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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2014	2014_108110_0006	T-366-14	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE ROUGE VALLEY
551 Conlins Road, TORONTO, ON, M1B-5S1

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

DIANE BROWN (110), ARIEL JONES (566)

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 24, 26, 27, 28, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, nurse practitioner, nutritional care manager, registered dietitian, registered practical nurse, food service supervisor, personal support workers.

During the course of the inspection, the inspector(s) reviewed clinical health records, the homes' policies related to food and fluid monitoring and registered dietitian/dietary department communication and referrals; observed meal and snack service.

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to hydration.

The home failed to implement their policy entitled "Food and Fluid Intake Monitoring" (Reference # RESI-05-02-05 dated November, 2013) to manage risks related to hydration, by the following:
- failing to provide for hydration assessments by registered nursing staff and referrals to the dietitian when resident's fluid intake was consistently below their estimated fluid requirement for three consecutive days
- failing to ensure nursing staff reviewed the fluid intake records of residents daily
- failing to revise the plan of care including strategies or interventions as required to manage identified risks and monitor outcomes based on the needs and preferences of the resident and/or family/substitute decision maker.

An interview with the registered dietitian indicated he/she assessed the hydration needs of all residents within the home on an identified date. Resident #001's hydration plan of care of an identified date, revealed the resident required 1900mls of fluid per

day to meet his/her hydration needs. Record review of resident #001's fluid intake pattern over an identified period of time, revealed 39 occasions where the resident consumed less than his/her estimated fluid intake for three consecutive days without a referral to the registered dietitian. Furthermore, there was no completion of a dehydration assessment, or revision to the plan of care, including strategies and interventions to manage identified risks. An interview with the registered staff, including the registered dietitian, revealed that there had been no hydration or dietary assessments performed during this period, and no monitoring of the resident's daily fluid intake records. [s. 68. (2) (a)]

2. Record review of resident #002 and #003's fluid intake pattern over an identified period of time, revealed 43 and 22 occasions, respectively, where these residents consumed less than their estimated fluid intake for three consecutive days without a referral to the registered dietitian, completion of a dehydration assessment, or revision to the plan of care, including strategies and interventions to manage identified risks. Resident 002's average fluid intake for this same period was approximately 66% of his/her recommended daily intake with no new interventions implemented to manage the resident's hydration risk.

An interview with the registered dietitian confirmed that referrals should be sent for further dietary assessment of residents' hydration status when a resident's fluid intake consistently falls below his/her assessed need. Furthermore, the registered dietitian identified that nursing is not reviewing residents' fluid intake records according to the home's policy, and that he/she has never received a referral from nursing regarding residents' fluid intakes. [s. 68. (2) (a)]

3. The licensee failed to identify residents' with hydration risks.

An interview with the food service supervisor revealed that his/her analysis of resident #001's fluid intake was incorrect and the resident's actual fluid consumption was 50% less than what the food service supervisor had reported. At the last quarterly dietary review, the food service supervisor stated resident #001's fluid intake was good and met his/her target range resulting in an overestimation of resident's fluid intake and an underestimation of resident's hydration risk. The food service supervisor also confirmed that a referral related to the resident's fluid intake should have been sent to the registered dietitian at the last quarterly review of resident #001. An interview with the registered dietitian confirmed that the resident was at high hydration risk and a referral should have been sent for further assessment of resident #001.

Record review and staff interviews revealed resident #001 was placed in isolation with flu symptoms on an identified date, during an enteric outbreak in the home. On an identified date, the nurse practitioner assessed the resident as dehydrated; discontinued medication A and ordered treatment for rehydration. The resident was transferred to hospital on an identified date. Between the resident's last quarterly review and his/her hospitalization, a record review confirmed that the resident's average daily fluid intake remained below his/her estimated fluid requirement.

Interview with the food service supervisor confirmed that his/her interpretation of residents' fluid intake records was incorrectly applied to the residents that he/she assessed, therefore, underestimating fluid intake and failing to identify residents with potential hydration risks.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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 licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #001's care set out in his/her plan of care, related to holding medication A when watery bowel movements continued, was not provided to the resident as specified in the plan.

Record review and staff interviews revealed resident #001 was placed in isolation with symptoms, during an enteric outbreak in the home. On an identified date, the resident was referred to the physician due to loose bowel movements. The physician assessed the resident on the same day and ordered to hold medication A if the resident continues to have watery bowel movements. On an identified date, the resident presented with diarrhea several times and medication A continued to be administered.

An interview with the nurse practitioner (NP) and record review revealed that resident #001 was referred to the NP for experiencing diarrhea, and other symptoms. On an identified date, the NP assessed resident #001. Record reviews and NP interview confirmed resident had symptoms of dehydration. The Nurse practitioner wrote an order to hold medication A and ordered treatment for rehydration.

Resident was transferred to the hospital on an identified date, and was admitted with an identified diagnosis. Resident #001 expired on an identified date.

2. Resident #002's plan of care, identified the resident's need for thick fluids, which were not provided.

On identified dates and meals, resident #002 was observed drinking regular consistency water and being served regular consistency beverages, without direct care staff intervention.

An interview with the registered dietitian confirmed that resident #002 is at high risk for choking and should not have received or consumed regular consistency fluids.

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective.

A review of resident #002's quarterly assessments completed by the registered dietitian on three separate occasions, revealed that the resident's "fluid intake falls short and nursing is to encourage at least eight glasses (250ml each) of fluids per day to maintain hydration". Despite ongoing shortfalls in the resident's fluid intake, the same intervention was repeated each quarter with no revisions to the resident's plan

of care. A review of resident #002's fluid intake records over an identified period of time, confirmed that his/her fluid intake remained consistently below his/her estimated fluid requirement.

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized hydration program to meet the hydration needs of residents by failing to consistently document residents' fluid intake, and accurately monitor residents' hydration status.

Staff interview confirmed that personal support workers (PSW) are responsible to record residents' fluid intake daily in an electronic documentation program. The home was unable to provide a policy and procedure directing PSW staff on how to record residents' fluid intake. The registered dietitian stated that large glasses are to be used for all meals, and that each full, large glass consumed should be recorded as two servings. He/she reported that small glasses are used at snacks, and when consumed, should be recorded as one serving. The registered dietitian also identified that the full coffee/tea mug, when consumed, should be recorded as one serving, and soup is not recorded as a fluid.

Staff interviews revealed an inconsistent approach to documenting residents' fluid

intake, which resulted in an unorganized hydration program and the inability to identify whether residents' hydration needs had been adequately met.
Staff D, PSW in an identified home area, stated each full glass, regardless of size, when consumed at all meals, would be recorded as 1.25 servings; except for the coffee/tea mug and nourishments, which when consumed would be recorded as two servings.
Staff E, PSW in an identified home area, stated that each full large glass, when consumed, at all meals and nourishments, would be recorded as 1.25 servings, and each small glass recorded as one. The full coffee/tea mug consumed would be recorded as two servings.
Staff F, PSW in an identified home area, stated each full glass consumed at all meals and snacks, regardless of size, would be recorded as 1.25 servings; except coffee/tea mug which would be recorded as two servings.
Staff G, PSW in an identified home area, stated that each full glass, including coffee/tea mug, when consumed at meals would be recorded as two servings. Soup would also be included in the fluid total and recorded as two servings when consumed. At morning nourishment each full glass consumed would be recorded as one serving, and as two during the afternoon and evening nourishments.

2. Staff A, PSW in an identified home area home area, stated each full glass, regardless of size, when consumed would be recorded as one serving for all meals and snacks.
Staff B, PSW in an identified home area, stated that each full large glass, when consumed, would be recorded as 1.5 servings, each small glass would be recorded as one, and a coffee/tea mug as two servings. All nourishment beverages, when consumed, would be recorded as one serving. He/she stated further that soup would also be included in the fluid total, and when consumed, should be recorded as two servings.
Staff C, PSW in an identified home area, stated that each full glass, regardless of size, when consumed at all meals and snacks, would be recorded as one serving, except the coffee/tea mug which, when consumed, would be recorded as two servings.

3. Observations and record review revealed that staff inaccurately documented residents' fluid intake resulting in an overestimation of actual fluid intake.

On an identified date, resident #003 was observed at breakfast. The inspector identified two full, large glasses (250ml) of fluids served to and consumed by resident totaling 500ml. Record review indicated that the resident's intake for breakfast was

inaccurately recorded as six servings, totaling 750mls.

4. Staff interviews identified an unawareness of residents' individualized hydration needs resulting in an unorganized hydration program. An interview with the home's registered dietitian revealed that there is no hydration policy specific to the home, but that he/she had individually assessed all residents estimated daily fluid requirement, and that this was outlined in the resident's plan of care and accessible to all staff. A registered nurse interview identified an unawareness of each residents' estimated daily fluid requirement, as assessed by the registered dietitian. Further comments revealed an understanding of a general fluid requirement for all residents of 1000-1200mls/day. An interview with the DOC, new to the home, revealed that he/she was unaware of the home's hydration policy, and stated that it was his/her understanding that a general fluid requirement is applied to all residents except those on supplements.

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 an organized program for monitoring residents' fluid intake, to be implemented voluntarily.

WN #4: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's hydration plan of care is based on the following risks: resident's dislike to drink and the need for regular encouragement to drink, and fluid consumption consistently less than his/her estimated fluid intake.

Resident #001's plan of care identified the resident with hydration risks related to an ongoing use of a medication and dietary intervention.

Record review of resident #001's fluid intake over an identified period of time, revealed 39 occasions where the resident consumed less than his/her estimated fluid intake for a three consecutive day period.

Nursing staff interviews revealed resident #001 disliked drinking and needed regular encouragement to drink, and record review confirmed resident's fluid intake did not meet his/her estimated fluid requirement. An interview with the food service supervisor revealed an unawareness of resident #001's additional hydration risks. The resident's plan of care was not based on all of the resident's known hydration risk factors.

Record review and staff interview identified that the home declared an enteric outbreak on an identified date. Documentation revealed that during the outbreak, resident #001 experienced flu symptoms. On an identified date, the resident was seen by the NP and assessed as dehydrated, and ordered treatment for rehydration.

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 each resident's plan of care is based on resident's hydration status and any risks related to hydration, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The home failed to ensure that the planned menu items are offered and available at each meal and snack.

An interview with the home's registered dietitian revealed that there is no hydration policy specific to the home, but a total of 2665mls of fluid per day are offered to residents including coffee/tea, or 2125mls per day excluding coffee/tea. Residents on thickened fluids were also required to be offered coffee/tea.

Resident #003's plan of care, identified the resident's hydration goal to meet his/her estimated fluid requirement of 2400mls per day. Further, the resident's plan of care identified the resident at high nutritional risk.
By offering resident #003 coffee/tea at meals, it allowed the resident to meet his/her fluid requirement of 2400mls per day. A staff interview confirmed that resident #003 liked thickened coffee at meals.
On an identified date, at breakfast, resident #003 was observed not to have been offered juice or coffee/tea. The lack of coffee/tea at breakfast, along with an identified intervention, did not allow resident #003 to meet his/her estimated fluid requirement. Record review of fluid intake for an identified date, confirmed the resident's intake was below his/her estimated hydration needs, consuming 2125mls per day.

Resident #004's plan of care also required the resident to have thickened fluids. On an identified date, the inspector observed the resident to not have been offered coffee/tea at breakfast or lunch.

Record review of the diet sheets revealed a space for documenting "strong dislikes", including coffee/tea. No dislike for coffee/tea was identified for resident #003 and #004, both of whom were not offered this beverage at the two meals observed on an identified date. An interview with the registered dietitian revealed that there was no was no formal way for staff to identify those residents with a preference for coffee/tea.

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 the planned menu items, including beverages, are offered and available at each meal and snack, to be implemented voluntarily.

Issued on this 6th day of May, 2014

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

Diane Brown

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) :	DIANE BROWN (110), ARIEL JONES (566)
Inspection No. / No de l'inspection :	2014_108110_0006
Log No. / Registre no:	T-366-14
Type of Inspection / Genre d' inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 5, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE ROUGE VALLEY 551 Conlins Road, TORONTO, ON, M1B-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CAROL BALDASTI

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home's hydration policies and procedures are followed, including but not limited to;

- identify measures to immediately address residents with hydration risks,
- to provide education or re-education to management and staff related to monitoring residents' hydration and intake, risks related to hydration and the home's hydration policies and procedures,
- develop a system to evaluate the effectiveness of the hydration program.

The plan must be submitted by e-mail to Diane.Brown@ontario.ca on for before May 19, 2014.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the care set out in the plan of care is

provided to the resident as specified in the plan.

Resident #001's care set out in his/her plan of care, related to holding medication A when watery bowel movements continued, was not provided to the resident as specified in the plan.

Record review and staff interviews revealed resident #001 was placed in isolation with symptoms, during an enteric outbreak in the home. On an identified date, the resident was referred to the physician due to loose bowel movements. The physician assessed the resident on the same day and ordered to hold medication A if the resident continues to have watery bowel movements. On an identified date, the resident presented with diarrhea several times and medication A continued to be administered.

An interview with the nurse practitioner (NP) and record review revealed that resident #001 was referred to the NP for experiencing diarrhea, and other symptoms. On an identified date, the NP assessed resident #001. Record reviews and NP interview confirmed resident had symptoms of dehydration. The Nurse practitioner wrote an order to hold medication A and ordered treatment for rehydration.

Resident was transferred to the hospital on an identified date, and was admitted with a diagnosis. Resident #001 expired on an identified date.

2. Resident #002's plan of care, identified the resident's need for thick fluids, which were not provided.

On identified dates and meals, resident #002 was observed drinking regular consistency water and being served regular consistency beverages, without direct care staff intervention.

An interview with the registered dietitian confirmed that resident #002 is at high risk for choking and should not have received or consumed regular consistency fluids.

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective.

A review of resident #002's quarterly assessments completed by the registered dietitian on three separate occasions, revealed that the resident's "fluid intake falls short and nursing is to encourage at least eight glasses (250ml each) of fluids per day to maintain hydration". Despite ongoing shortfalls in the resident's fluid intake, the same intervention was repeated each quarter with no revisions to the resident's plan of care. A review of resident #002's fluid intake records over an identified period of time, confirmed that his/her fluid intake remained consistently below his/her estimated fluid requirement. (566)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 13, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu' il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Diane Brown

Name of Inspector / Nom de l'inspecteur : DIANE BROWN

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