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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2016;	2016_346133_0024 (A1) (Appeal\Dir#: 003175-16)	003175-16	Critical Incident System

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE COBDEN
12 WREN DRIVE P.O. BOX 430 COBDEN ON K0J 1K0

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

JESSICA LAPENSEE (133) - (A1)(Appeal\Dir#: 003175-16)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Compliance order #001, #002 and #003 have been rescinded to reflect a decision of the Director on a review of the Inspector's orders. The Director's review was completed on August 15th, 2016. One Director order was issued, substituting for the three Inspector's orders.

Issued on this 18 day of August 2016 (A1)(Appeal\Dir#: 003175-16)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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CARESSANT CARE COBDEN
12 WREN DRIVE P.O. BOX 430 COBDEN ON K0J 1K0

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

JESSICA LAPENSEE (133) - (A1)(Appeal/Dir# 003175-16)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 2, 2016

This Critical Incident Inspection is related to a Critical Incident Report that the home submitted related to the elopement of a resident through an unlocked exit door in a dining room on an identified day in 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and the Environmental Services Manager.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. i. in that the licensee has failed to ensure that all resident accessible doors that lead to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident are kept closed and locked.

On an identified day in January 2016, resident #001 eloped from the home. As per the submitted Critical Incident Report (CIR), the resident eloped through an unlocked an unalarmed exit door within the unit #1 dining room. Resident #001 was found wandering outside of the home's front doors approximately 15 minutes after the resident was thought to have eloped. Foot steps were observed in the snow, leading from the unlocked dining room door. The resident did have shoes on, and was not harmed as a result of the elopement. At the time of the resident's elopement, it was reported that the doors leading into one side of the dining room were open and the area was not supervised.

On June 2nd, 2016, the Inspector reviewed the CIR with the Administrator, the Director of Care (DOC), and the Environmental Services Manager (ESM). It was explained to the Inspector that the exit door in the dining room had not been not locked at the time of resident #001's elopement because the magnetic lock in place on the door had been intentionally demagnetized. This exit door is connected to the resident-staff communication and response system (the system). On an identified day in January 2016, a door malfunction had re-occurred, whereby the magnetic lock was continuously activating the system. In order to stop this, the ESM had to demagnetize the lock. Although unlocked, the exit door remained connected to the system. The ESM indicted that when he left the home on that evening in January 2016, the system console at the door was in the locked position. If the unlocked door had been opened, the system would have activated and a call would have been heard throughout the care units. The ESM explained that the malfunction had re-occurred after regular business hours on a Friday, and that he had intended to call the company who works on the doors the next week for service. The ESM elaborated that this malfunction had occurred earlier in January 2016 as well. The ESM explained that when a door technician had come in a few days after the first incident of malfunction and had remagnetized the door lock, the malfunction did not occur. It appeared as if the problem had resolved itself. Two days following resident #001's elopement, it was determined by a different door technician that the problem was a malfunctioning relay on the unit 2 dining room exit door. It was determined by that technician that in fact the two dining room exit doors were connected.

When the dining room exit door had been left unlocked, on both occasions in January 2016, it was believed that appropriate safety measures were in place. Residents were not to be left unsupervised in the dining room, and the doors into the dining room were to be locked between meal services. The DOC explained that at the time of resident #001's elopement, the doors into one side of the dining room were open because another resident had become combative and had refused to leave the dining room after a meal. Staff had left the resident in the dining room, returning periodically to re-approach him/her. The resident continued to refuse to leave the dining room. It was during this time that resident #001 wandered into the dining room and eloped from the home.

At some point between the identified evening in January 2016 when the ESM demagnetized the exit door in dining room #1, and the morning when resident #001 eloped, the system connection at the door had been bypassed. When resident #001 exited through the unlocked door, staff were therefore not alerted that the door had been opened. As per discussion with the ESM, the Administrator, and the DOC, it could not be determined who had bypassed the system connection at the door.

The unlocked exit door within the dining room in January 2016 presented a widespread risk to the residents of the home. The licensee failed to ensure that all resident accessible doors leading to the outside of the home were kept locked. [s. 9. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1iii in that the licensee has failed to ensure that all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to the resident-staff communication and response system, or, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

On June 2, 2016, the Administrator and the Environmental Services Manager worked with the Inspector to conduct as assessment of the home's current door security systems in light of the requirements outlined in O. Reg. 79/10, s. 9 (1). This inspection occurred as a result of a reported resident elopement on an identified day in January 2016, through an unlocked an unalarmed exit door within

the unit #1 dining room.

With regards to the home's main exit door (the front door), it was confirmed that the door is not equipped with an audible alarm or connected to the resident-staff communication and response system. It was noted that the WanderGuard system is in place at the door, which serves as a security feature for those residents who wear a WanderGuard bracelet only.

With regards to the two dining room exit doors (DINDR), the two exit doors within unit #1 (DR10, DR25) and the two exit doors within unit #2 (DR52, DR38), it was confirmed that the doors are not equipped with an audible alarm system independent of the resident-staff communication and response system (the system). When one of the referenced doors was unlocked and opened, the system would activate. There was one enunciator, connected to the system, in each hallway and in each dining room. When the testing process first began, at door #DR10 in unit #1, the enunciator in the hallway was at the low volume (vs the high volume setting). The Inspector and the Administrator had difficulty hearing the sound from the system, activated by door #DR10, when at the unit #1 nurses' station. The Administrator speculated that night staff had turned the system to low volume. The enunciators throughout both units were found to be at the low volume. When turned to the high volume setting, the sound from the system, activated by an opened door, was audible throughout the care units.

The sound from the system as a result of an opened door was no different than the sound from the system as a result of a call from a resident bedroom, bathroom, or common areas. It was noted that in key hallway areas, there were ceiling mounted dome lights. When the system was activated as a result of a call from a resident washroom, or from an opened door, a red dome light would illuminate. In order to make a final determination that the system was sounding in response to an opened door, staff would have to first go to the nurses' station. Within the two unit nurses stations, there was a panel that illuminated a room number or door number (see above for door numbers). There was no independent alarm system in place for the doors that would immediately alert staff in the area of a potentially compromised door.

In relation to the exit door within the unit #2 dining room, it was noted that this door is in fact connected to the exit door within the unit #1 dining room. When either door is unlocked and opened, the system activates, the enunciators throughout the two care units sound, and the panel in the unit #1 nurses' station illuminates for

"DINDR". The red dome light system in place for the other previously noted exit doors is not in place for the dining room doors. There is no differentiation between the two dining room doors.

If the audible function of the system failed, there would be no audible notification that a door had been opened, as the doors are not equipped with an independent audible alarm system.

With regards to the door that leads into the Cobden community public library, which is considered to be outside of the home, it was confirmed that the door is not equipped with an audible alarm system independent of the resident-staff communication and response system (the system). The library is located within the entrance area of the home, just past the Administrator's office. Within the library, there is an unlocked and unalarmed door that leads to the outside parking lot area. When the Administrator, ESM and Inspector first observed this door, it was noted that the door's connection to the system was on bypass. The ESM rearmed the door, unlocked and opened it. The Inspector and the Administrator went back into the care unit area and it was noted that the system enunciators were sounding in response to the opened door. The panel at the nurses' station illuminated the "LIBDR" box on the panel. It was determined that the red dome light system in place for the care unit exit doors was not in place for the library door.

The sound from the system enunciators within the care unit areas could not be heard when in the area of the library door.

The lack of audible door alarm for the doors noted above is a widespread issue that presents a potential risk to the resident's at the home. [s. 9. (1)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

This non-compliance is specifically related to the door that leads into the home's service corridor.

The licensee has a history of non-compliance related to the unlocked door that leads into the service corridor. As a result of Resident Quality Inspection #2015_384161_0019, conducted in October 2015, the licensee was issued a Written Notification with the additional required action of a Voluntary Plan of

Correction.

On June 2, 2016, the Administrator and the Environmental Services Manager worked with the Inspector to conduct as assessment of the home's current door security systems in light of the requirements outlined in O. Reg. 79/10, s. 9. This inspection occurred as a result of a reported resident elopement on an identified day in January 2016, through an unlocked an unalarmed exit door within the unit #1 dining room.

It was confirmed that the doors that lead into the home's service corridor had not been equipped with locks to restrict unsupervised access to the area by residents. At the end of the service corridor, there was a door that led to the retirement home service corridor, which is considered to be outside of the home. The door was locked but not equipped with an audible alarm. The door was connected to the resident-staff communication and response system (the system). The ESM explained that the door's connection to the system was always on bypass as staff often go back and forth between long term care and retirement. The system would be activated every time the door was opened if it was engaged.

The Administrator and the ESM acknowledged that the service corridor is not a residential area. They qualified that sometimes, a resident would use the service corridor to go to the retirement side of the building, but typically the resident would be accompanied. They referenced one resident who used to be able to go through on his own, noting he was no longer capable to do so.

This widespread issue presents a potential for risk to the residents of the home. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 001, 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)(Appeal/Dir# 003175-16)
The following order(s) have been rescinded:CO# 001,002,003

Issued on this 18 day of August 2016 (A1)(Appeal/Dir# 003175-16)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA LAPENSEE (133) - (A1)(Appeal/Dir# 003175-16)

Inspection No. / No de l'inspection : 2016_346133_0024 (A1)(Appeal/Dir# 003175-16)

Appeal/Dir# / Appel/Dir#: 003175-16 (A1)

Log No. / Registre no. : 003175-16 (A1)(Appeal/Dir# 003175-16)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 18, 2016;(A1)(Appeal/Dir# 003175-16)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : CARESSANT CARE COBDEN
12 WREN DRIVE, P.O. BOX 430, COBDEN, ON, K0J-1K0

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Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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Name of Administrator / Nom de l'administratrice ou de l'administrateur : Alexis Anderson

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To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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

Ministère de la Santé et des Soins de longue durée

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

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

(A1)(Appeal/Dir# 003175-16)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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

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

(A1)(Appeal/Dir# 003175-16)
The following Order has been rescinded:

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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

(A1)(Appeal/Dir# 003175-16)
The following Order has been rescinded:

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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
Long-Term Care Inspections 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

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

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 18 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

Service Area Office /
Bureau régional de services : Ottawa