well as to be included in the resident's plan of care and meet the provisions under section 31 (2) of the Act. The staff also confirmed the resident should not have been tilted in their wheelchair and the tilt function should not be used, and confirmed the requirements under the Act were not met for the use of the tilt wheelchair as a restraint for resident #010.

B) Observation of resident #008 on January 14 and 15, 2016, revealed the resident was tilted back in their wheelchair. Review of the resident's plan of care did not include the use of a tilt wheelchair. Interview with the Administrator, DOC, ADOC, PT and NRRC confirmed that the tilt chair would be considered a restraint, and would need to meet the requirements under section 31 (3) of the Act, as well as to be included in the resident's plan of care and meet the provisions under section 31 (2) of the Act. The staff also confirmed the resident should not have been tilted in their wheelchair and the tilt function should not be used, and confirmed the requirements under the Act were not met for the use of the tilt wheelchair as a restraint for resident #008. [s. 30. (1) 3.]

2. C) Observation of resident #017 on January 19 and 20, 2016, revealed the resident was sitting in a wheelchair that was tilted so that their feet were almost level with their torso. Interview with staff #007 and #008, the Behavioural Supports Ontario (BSO) stated that the resident became restless in the wheelchair and tilting the chair prevented them from ambulating out of the chair. They confirmed that the chair in the tilt position acted as a restraint as it prevented the resident from voluntarily ambulating from the chair. Staff person #008 confirmed this and that the tilt chair as a restraint had not been ordered or approved by a physician or registered nurse in extended class. During interview, the ADOC and DOC confirmed the following: i) that the tilt chair acted as a restraint; ii) that the resident's plan of care did not include tilting their chair; iii) that requirements under section 31 of the Act had not been satisfied for resident #017; and iv) that the resident should not have been placed in a tilt position as a way to restrain them. [s. 30. (1) 3.]

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A) Resident #046's electronic care plan indicated that the resident's wheelchair footrests were not to be attached while the resident was sitting in the chair because at times they would decide to stand up and walk around the unit, which was a tripping hazard. Review of the unit's Care Plan Binder, which frontline staff refer to while providing direct care, was not updated, and still indicated that the resident's footrests should remain on the wheelchair at all times. Observation throughout the review revealed the resident was sitting in the wheelchair without foot residents attached to the wheelchair. This was confirmed by registered staff member #001. [s. 6. (1) (c)]

2. The licensee failed to ensure that resident #044's substitute decision maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #044 had a diagnosis and consultant assessments which indicated their need for the use of substitute decision maker (SDM) for the development of their plan of care. The resident's plan of care directed staff to regularly involve the SDM in decisions about the resident's care.

A) Review of the resident's health records indicated that the SDM had not been contacted and allowed an opportunity to participate in the development of the plan of care.

C) Health record review revealed a progress note entry on October 17, 2014 that indicated that the resident had a change in condition for which the Nurse Practitioner assessed the resident and wrote new orders for direct care staff. According to the doctor's order sheet and progress notes, the SDM was not notified of this change in condition and recommended treatment plan until October 20, 2014. They did not have the opportunity to participate in the development of the plan of care.

The Administrator confirmed that it was the home's expectation that SDM be notified and the notification be documented. [s. 6. (5)]

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

A) Observation of resident #046 on January 15, 2016, revealed the resident was tilted back in their wheelchair with their legs dangling. Observation of the resident on January 18 and 19, 2016, revealed the resident was tilted back slightly in their wheelchair, with their feet just able to rest on the floor. Resident #046's care plan directed staff to un-tilt the wheelchair as the resident will try to stand up from wheelchair. Interview with PSW #002 and registered staff #001 confirmed the tilt function of the resident's wheelchair was not to be used and the chair should never be tilted. The RN confirmed care was not provided to the resident as per their plan of care. [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 that ensures there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1)., to be implemented voluntarily.

WN #3: 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #046's documented plan of care indicated staff were to ensure that the resident's feet were placed on both footrests at all times while transferring or portering the resident. On January 19, 2016, PSW #003 was observed transferring/portering the resident to the dining room in their wheelchair with the resident's legs crossed and their left foot dragging on the floor. Registered staff #001 confirmed the resident was to have their footrests on their wheelchair at all times when transferring/portering the resident around the unit, and confirmed the resident was not transferred/portered safely. [s. 36.]

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 that ensures staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements as set out in the lighting table were not maintained. Light fixtures were measured using a portable digital light meter, held 30 inches above and parallel to the level of the floor. Seven bathroom fixtures were measured. All bathrooms were equipped with flush mount dome lights each with 2 bulbs and an opaque covered lens. All bathroom doors were closed prior to testing lux levels. Those that were tested are listed below.
A minimum of 215.28 lux is required in washrooms.
-room A- Directly under the lights, illumination levels ranged between 215 to 218 lux however, at the sink level were 133-135 lux, and at the toilet were 130-136 lux.
-room B- Directly under the lights, illumination levels ranged between 226 to 230 lux however, at the sink level were 161-163 lux, and at the toilet were 148-150 lux.
-room C- Directly under the lights, illumination levels ranged between 276 to 279 lux however, at the sink level was 185-187 lux, and at the toilet was 183-193 lux.
-room D- Directly under the lights, illumination levels ranged between 213 to 218 lux however, at the sink level was 137-138 lux, and at the toilet was 158-159 lux.
-room E- Directly under the lights, illumination levels ranged between 211 to 215 lux. At the sink level was 142-144 lux, and at the toilet was 139-145 lux.
-room F- Directly under the lights, illumination levels ranged between 176 to 178 lux. At the sink level was 104-105 lux, and at the toilet was 114 -116 lux.
-room G- Directly under the lights, illumination levels ranged between 175 to 186 lux. At the sink level was 101-104 lux, and at the toilet was 125 -126 lux.

The Environmental Supervisor who was present for four out of seven rooms viewed and confirmed the lighting lux levels. [s. 18.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Resident #009's plan of care indicated they required extensive assistance during meals, and total assistance if fatigued. During lunch meal service on January 14, 2016, the resident was observed awake at their table with their entrée in front of them from 1257 hours until 1307 hours when someone came to provide full assistance with eating and drinking; 10 minutes after their entrée was placed in front of them. This was confirmed by registered staff #001. [s. 73. (2) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum.

According to staff interviews the home's communication and response system functioned so that when activated, call stations triggered a quiet alarm at the nursing station, illuminated a light above residents' doorways and activated personal support worker pagers to notify them when and where a call station had been activated.

On January 15, 2016, seven call bell stations did not activate staff pagers according to the home's policy. Staff person #006 and DOC confirmed that the triggered call bells were not consistently activating staff pagers and were not in a timely manner. According to interview with the Administrator, on January 17, 2016, the home's system maintenance provider identified poorly functioning pagers and recommended an audit of all paging devices in the home. In addition, "slow or no response on pagers was noted during service on January 17, 2016.

The home's Nurse Call System Policy number 08-03 last revised directed staff to ensure that system malfunctions were reported immediately to the registered staff member/maintenance to ensure repairs were made quickly. During interview staff #004 confirmed this. During interview, the home's Environmental Supervisor stated that call bell functioning was audited two times per year that included determining whether the call bell triggered the hallway light above the resident's room and the nursing station control board. They stated that the home had not developed or implemented a procedure to regularly audit staff pagers to ensure that they were in good repair, and maintained at a level that met manufacturer specifications, at a minimum. Staff were expected to notify maintenance of problems with paging devices. The Environmental Supervisor confirmed that staff may not be aware that their paging devices were not activated if the device was not functioning or triggered by call stations. [s. 90. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #015's seat belt was applied according to manufacturer's guidelines.

Resident #015 was noted to be wearing a seat belts that was very tight fitting and not applied according to manufacturer's guidelines. Review of the resident's plan of care confirmed that the seat belt was a restraint and the resident could not remove the seat belt. Interview with the PT and NRRC confirmed that seat belts used to restrain a resident should be tightened to the distance of approximately two finger widths. The seat belt observed on January 15, 2016, was less than two finger widths from the residents' abdomen which was not in accordance with the manufacturer's guidelines. [s. 110. (1) 1.]

Issued on this 9th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YVONNE WALTON (169), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2016_210169_0001
Log No. / Registre no:	019295-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2016
Licensee / Titulaire de permis :	1245556 ONTARIO INC. 200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	BURTON MANOR 5 Sterritt Drive, BRAMPTON, ON, L6Y-5P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jill Knowlton

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 1245556 ONTARIO INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee failed to ensure that no resident in the home was (3) restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. s. 30. (1)3.

The licensee shall do the following:

1) Review and revise the home's Minimizing Restraints Policy so that it is in accordance with the Act and Regulations and includes the use of tilt chair as a form of resident restraint.

2) Re educate staff on the revised policy identified in #1.

3) Review the plans of care for resident #008, #010 and #017 to reflect the use of a tilt wheelchair that includes all the requirements under the Act.

4) Develop a process to monitor and ensure tilt wheelchair use for any resident is included in their plan of care and meets all the requirements under the Act.

Grounds / Motifs :

1. The licensee failed to ensure that, no resident in the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

On January 19 and 20, 2016, resident #017 was observed sitting in a wheelchair that was tilted so that their feet were almost level with their torso. Interview with staff #007 and #008, the Behavioural Supports Ontario (BSO) revealed that the resident became restless in the wheelchair and tilting the chair prevented them from ambulating out of the chair. They confirmed that the chair in the tilt position acted as a restraint as it prevented the resident from voluntarily ambulating from the chair.

Staff person #008 confirmed this and that the tilt chair as a restraint had not been ordered or approved by a physician or registered nurse in extended class.

During interview, the ADOC and DOC confirmed the following: i) that the tilt chair acted as a restraint; ii) that the resident's plan of care directed staffs' responses to prevent falls and that this did not include tilting their chair; iii) that requirements under section 31 of the Act had not been satisfied for resident #017; and iv) that the resident should not have been placed in a tilt position as a

way to restrain them. (526)

2. The licensee failed to ensure that residents #008 and #010 were not restrained by the use of a physical device.

A) Observation of resident #010 on January 14, 2016, revealed the resident was tilted back in their wheelchair. Review of the resident's plan of care did not include the use of a tilt wheelchair. Interview with the Administrator, DOC, ADOC, PT and NRRC confirmed that according to the home's policy, the tilt chair would be considered a restraint, and would need to meet the requirements under section 31 (3) of the Act, as well as to be included in the resident's plan of care and meet the provisions under section 31 (2) of the Act. The staff confirmed the resident should not have been tilted in their wheelchair and the tilt function should not be used, and confirmed the requirements under the Act were not met for the use of the tilt wheelchair as a restraint for resident #010. (586)

3. B) Observation of resident #008 on January 14 and 15, 2016, revealed the resident was tilted back in their wheelchair. Review of the resident's plan of care did not include the use of a tilt wheelchair. Interview with the Administrator, DOC, ADOC, PT and NRRC confirmed the tilt chair would be considered a restraint, and would need to meet the requirements under section 31 (3) of the Act, as well as to be included in the resident's plan of care and meet the provisions under section 31 (2) of the Act. The staff confirmed the resident should not have been tilted in their wheelchair and the tilt function should not be used, and confirmed the requirements under the Act were not met for the use of the tilt wheelchair as a restraint for resident #008. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2016

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 9th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YVONNE WALTON

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