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 14, 16, 2013	2013_162109_0020	T-2178-12, T-2179-12, T-177-13	Follow up

Licensee/Titulaire de permis

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

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

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

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

SUSAN SQUIRES (109), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): April 17, 18, 22, 23, 24, 25, 2013

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers, Residents, Family Members, Social Worker

During the course of the inspection, the inspector(s) Conducted walk through of resident care areas, observed resident care activities, reviewed the home's policies for abuse, lifts and transfers, reviewed the home's compliance plan for orders, reviewed health records for identified residents, reviewed the home's complaints procedure and files.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which is was based to the Director: (2) Abuse of a resident by anyone or neglect of a resident by the licensee of staff that resulted in harm or risk of harm.
In February 2013 resident # 19 reported to the Social Worker that he/she observed a PSW "manhandle" a male/female resident in the dining room. The resident told the inspector that he/she observed a PSW grab the resident in a rough manner and push him/her down into his/her wheelchair. The Social Worker acknowledged to the inspector that this is considered physical abuse and he/she reported it to the Administrator as per the home's protocol. The Administrator acknowledged this as a physical abuse. The licensee did not determine who the resident was. The allegation of abuse was not reported to the Director. [s. 24. (1)]

2. The Power of Attorney (POA) for resident # 04 reported to the licensee during a family care conference in January 2013, that the resident reported to the POA that he/she was slapped on the legs by the Personal Support Worker (PSW) some time in mid to late December, 2012. The POA requested that any investigation and follow up completed by the home to exclude the resident's identity. An internal incident form was completed by the Social Worker and submitted to the home's Executive Director. The allegation of abuse was not reported to the Director. The POA for resident #04 reported to the charge nurse that the resident reported that the same PSW from the previous complaint hit the resident on the head during a shower on an identified date. The RN reported to inspector that he/she spoke to the resident and the resident gestured that he/she was hit at the back of the neck and told the RN that it was the PSW who had given him/her a shower. The RN reported the allegation of abuse to the Assistant Director of Care (ADOC) who followed up with the staff member and the resident assessment. The allegation of abuse was not reported to the Director. [s. 24. (1)]

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan of care for resident # 1 states that the resident requires 2 staff to use the ceiling lift while transferring the resident. The second staff member is to provide physical help and constant supervision. Resident #1 was not transferred with 2 direct care staff as required. During an interview with the resident on April 18, 2013, the resident reported to the inspector that he/she was transferred on April 16, 2013 with a ceiling lift by identified PSW #1 while the housekeeping staff member stood in the room and observed the PSW transfer the resident. The resident reported that the housekeeping aide has observed such transfers on multiple occasions.

The housekeeping aide does not provide physical assistance as required in resident #1's plan of care. The housekeeping aide role does not include provision of direct care to residents. Furthermore, in the position as a housekeeping aide, he/she does not have recent training from the licensee on the safe and correct use of mechanical lifts as required in the Long Term Care Homes Act, 2007.

The housekeeping aide was interviewed in April 2013. He/she reported that on an identified date, he/she stood and observed PSW # 1 transfer resident # 1 with a mechanical lift unassisted.
Interviews with both PSW # 1 and housekeeping aide confirms that PSW # 1 transferred resident # 1 unassisted with the ceiling lift while the housekeeping aide stood and observed on multiple occasions. Staff interview also confirmed that the same housekeeping aide has observed transfers for resident #5 in the same manner.

An interview with the housekeeping aide confirmed that it is a common practice on the unit for the PSW staff to seek out and accept assistance from the housekeeping aide to observe resident transfers with the mechanical lift. The housekeeping aide identified 3 other staff members (PSW #2, PSW #3 and PSW #4) who have asked the housekeeping aide to observe transfers for other residents. [s. 36.]

2. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Plan of care for resident #2 states resident is to be transferred to the toilet after meals and as needed (PRN) by hoyer lift. Resident is totally dependent for all aspects of

toileting activity and is non weight bearing. Resident #2 was not transferred by hoyer lift as required.

The PSW reported to the inspector that on an identified date, he/she wheeled the resident into the washroom to use the toilet. The resident held onto the hand rail and was transferred by the PSW to the toilet. While the resident was on the toilet, he/she stepped outside the washroom to get his/her wheelchair. The resident was left unattended on the toilet and fell. The resident was diagnosed with a fracture of the right hip on an identified date.

LTCH, 2007 O. Reg. 79/10 s. 36 has been previously issued as an order on November 30, 2012. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. On an identified date resident # 19 reported to the Social Worker that he/she witnessed a staff member "manhandle" a resident on the Hughes Unit at supper time. The resident expressed that he/she was fearful of this staff member and did not want him/her to provide care to him/her. The resident told the inspector that the PSW grabbed the resident in a rough manner and pushed him/her down into his/her wheelchair. Both the Social Worker and the Executive Director acknowledged this as an incident of physical abuse. The licensee did not determine who the resident was. The licensee did not investigate the alleged abuse of the resident. [s. 23. (1) (a)]

2. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated including (i) abuse of a resident by anyone. The Power of Attorney (POA) for resident # 04 reported to the licensee during a family care conference on an identified date, that the resident reported to the POA that he/she was slapped on the legs by the Personal Support Worker (PSW) some time in mid to late December, 2012. The POA requested that any investigation and follow up completed by the home to exclude the resident's identity. An internal incident form was completed by the Social Worker and submitted to the home's Executive Director. There was no further investigation into this allegation of physical abuse by the licensee. [s. 23. (1) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all written complaints received concerning the care of a resident or the operation of the long-term care home are immediately forwarded to the Director.
The licensee received complaints concerning the care of a resident or the operation of the home on the following dates:

On January 16, 2013.
On January 14, 2013.
On January 24, 2013.
On March 1, 2013.
On March 14, 2013.

The licensee did not forward any of the complaints to the Director. [s. 22. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The POA for resident # 4 reported to inspector that he/she made a complaint to the charge nurse on an identified date that the resident reported the PSW hit the resident on the head during his/her shower. The RN reported to the inspector that he/she spoke to the resident and the resident gestured that he/she was hit at the back of the neck and that it was the PSW who gave him/her the shower.

The POA stated that he/she was not notified of the results of the investigation of alleged abuse to resident #4 in February 2013. [s. 97. (2)]

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

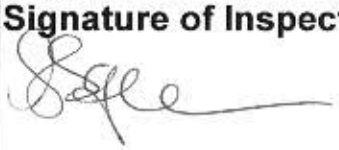
THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2012_162109_0003	109

Issued on this 23rd day of May, 2013

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

Ministère 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), NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2013_162109_0020
Log No. / Registre no:	T-2178-12, T-2179-12, T-177-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 14, 16, 2013
Licensee / Titulaire de permis :	WEST PARK HEALTHCARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	WEST PARK LONG TERM CARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TRISH TALABIS

To WEST PARK HEALTHCARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all alleged, suspected, or witnessed incidents of abuse are immediately reported to the Director.

Submit compliance plan to susan.squires@ontario.ca by May 31, 2013

Grounds / Motifs :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which is was based to the Director: (2) Abuse of a resident by anyone or neglect of a resident by the licensee of staff that resulted in harm or risk of harm.

The Power of Attorney (POA) for resident # 04 reported to the licensee during a family care conference in January 2013, that the resident reported to the POA that he/she was slapped on the legs by the Personal Support Worker (PSW) some time in mid to late December, 2012. The POA requested that any investigation and follow up completed by the home to exclude the resident's identity. An internal incident form was completed by the Social Worker and submitted to the home's Executive Director. The allegation of abuse was not reported to the Director. The POA for resident #04 reported to the charge nurse that the resident reported that the same PSW from the previous complaint hit the resident on the head during a shower on an identified date. The RN reported to inspector that he/she spoke to the resident and the resident gestured that he/she was hit at the back of the neck and told the RN that it was the PSW who had given him/her a shower. The RN reported the allegation of abuse to the Assistant Director of Care (ADOC) who followed up with the staff member and the resident assessment.

The allegation of abuse was not reported to the Director. (189)

2. In February 2013 resident # 19 reported to the Social Worker that he/she observed a PSW "manhandle" a male/female resident in the dining room. The resident told the inspector that he/she observed a PSW grab the resident in a rough manner and push him/her down into his/her wheelchair. The Social Worker acknowledged to the inspector that this is considered physical abuse and he/she reported it to the Administrator as per the home's protocol. The Administrator acknowledged this as a physical abuse. The licensee did not determine who the resident was.

The allegation of abuse was not reported to the Director
(109)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2013

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2012_174189_0010, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that direct care staff use safe transferring and positioning techniques when assisting resident # 1 and # 5 with mechanical lifts.

Grounds / Motifs :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan of care for resident # 1 states that the resident requires 2 staff to use the ceiling lift while transferring the resident. The second staff member is to provide physical help and constant supervision. Resident #1 was not transferred with 2 direct care staff as required. During an interview with the resident on April 18, 2013, the resident reported to the inspector that he/she was transferred on April 16, 2013 with a ceiling lift by identified PSW #1 while the housekeeping staff member stood in the room and observed the PSW transfer the resident. The resident reported that the housekeeping aide has observed such transfers on multiple occasions.

The housekeeping aide does not provide physical assistance as required in resident #1's plan of care. The housekeeping aide role does not include provision of direct care to residents. Furthermore, in the position as a housekeeping aide, he/she does not have recent training from the licensee on the safe and correct use of mechanical lifts as required in the Long Term Care Homes Act, 2007.

The housekeeping aide was interviewed in April 2013. He/she reported that on

an identified date, he/she stood and observed PSW # 1 transfer resident # 1 with a mechanical lift unassisted.
Interviews with both PSW # 1 and housekeeping aide confirms that PSW # 1 transferred resident # 1 unassisted with the ceiling lift while the housekeeping aide stood and observed on multiple occasions. Staff interview also confirmed that the same housekeeping aide has observed transfers for resident #5 in the same manner.

An interview with the housekeeping aide confirmed that it is a common practice on the unit for the PSW staff to seek out and accept assistance from the housekeeping aide to observe resident transfers with the mechanical lift. The housekeeping aide identified 3 other staff members (PSW #2, PSW #3 and PSW #4) who have asked the housekeeping aide to observe transfers for other residents.

LTCH, 2007 O. Reg. 79/10 s. 36 has been previously issued as an order on November 30, 2012.
(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2013

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 : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall investigate the allegation of physical abuse reported by resident #19 and shall investigate allegation of physical abuse of resident #4. The licensee shall ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Grounds / Motifs :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated including (i) abuse of a resident by anyone.

The Power of Attorney (POA) for resident # 04 reported to the licensee during a family care conference on an identified date, that the resident reported to the POA that he/she was slapped on the legs by the Personal Support Worker (PSW) some time in mid to late December, 2012. The POA requested that any investigation and follow up completed by the home to exclude the resident's identity. An internal incident form was completed by the Social Worker and submitted to the home's Executive Director.

There was no further investigation into this allegation of physical abuse by the licensee (189)

2. On an identified date resident # 19 reported to the Social Worker that he/she witnessed a staff member "manhandle" a resident on the Hughes Unit at supper time. The resident expressed that he/she was fearful of this staff member and did not want him/her to provide care to him/her. The resident told the inspector that the PSW grabbed the resident in a rough manner and pushed him/her down into his/her wheelchair. Both the Social Worker and the Executive Director acknowledged this as an incident of physical abuse. The licensee did not determine who the resident was.

The licensee did not investigate the alleged abuse of the resident (109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
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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 14th day of May, 2013

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