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
May 7, 2014	2014_163109_0015	T-539-14	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

WESBURN MANOR
400 The West Mall, ETOBICOKE, ON, M9C-5S1

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 16, 17, 22, 23, 25, 27, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, registered nursing staff, registered dietitian (RD), personal support workers (PSW), nurse managers, manager of nutritional care.

During the course of the inspection, the inspector(s) reviewed the health records for identified residents, reviewed the home's policies for skin management program, pain management program, education records.

The following Inspection Protocols were used during this inspection:

Pain
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from the hospital.

Resident #1 was identified to be at a high risk of altered skin integrity and was diagnosed with multiple pressure ulcers.

Staff interview revealed that the home believed that the resident's wounds were much

worse after hospitalization however, staff interview and record review confirmed that there were no skin assessments completed for the three identified dates upon return from the hospital.

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

Resident #1 had multiple pressure ulcers present. The home uses a specific weekly ulcer/wound assessment record which is to be completed for each wound.

Record review and staff interview revealed that the skin assessments were not completed using the home's skin assessment tool for identified dates.

3. The licensee failed to ensure that resident # 3 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #3 had multiple pressure ulcers present.
Record review and staff interview revealed that the skin assessments were not completed using the home's skin assessment tool in identified dates for some of the wounds. Furthermore the different wounds are assessed on one form at a time as opposed to one wound for each form as per the home's policy. Some of the assessments for this resident do not identify which wound was being assessed because the wound site was not filled out by the staff who completed the assessment. [s. 50. (2) (b) (i)]

4. The licensee failed to ensure that resident #2 exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #2 has chronic ulcers which require routine care. The home uses a specific weekly ulcer/wound assessment record which is to be completed for each wound on the resident.
Record review and staff interview revealed that skin assessments were not completed on the home's assessment tool for the identified dates. [s. 50. (2) (b) (i)]

5. The licensee failed to ensure that the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tear or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Resident #1 had multiple pressure ulcers. Record review and staff interview revealed that the wounds were not assessed weekly on identified dates. The resident was transferred to the hospital and passed away in the hospital. [s. 50. (2) (b) (iv)]

6. The licensee failed to conduct weekly skin assessments for resident #3 with altered skin integrity.

Resident #3 has multiple pressure ulcers.
Record review and staff interview revealed that there are no weekly skin assessments completed for some of the pressure ulcers on identified dates. [s. 50. (2) (b) (iv)]

7. The licensee failed to conduct weekly skin assessments for resident #2 with altered skin integrity.

Resident #2 has ulcers which require daily dressing changes. The assessments that were completed between specified dates do not include all of wounds which vary in size and location. There were no weekly skin assessments completed between identified dates, for any of the wounds.
Record review and staff interview confirmed that the assessments were not completed weekly as required. [s. 50. (2) (b) (iv)]

8. The licensee failed to ensure that supplies that were ordered to treat the skin wounds and promote healing were readily available for resident #1.

Resident #1 had multiple pressure ulcers present.
The resident had been prescribed a treatment by the ET nurse which included a specific wound packing substance.

Interview of the staff revealed that the specific packing substance was not available to use for the resident. According to the staff member, the specific substance was never available to use and the staff were instructed to improvise with other substances and supplies.

The resident's wounds progressed and the resident was hospitalized for deteriorating health. [s. 50. (2) (c)]

9. The licensee failed to ensure that the supplies that were ordered to treat the skin wounds and promote healing were readily available for resident #3.

Resident #3 has multiple pressure ulcers.

On an identified date the physician ordered a specific treatment for the wounds which included a specific antimicrobial product which is to be used to pack a wound.

Six days after the identified date the inspector and the RN checked the wound care supplies for this
resident's treatments. The specific treatment was not available and had not been available for the nurse to pack the wound. The nurse used a different product on the wound which was not the prescribed product and according to the wound care nurse was merely a dressing or wound cover and not an antimicrobial packing.

The nurse contacted the physician and had the order changed after the inspector noted that the supplies were not available to this resident. [s. 50. (2) (c)]

10. Resident #2 has ulcers which have a medically prescribed treatment to be administered to the wounds. On a specified date, the resident was seen by a specialist and a new treatment was ordered which included a specific product to be applied to the wound.

According to the progress notes on multiple identified dates the wound care product was not available.

On a specified date, staff interview revealed that the specified product prescribed for the wounds was still not available for application even though the treatment was ordered almost 2 weeks prior to this date. The staff revealed that they had substituted treatment products to apply to the wounds because the treatment was not available.

The treatment order was transcribed onto the treatment records and signed off by the nursing staff as having been administered as prescribed even though they did not have the actual product available and used substitutions which were not ordered by the physician to treat the wound.

The home had ordered the product but the product was not delivered to the care unit to the staff when they requested it for resident #2. [s. 50. (2) (c)]

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident#1 as specified in the plan of care.

Resident #1 had multiple pressure ulcers for which prescribed treatments were implemented on an identified date. The treatment recommended by the ET nurse and prescribed by the physician included packing a wound with an identified product. The prescribed treatment had been written out on the treatment record as ordered and signed for by the staff as having been administered as ordered.

Staff interviews revealed that the identified product prescribed for packing the wound had not been available at any time since it was ordered on the identified date, until the resident was transferred to the hospital a month later. Staff members further stated that they used a substitute product or products depending upon what was available on the care units to use to pack the wound. [s. 6. (7)]

2. Resident #1 was experiencing pain due to pressure ulcers. On an identified date the physician ordered the staff to monitor pain control on each shift and document for seven days.

The home's pain monitoring form was put into place to be completed.

Record review and staff interview revealed that assessments were not completed for multiple shifts as per the medical plan of care.

3. On an identified date, the physician ordered a specific treatment for resident #3's wounds which included a specific antimicrobial product which is to be used to pack a wound.

Six days later, the inspector and the RN checked the wound care supplies for this resident's treatments. The specific treatment was not available. According to the staff the product had not been available for the nurse to pack the wound. The nurse used a different product on the wound which was not the prescribed product and according to a staff member was merely a dressing or wound cover and not an antimicrobial packing. The nurse signed the treatment record as having provided the treatment as prescribed by the physician even though the specific treatment product was not available.

The nurse contacted the physician and had the order changed after the Inspector noted supplies were not available to this resident. [s. 6. (7)]

4. Resident #2 has ulcers which have a medically prescribed treatment to be administered to the wounds daily.

On an identified date, the resident was seen by a specialist and a new treatment was ordered which included a specific product to be applied to the wound.
The treatment order was transcribed onto the treatment records and signed off by the nursing staff as having been administered as prescribed.

On a specified date staff interview revealed that they had not had the specified product available for application to the wounds since the treatment was ordered almost 2 weeks prior.

The staff further revealed that they substituted the prescribed treatment products with products which were available on the care unit to apply to the wounds.

According to a progress note on a specified date, the wounds were not improving and in fact the wounds were getting bigger. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Resident #1 was identified as being at a high nutritional risk due to poor intake, weight loss and multiple pressure ulcers. The resident was assessed by the RD on an identified date. Weight loss had been reviewed and new interventions were implemented. The resident lost an additional 12% of his/her weight over a one month period. The RD was not informed of the significant weight loss as required by the home's policy # RC-0523-10 entitled Referral to the Dietitian. The RD did not assess the resident in the identified month. The resident was hospitalized and passed away while in the hospital. [s. 69. 1.]

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 residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

Issued on this 13th day of June, 2014

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

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) :	SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2014_163109_0015
Log No. / Registre no:	T-539-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 7, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	WESBURN MANOR 400 The West Mall, ETOBICOKE, ON, M9C-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rosemary Stekar (acting)

To TORONTO LONG-TERM CARE HOMES AND SERVICES, 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
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Ontario

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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. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following areas are addressed:

Skin assessments are completed by a member of the registered nursing staff, using the homes clinically appropriate assessment instrument that is specifically designed for skin and wound for resident #2 and #3 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

Reassessments are conducted at least weekly by a member of the registered nursing staff for resident #2 and #3 who are exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

Supplies are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Skin assessments are completed by a member of the registered nursing staff for any resident at risk of altered skin integrity upon any return of the resident from hospital.

The compliance plan must identify short and long-term strategies to ensure the actions taken are monitored and evaluated.

Please submit the compliance plan to susan.squires@ontario.ca on or before May 14, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from the hospital.
Resident #1 was identified to be at a high risk of altered skin integrity and was diagnosed with multiple pressure ulcers.

Staff interview revealed that the home believed that the resident's wounds were much worse after hospitalization, however staff interview and record review confirmed that there were no assessments for the identified dates completed upon return from the hospital.

Resident #1 did not receive a skin assessment by a member of the registered nursing staff upon return from the hospital on several identified dates. (109)

2. Resident #2 has chronic ulcers which require routine care. The home uses a specific weekly ulcer/wound assessment record which is to be completed for each wound on the resident.

Record review and staff interview revealed that skin assessments were not completed on the home's assessment tool for identified dates.

(109)

3. Resident #3 had multiple pressure ulcers present.

Record review and staff interview revealed that the skin assessments were not completed using the home's skin assessment tool on identified dates, for some of the wounds. Furthermore the different wounds are assessed on one form at a time as opposed to one wound for each form as per the home's policy. Some of the assessments for this resident do not identify which wound was being assessed because the wound site was not filled out by the staff member who completed the assessment.

(109)

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

Resident #1 had multiple pressure ulcers present. The home uses a specific weekly ulcer/wound assessment record which is to be completed for each wound.
Record review and staff interview revealed that the skin assessments were not completed using the home's skin assessment tool for several identified dates.
(109)

5. The licensee failed to conduct weekly skin assessments for resident #2 with altered skin integrity.

Resident #2 has three ulcers present which require daily dressing changes. The

assessments that were completed between identified dates, do not include all wounds which vary in size and location. There was no weekly skin assessment completed between identified dates, for any of the wounds.

Record review and staff interview confirmed that the assessments were not completed weekly as required.
(109)

6. The licensee failed to conduct weekly skin assessments for resident #3 with altered skin integrity.

Resident #3 has multiple pressure ulcers located.
Record review and staff interview revealed that there were no weekly skin assessments completed for some of the pressure ulcers on specified dates.
(109)

7. The licensee failed to ensure that the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tear or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Resident #1 had multiple pressure ulcers. Record review and staff interview revealed that the wounds were not assessed weekly for several identified dates. The resident was transferred to the hospital and passed away in the hospital.
(109)

8. Resident #2 has ulcers which have a medically prescribed treatment to be administered to the wounds. On an identified date, the resident was seen by a specialist and a new treatment was ordered which included a specific product to be applied to the wound. According to the progress notes on several identified dates, the wound care product was not available.

On a specified date, staff interview revealed that the specified product prescribed for the wounds was still not available for application even though the treatment was ordered almost 2 weeks prior to this date. The staff revealed that they had substituted treatment products to apply to the wounds because the treatment was not available.

The treatment order was transcribed onto the treatment records and signed off by the nursing staff as having been administered as prescribed even though

they did not have the actual product available and used substitutions which were not ordered by the physician to treat the wound.

The home had ordered the product, but the product was not delivered to the care unit to the staff when they requested it for resident #2.
(109)

9. The licensee failed to ensure that supplies are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Resident #3 has multiple pressure ulcers.

On a specified date, the physician ordered a specific treatment for the wounds which included a specific antimicrobial product which is to be used to pack a wound.

On an identified date, the inspector and the RN checked the wound care supplies for this resident's treatments. The specific treatment was not available and had not been available for the nurse to pack the wound. The nurse used a different product on the wound which was not the prescribed product and according to the wound care nurse was merely a dressing or wound cover and not an antimicrobial packing.

The nurse contacted the physician and had the order changed after the inspector noted that the supplies were not available for this resident.
(109)

10. The licensee failed to ensure that supplies that were ordered to treat the skin wounds and promote healing were readily available.

Resident #1 had multiple pressure ulcers present.
The resident had been prescribed a treatment by the ET nurse which included a specific wound packing substance.

Interview of the staff revealed that the specific packing substance was not available to use for the resident. According to the staff member, the specific substance was never available to use and the staff were instructed to improvise with other substances and supplies.

The resident's wounds progressed and the resident was hospitalized for deteriorating health.
(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 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 nstructions regarding the appeal process. The Licensee may learn nore about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

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

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

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 7th day of May, 2014

Signature of Inspector / Signature de l'inspecteur :

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

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