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
Sep 16, 2013	2013_190159_0022	H-000539-13	Follow up

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 26, 27, 28, 30, 2013

During the course of the inspection, the inspector(s) spoke with administrator, Director of Care(DOC), Assistant Director Of Care(ADOC), registered staff, Personal Support Workers(PSWs), Food Service Supervisor, Registered Dietitian and residents.

During the course of the inspection, the inspector(s) observed resident care, dining service, reviewed health records and policies and procedures specific to nutritional care, and Bowel Management program.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. [O.Reg.79/10,s.26(4)(b)]Previously issued as Compliance Order December 31, 2012.
The Registered Dietitian did not assess resident#0001's hydration status, and any risk related to hydration when the resident's fluid intake was less than their assessed fluid requirements.
(A) The plan of care for resident#0001 identified risk for dehydration related to poor fluid intake. The Registered Dietitian had documented on a specified date in June, 2013 under the "Goal" hydration will be achieved by provision of assessed fluid requirements a day. A review of the fluid monitoring Point Of Care(POC)record indicated for eleven days resident consumed less than 1200 ml fluids a day. A review of resident's health record identified the registered dietitian completed the dietary referral /request form on a specified date in August 2013. At the nutritional review by the dietitian, the resident was noted to be consuming less than the assessed fluid requirements a day. However, there was no assessment of poor hydration and action was not taken to address the noted concerns.
[O.Reg. 79/10, s. 26(4)(b)]
(B) The Registered Dietitian did not assess resident's #0001 nutritional status, including risks related to nutrition care.
On a specified date in August 2013 the attending physician of the resident#0001 had ordered dietitian to assess resident's food intake/specific food group consumed by resident. The multidisciplinary progress notes dated in August 2013 documented by the registered dietitian stated " reassessed by RD on a specified date in August 2013. The recommendation as a result of the review will initiate supplement BID with med pass to increase calorie intake and to prevent weight loss". The review by the dietitian in response to the attending physician's referral did not include an assessment of the resident food intake and the consumption of specific food groups. There was no assessment of the resident in relation to the nutritional requirements.

(C)On August 26,2013 a review of the weight record for resident #0001 indicated resident had a significant weight loss over six months. Interview with the registered staff, Personal Care Provide (PCP) and the registered dietitian confirmed resident had been refusing meals. The progress notes documented by Registered Nurse on a specified date in August 2013 identified resident was not eating meals routinely, had lost weight. The goal weight range(GWR)established was documented in the plan of care by the registered dietitian. The Current weight recorded in August, 2013 was below the goal weight. The Nutritional interventions/strategies were not evaluated, action was not taken despite of attending physician concern with the resident's poor

nutrition and hydration intake and ongoing unplanned weight loss.
. [s. 26. (4)]
2. The Registered Dietitian did not assess resident #00002's nutritional status including risks related to nutrition care
At a nutritional review by the registered dietitian on a specified date in August 2013 resident #0002 was identified to be at high nutritional risk due to skin breakdown, chronic constipation, abnormal lab values and poor food intake. The plan of care stated under "Focus" the risk for ulceration, average nutritional intake will be adequate to meet estimated nutrient needs for wound healing. However, interview with the Registered Dietitian on August 27, 2013 confirmed that there was no re-assessment of the resident's nutritional and fluids need in relation to the change resident's nutritional status and the risks identified.
[s.26.(4)]

3.[O.Reg.79/10, s. 26(4) (b)]
The Registered Dietitian did not assess resident #0003's nutritional status, including any risks related to nutrition care.
The plan of care dated in July 2013 identified impaired skin condition related to impaired mobility, poor food and fluid intake. The registered dietitian reviewed the resident on two specified dates in August 2013 in response to the referral related to chewing problem and resident not eating. However, there was no assessment of the resident in relation to nutritional requirements. The registered dietitian indicated on a specified date in August 2013 recommendation as a result of the review will continue with supplement. On a specified date in August 2013, the registered dietitian changed the resident's diet to pureed consistency. A review of the resident's weight record, quarterly Minimum Data Set(MDS)assessment and the progress notes indicated there had been a significant change in resident's health status i.e in relation to unplanned weight change, compromised skin integrity, and poor food and fluid intake. The nutritional strategies were not reviewed and there was no re- assessment of energy and protein and fluid requirements in relation to the concerns identified. The registered dietitian confirmed that assessment of nutritional requirements was only done at the admission and not when there was a change in resident's nutritional status.[s. 26. (4)]

4. [O.Reg. 79/10, s. 26(4)(b)]
The Registered Dietitian did not assess resident #0006's nutritional status, including any risks related to nutrition care.
Interview with the registered nursing staff and the review of multidisciplinary progress

notes confirmed resident #0006 was hospitalized due to an injury. A review of the resident's blood sugar record indicated resident was experiencing unstable blood sugars post hospitalization. On a specified date in August 2013, the registered dietitian had completed the Resident Assessment Protocol (RAP)summary of nutritional status. The registered dietitians review notes stated "this is the same triggered rap no changes, continue with the current intervention. "A re-assessment of the resident's nutritional risk status in relation medical diagnosis and the dietary requirements did not occur when the resident experienced a significant change in health status. The resident's dietary requirement i.e. Calories, protein and fluids needs were not evaluated since November 2011. Interview with the registered dietitian on August 26, 2013 confirmed assessment of resident's nutrient needs were not done. The resident continued to be identified as moderate nutritional risk, despite the increased risks identified. [s. 26. (4)]

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Plan of care for Resident#0003 did not provide clear directions to staff regarding provision of the texture modified diet. The Active Care Plan under eating section indicated resident was to be provided finger foods, however, under the nutritional status of care plan indicated resident to be provided pureed texture diet. The staff confirmed resident had chewing and swallowing problem and could not eat finger foods. [s. 6. (1) (c)]

2. The plan of care for resident #0007 was not updated to reflect the changes in skin integrity. The current nutritional care plan completed by the dietary department indicated that the resident had a specific staged ulcer. The Progress notes and the weekly wound treatment record indicated that the resident had a different staged ulcer. Registered staff confirmed on August 30, 2013, that the stage of the ulcer was changed since July 2013, and the wound was healing well. The nutritional care plan was not current.[s. 6.(10)(b)]

3. The plans of care for resident #0007, and resident #0003 initiated in January 2013 by the registered dietitian had recommended intervention for wound healing supplement for three months. When the registered dietitian was asked if the supplement i.e.interventions were evaluated after a three month period, the registered dietitian was unaware of the effectiveness of the supplement and monitoring the resident's response to interventions. Interview with the registered dietitian confirmed the interventions were not evaluated and monitored.[s.6.(10)(b)] [s. 6. (10) (b)]

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 there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident and ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when,(a)a goal in the plan is met;(b)the resident's care needs change or care set out in the plan is no longer necessary;or (c) care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Resident#0004 was not provided the level of personal assistance they required to safely eat and drink as independently as possible at the lunch meal on August 26, 2013. During the noon meal service observation resident was served 1230 hours soup and was not eating. The resident sat with the soup and played with the spoon for more than 45 minutes, and with no encouragement/assistance with eating. At 1315 hours a staff person, Personal Care Provided(PCP removed the soup, served the entrée and placed ½ sandwich in resident's hand and walked away. The resident was noted holding sandwich in hand and not eating. At 1345 hours the PCP removed the entrée which resident had not consumed and served the dessert. Resident did not consume food and the beverages served at noon meal. The plan of care for the resident stated " totally fed if noted to be fatigued, week, lose concentration or refuse to feed. Resident requires lots of encouragement to remain focussed." The Resident Assessment Protocol summary completed August in 2013 identified resident needed supervision from one staff but required lots of encouragement to remain focussed. However, the staff did not provide encouragement/assistance as result resident did not consume food and fluids. [s. 73. (1) 9.]

2. On August 26, 2013 resident #0005 was observed in the dining room during the lunch meal sitting at the table with eyes closed. The resident was noted sitting until 1335 hour with no assistance with eating. Interview with the Registered Nurse confirmed that a recreation staff person came to assist resident with eating but left and did not feed the resident. At approximately 1345 hour the resident was fed by a Personal Care Provider (PCP)only after the inspector intervened and spoke with the registered staff. The resident was identified to be at high nutritional risk due to underweight and low Basal Metabolic Index(BMI). The plan of care for resident#0005 identified required extensive assistance with eating(one person physical assist). [s. 73. (1) 9.]

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 providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably as possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Resident #0002 and #0003 did not receive medication in accordance with the directions for use specified by the attending physician.
A)For resident #0002 the bowel movement documented in Point of Care (POC) identified resident did not have bowel movement for 3 consecutive days on specified dates in August 2013. The Medical Administration Record (MAR) specified resident to receive medication by mouth for constipation if no bowel movement for 2 days. The MAR indicated the resident did not receive medication for constipation in accordance with the directions for use specified by the attending physician.
B)On a specified date in March 2013, resident #0003 had an order written for medication by mouth for constipation if no bowel movement for 2 days. A review of Point Of Care (POC) record indicated resident did not have bowel movement for 3 consecutive day X2. The Medical Administration Record indicated resident did not receive medication for constipation in accordance with the directions for use as specified by the physician. [s. 131. (2)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 50. (2)	CO #002	2012_191107_0001	159

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

O.Reg 79/10 s. 69.	CO #003	2012_191107_0001	159

Issued on this 18th day of September, 2013

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

Asha Sehgal

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) :	ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2013_190159_0022
Log No. / Registre no:	H-000539-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 16, 2013
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 :	ADAM BANKS

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_191107_0001, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

[O.Reg. 79/10, s. 26(4) (b)] was previously issued a Compliance Order December 31, 2012.
The licensee must prepare, submit, and implement a plan that outlines how the home will ensure that:
a) home's registered dietitian assess residents with change in nutrition and hydration status and any risks, specifically related to poor food and fluid intake, uncontrolled diabetes, unplanned weight loss,
b)action is taken and outcomes are evaluated for effectiveness to address the identified risks related to nutrition anf hydration.
c)quality management activities, including person responsible and frequency of monitoring.
The plan is to be submitted by September 30, 2013 to Long Term Care Homes Inspector Asha Sehgal. Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King Street West, 11th floor, Hamilton, Ontario, L8P 4Y7 e.mail: Asha.sehgal@ontario.ca or Fax: 905-546-8255

Grounds / Motifs :

1. [O.Reg. 79/10, s. 26(4)(b)]
The Registered Dietitian did not assess resident #0006's nutritional status, including any risks related to nutrition care.
Interview with the registered nursing staff and the review of multidisciplinary

progress notes confirmed resident #0006 was hospitalized due to an injury. A review of the resident's blood sugar record indicated resident was experiencing unstable blood sugars post hospitalization. In August 2013 the registered dietitian had completed the Resident Assessment Protocol (RAP) summary of nutritional status.The registered dietitians review notes stated "this is the same triggered rap no changes, continue with the current intervention." A re-assessment of the resident's nutritional risk status in relation to medical diagnosis and the dietary requirements did not occur when the resident returned from the hospital after a significant change in status. The resident's dietary requirement i.e. calories, protein and fluids needs were not evaluated since November 2011. Interview with the registered dietitian on August 26, 2013 confirmed assessment of resident's nutrient needs i.e energy, protein and fluid were not done. The resident continued to be identified as moderate nutritional risk, despite the increased risks identified.
(159)

2. [O.Reg.79/10, s. 26(4) (b)]
The Registered Dietitian did not assess resident #0003's nutritional status, including any risks related to nutrition care.
The plan of care dated in July 2013 identified skin impairment condition related to impaired mobility, poor food and fluid intake. The registered dietitian reviewed the resident on 2 different specified dates in August 2013 in response to the referral related to chewing problem and resident not eating. However, there was no assessment of the resident in relation to nutritional requirements. The registered dietitian indicated on a specified date recommendation as a result of the review will continue with supplement. On a specified date in August the registered dietitian changed the resident's diet to pureed consistency. A review of the resident's weight record, quarterly Minimum Data Set (MDS) assessment and the progress notes indicated there had been a significant change in resident's health status in relation to unplanned weight change compromised skin integrity, and poor food and fluid intake. The nutritional strategies were not reviewed and there was no re- assessment of energy and protein and fluid requirements in relation to the concerns identified. The registered dietitian confirmed that assessment of nutritional requirements was only done at the admission and not when there was a change in resident's nutritional status.
(159)

3. [[O.Reg. 79/10, s. 26(4) (b)]

The Registered Dietitian did not assess resident #00002's nutritional status including any risks related to nutrition care
At a nutritional review by the registered dietitian in August 2013 resident #0002 was identified to be at high nutritional risk due to skin breakdown, chronic constipation, abnormal lab values and poor food intake. The plan of care stated under "Focus" the risk for ulceration, average nutritional intake will be adequate to meet estimated nutrient needs for wound healing. However, interview with the Registered Dietitian on August 27, 2013 confirmed that there was no re-assessment of the resident's nutrients and fluid needs in relation to the change resident's nutritional status and the risks identified related to nutrition. (159)

4. [O.Reg. 79/10, s. 26(4) (b)]
The Registered Dietitian did not assess resident #0001's hydration status, and any risk related to hydration when the resident's fluid intake was less than their assessed fluid requirements..
(A) The plan of care for resident #0001 identified risk for dehydration related to poor fluid intake. The Registered Dietitian had documented in June 2013 under the "Goal " hydration will be achieved by provision of assessed fluids requirements a day. A review of the fluid monitoring Point Of Care (POC) record indicated for eleven days resident consumed less than 1200 ml fluids a day. A review of resident's health record identified the registered dietitian completed the dietary referral /request form in August 2013. At the nutritional review by the dietitian, the resident was noted to be consuming less than the assessed fluid requirements a day. However, there was no assessment of poor hydration and action was not taken to address the noted hydration concerns.
[O.Reg. 79/10, s. 26(4) (b)]
(B) The Registered Dietitian did not assess resident's #0001 nutritional status, including risks related to nutrition care.
In August 2013 the attending physician of the resident had ordered dietitian to assess resident's food intake/ specific food group consumed by resident. The multidisciplinary progress notes dated in August 2013 documented by the registered dietitian stated " reassessed by RD on a specified date in August 2013. The recommendation as a result of the review will initiate supplement BID with med pass to increase calorie intake and to prevent weight loss". The review by the dietitian in response to the attending physician's referral did not include an assessment of the resident food intake and the consumption of specific food groups. There was no assessment of the resident in relation to the nutritional requirements.

(C) On August 26, 2013 a review of the weight record for resident #0001 indicated resident had a significant weight loss over six months. Interview with the registered staff, Personal Care Provide (PCP) and the registered dietitian confirmed resident had been refusing meals. The progress notes documented by Registered Nurse on aspecified date in August 2013 identified resident was not eating meals routinely, had lost weight. The goal weight range (GWR) established and was documented in the plan of care by the registered dietitian. The Current weight recorded in August 2013 was below the goal weight. The Nutritional interventions /strategies were not evaluated, action was not taken despite of attending physician concern with the resident's poor nutrition and hydration intake and ongoing unplanned weight loss. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2013

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
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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 16th day of September, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ASHA SEHGAL

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