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

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

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

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5700 rue Yonge 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 3, 2017	2017_168202_0001	035224-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

COLEMAN CARE CENTRE
140 CUNDLES ROAD WEST BARRIE ON L4N 9X8

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

VALERIE JOHNSTON (202), KAREN MILLIGAN (650), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 04, 05, 06, 09, 10, 11, 12, 13, 2017.

During the course of the inspection, complaint intake 011420-16 was inspected related to the number of falls that resident #006 had with injury and lack of assessment post fall.

During the course of the inspection, the inspector(s) spoke with General Manager, Director of Care, Neighbourhood Coordinators, Maintenance Technician, Kinesiologist, Registered Nursing staff, Personal Support Workers, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 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 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 had been provided to the resident as specified in the plan.

In response to a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) regarding the number of falls that resident #006 had with injury and the lack of assessment post fall, prompted an inspection.

Resident #006 had been admitted to the home on an identified date in 2016. A review of the clinical records revealed that at the time of resident #006's admission he/she had been identified at high risk for falls due to self-transferring. A review of the written plan of care for resident #006 identified that the resident was at high risk for falls and as intervention to prevent injury from falls, staff had been directed to apply both a fall mat to the floor beside the bed and a Curbell bed/chair alarm system to be on and working.

A review of resident #006's progress notes and fall incident reports revealed that the resident had an identified number of documented falls. Of the documented falls three falls were identified as falls with injury and for which the licensee failed to ensure that the fall prevention interventions set out in the resident #006's plan of care had been provided to the resident.

-Fall #1 resident #006 was found sitting on the floor beside the bed, sustained an injury to an identified area of the body and floor mat was not in place on the floor.

-Fall #2 resident #006 was found at the foot of the bed on the floor and the Curbell bed alarm system's 'box' was missing. Resident #006 sustained an identified injury.

-Fall #3 resident #006 was found by staff to be lying on his/her back beside the wheelchair. The Curbell alarm system had been on the wheelchair but found not plugged in. Resident was sent to hospital for further assessment the following day and returned to the home diagnosed with an inoperable injuries.

PSWs #110, #111, #116, RPN # 117 and RN #112 all indicated in interviews that resident #006 had been a high risk for falls since admission. The staff indicated that resident #006 had been found often trying to self-transfer either from his/her bed or wheelchair. All staff confirmed that the resident was to have a fall mat beside the bed and a Curbell alarm system for both the bed and the wheelchair to be in place and working at all times.

Interview with RN #112 confirmed that at the beginning of an identified shift for fall #1, fall #2 and fall #3, identified above, resident #006 fell resulting in injury. At the time of each fall RN #112 further confirmed that resident #006 did not have the appropriate fall

prevention strategies in place as specified in resident #006's plan of care confirming that on fall #1, the resident's fall mat was beside the night stand and not in place on the floor beside the right side of the bed, on fall #2, the resident's Curbell alarm systems 'box' was missing and on fall #3, the resident's Curbell alarm system was not plugged while the resident was sitting in his/her wheelchair. RN #112 indicated that at the beginning of his/her scheduled shift he/she will conduct rounds to ensure that the prior shift staff have left all the residents in the home with the interventions in place as specified in each resident's plan of care. The RN further indicated that the prior shift staff would not always leave the resident's with the identified interventions, that would have included resident #006 and revealed that resident #006's fall mat was often found upright beside the residents bed and not in place as specified in his/her plan of care.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #006 was deemed high risk for falls upon admission to the home and was to have in place a fall mat on the floor bedside the bed and Curbell alarm system to be in place and working while the resident is in bed and/or wheelchair. Resident #006 had an identified number for an identified period of time, and sustained injuries for three falls when the resident did not have the fall prevention interventions in place as specified in the resident's plan of care.

The scope of the non-compliance is related to resident #006.

The home has previously been issued a Voluntary Plan of Correction (VPC), under LTCHA, 2007,.c.8, s. 6 (7), on January 12, 2015, within report #2015_363591_0001, and on May 20, 2014, within report #2014_312503_0014, both Resident Quality Inspections. [s. 6. (7)]

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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available at the home.

In response to a complaint received by the MOHLTC regarding the number of falls that resident #006 had with injury and the lack of assessment that had been completed, prompted an inspection.

A review of the home's Fall Prevention and Management (LTC), policy, dated February 2013, states "residents who have a high risk for falls, falls prevention equipment may be considered by the Team and will be identified in the plan of care. Examples include, but are not limited to the following: c. floor mat beside the bed and d. chair/bed alarm".

A review of the written plan of care for resident #006 identified that the resident was at high risk for falls and as intervention to prevent injury from falls, staff had been directed to apply both a fall mat to the floor beside the bed and a Curbell alarm system to be on and working.

A review of resident #006's progress notes and fall incident reports for an identified period of time revealed that the resident had an identified number of documented falls. On an identified date resident #006 was found on the floor by staff in his/her room and the box for the Curbell alarm system was missing and as a result did not sound to alert staff. Resident #006 sustained an identified injury.

An interview with RN #112 who had documented the above mentioned fall confirmed that the Curbell alarm system's 'box' was not in the resident's room at the time of the fall. The RN indicated that resident #006 required the Curbell alarm system to be in place and working and indicated an unawareness as to why the Curbell alarm systems 'box' had been missing. RN #112 further indicated that the Curbell alarm systems 'box' for resident #006 may have been removed if it required repair and stated that there are times that the Curbell alarm systems used in the home need replacement, will break or need new

batteries. The RN indicated that batteries are available and can be replaced by nursing staff, however, should the Curbell alarm system break or become damaged, it is set aside and a maintenance request is forwarded to the Maintenance Technician (MT). RN #112 further indicated that he/she does not have access to a replacement at the time of Curbell alarm system removal and when this happens he/she will direct the staff to monitor the resident more frequently.

An interview with the Neighbourhood Coordinator (NC) indicated that Curbell alarm systems are used in the home to alert staff if a resident is moving from the bed or wheelchair as a fall prevention strategy. When asked if the Curbell alarm systems are readily available to staff for residents that are required to have one, the NC replied 'yes' and 'no". The NC indicated that last week both him/herself and another RN required a replacement Curbell alarm system for a resident and was able to find a couple, but none of the Curbell alarms systems found were working. The NC stated that there is a home's process for obtaining a Curbell alarm system and that is to place an online request to maintenance. The NC further stated that in light of having to search for a functioning Curbell alarm system, had sent a maintenance request suggesting that the maintenance department have two readily available Curbell alarm systems for the home.

An interview with the Maintenance Technician (MT) confirmed that Curbell alarm systems are not readily available to staff in the home. The MT indicated that the normal process is for staff to put in a maintenance request and he/she will fix or replace the Curbell alarm system when he/she is on shift. When asked if a resident would go without a required Curbell alarm system if the resident's is in need of repair, the MT stated that yes, and the resident would be without until he/she is able to fix one. The MT indicated that the plan for the home is to have two Curbell alarm systems prepared and readily available for staff as requested by the NC on January 06, 2017. The MT further indicated that because he/she is currently dealing with other issues in the home and prioritizes maintenance requests based on risk, the plan for available Curbell alarm systems is in the works.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The home's Fall Prevention and Management policy/program identified the use of a chair/bed alarm to be used as a strategy in the reduction of fall risk for residents at high risk of falls and identified in the plan of care. Resident #006 identified as high risk of falls required a Curbell alarm system to be working and in place at the bedside. On an identified date resident #006 sustained an identified injury after having fallen to the floor

in his/her bedroom and Curbell box was found to be missing. RN #112 indicated that the Curbell system's alarm box may have been removed for repair. Interviews with RN #112, NC and MT confirmed that Curbell alarm systems that have been included in resident plans of care for those at high risk for falls are not readily available for use in the home.

The scope of the non-compliance is widespread.

There is no previous non-compliance related to this area of the legislation. [s. 49. (3)]

Additional Required Actions:

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

Issued on this 3rd day of February, 2017

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), KAREN MILLIGAN (650), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2017_168202_0001
Log No. / Registre no:	035224-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 3, 2017
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	COLEMAN CARE CENTRE 140 CUNDLES ROAD WEST, BARRIE, ON, L4N-9X8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Wiebe

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

1. Within one week of receipt of this order, identify all residents in the home at high risk of falls.

2. Review each of the resident's plan of care as identified in task 1 with direct care staff to ensure that the fall prevention interventions are provided to the residents as specified in the plan.

3. Develop and implement a quality improvement process to ensure that all residents assessed at high risk of falls receive the fall prevention intervention(s) as specified in the plan of care. The fall prevention interventions shall include items from the home's Fall Prevention program, and not be limited to floor mats and Curbell alarm systems.

The licensee shall prepare and submit a plan that includes tasks 1-3 and the person(s) responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by February 28, 2017, and implemented by April 30, 2017.

Grounds / Motifs :

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

In response to a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) regarding the number of falls that resident #006 had with injury and the lack of assessment post fall, prompted an inspection.

Resident #006 had been admitted to the home on an identified date in 2016. A

review of the clinical records revealed that at the time of resident #006's admission he/she had been identified at high risk for falls due to self-transferring. A review of the written plan of care for resident #006 identified that the resident was at high risk for falls and as intervention to prevent injury from falls, staff had been directed to apply both a fall mat to the floor and a Curbell bed/chair alarm system to be on and working.

A review of resident #006's progress notes and fall incident reports revealed that the resident had an identified number of documented falls. Of the documented falls three falls were identified as falls with injury and for which the licensee failed to ensure that the fall prevention interventions set out in the resident #006's plan of care had been provided to the resident.

-Fall #1 resident #006 was found sitting on the floor beside the bed, sustained a skin tear to an identified area of the body and floor mat was not in place on the floor.

-Fall #2 resident #006 was found at the foot of the bed on the floor and the Curbell bed alarm system's 'box' was missing. Resident #006 sustained an identified injury.

-Fall #3 resident #006 was found by staff to be lying on his/her back beside the wheelchair. The Curbell alarm system had been on the wheelchair but found not plugged in. Resident was sent to hospital for further assessment the following day and returned to the home diagnosed with an inoperable injuries.

PSWs #110, #111, #116, RPN # 117 and RN #112 all indicated in interviews that resident #006 had been a high risk for falls since admission. The staff indicated that resident #006 had been found often trying to self-transfer either from his/her bed or wheelchair. All staff confirmed that the resident was to have a fall mat beside the bed and a Curbell alarm system for both the bed and the wheelchair to be in place and working at all times.

Interview with RN #112 confirmed that at the beginning of an identified shift for fall #1, fall #2 and fall #3, identified above, resident #006 fell resulting in injury. At the time of each fall RN #112 further confirmed that resident #006 did not have the appropriate fall prevention strategies in place as specified in resident #006's plan of care confirming that on fall #1, the resident's fall mat was beside the night stand and not in place on the floor beside the right side of the bed, on

fall #2, the resident's Curbell alarm systems 'box' was missing and on fall #3, the resident's Curbell alarm system was not plugged while the resident was sitting in his/her wheelchair. RN #112 indicated that at the beginning of his/her scheduled he/she will conduct rounds to ensure that the prior shift staff have left all the residents in the home with the interventions in place as specified in each resident's plan of care. The RN further indicated that the prior shift staff would not always leave the resident's with the identified interventions, that would have included resident #006 and revealed that resident #006's fall mat was often found upright beside the residents bed and not in place as specified in his/her plan of care.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #006 was deemed high risk for falls upon admission to the home and was to have in place a fall mat on the floor bedside the bed and Curbell alarm system to be in place and working while the resident is in bed and/or wheelchair. Resident #006 had an identified number for an identified period of time, and sustained injuries for three falls when the resident did not have the fall prevention interventions in place as specified in the resident's plan of care.

The scope of the non-compliance is related to resident #006.

The home has previously been issued a Voluntary Plan of Correction (VPC), under LTCHA, 2007,.c.8, s. 6 (7), on January 12, 2015, within report #2015_363591_0001, and on May 20, 2014, within report #2014_312503_0014, both Resident Quality Inspections. [s. 6. (7)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that Curbell alarm systems, identified as an intervention to prevent injury from falls in the home's falls prevention and management program are readily available in the home and that direct care staff have a system to obtain a working Curbell alarm system as required.

The plan and the person (s) responsible for completing the plan shall be submitted to valerie.johnston@ontario.ca by February 28, 2017, and implemented by April 30, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available at the home.

In response to a complaint received by the MOHLTC regarding the number of falls that resident #006 had with injury and the lack of assessment that had been completed, prompted an inspection.

A review of the home's Fall Prevention and Management (LTC), policy, dated February 2013, states "residents who have a high risk for falls, falls prevention equipment may be considered by the Team and will be identified in the plan of care. Examples include, but are not limited to the following: c. floor mat beside the bed and d. chair/bed alarm".

A review of the written plan of care for resident #006 identified that the resident was at high risk for falls and as intervention to prevent injury from falls, staff had

been directed to apply both a fall mat to the floor beside the bed and a Curbell alarm system to be on and working.

A review of resident #006's progress notes and fall incident reports for an identified period of time revealed that the resident had an identified number of documented falls. On an identified date resident #006 was found on the floor by staff in his/her room and the box for the Curbell alarm system was missing and as a result did not sound to alert staff. Resident #006 sustained an identified injury.

An interview with RN #112 who had documented the above mentioned fall confirmed that the Curbell alarm system's 'box' was not in the resident's room at the time of the fall. The RN indicated that resident #006 required the Curbell alarm system to be in place and working and indicated an unawareness as to why the Curbell alarm systems 'box' had been missing. RN #112 further indicated that the Curbell alarm systems 'box' for resident #006 may have been removed if it required repair and stated that there are times that the Curbell alarm systems used in the home need replacement, will break or need new batteries. The RN indicated that batteries are available and can be replaced by nursing staff, however, should the Curbell alarm system break or become damaged, it is set aside and a maintenance request is forwarded to the Maintenance Technician (MT). RN #112 further indicated that he/she does not have access to a replacement at the time of Curbell alarm system removal and when this happens he/she will direct the staff to monitor the resident more frequently.

An interview with the Neighbourhood Coordinator (NC) indicated that Curbell alarm systems are used in the home to alert staff if a resident is moving from the bed or wheelchair as a fall prevention strategy. When asked if the Curbell alarm systems are readily available to staff for residents that are required to have one, the NC replied 'yes' and 'no". The NC indicated that last week both him/herself and another RN required a replacement Curbell alarm system for a resident and was able to find a couple, but none of the Curbell alarms systems found were working. The NC stated that there is a home's process for obtaining a Curbell alarm system and that is to place an online request to maintenance. The NC further stated that in light of having to search for a functioning Curbell alarm system, had sent a maintenance request suggesting that the maintenance department have two readily available Curbell alarm systems for the home.

An interview with the Maintenance Technician (MT) confirmed that Curbell alarm systems are not readily available to staff in the home. The MT indicated that the normal process is for staff to put in a maintenance request and he/she will fix or replace the Curbell alarm system when he/she is on shift. When asked if a resident would go without a required Curbell alarm system if the resident's is in need of repair, the MT stated that yes, and the resident would be without until he/she is able to fix one. The MT indicated that the plan for the home is to have two Curbell alarm systems prepared and readily available for staff as requested by the NC on January 06, 2017. The MT further indicated that because he/she is currently dealing with other issues in the home and prioritizes maintenance requests based on risk, the plan for available Curbell alarm systems is in the works.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The home's Fall Prevention and Management policy/program identified the use of a chair/bed alarm to be used as a strategy in the reduction of fall risk for residents at high risk of falls and identified in the plan of care. Resident #006 identified as high risk of falls required a Curbell alarm system to be working and in place at the bedside. On an identified date resident #006 sustained an identified injury after having fallen to the floor in his/her bedroom and Curbell box was found to be missing. RN #112 indicated that the Curbell system's alarm box may have been removed for repair. Interviews with RN #112, NC and MT confirmed that Curbell alarm systems that have been included in resident plans of care for those at high risk for falls are not readily available for use in the home.

The scope of the non-compliance is widespread.

There is no previous non-compliance related to this area of the legislation. [s. 49. (3)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

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

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
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
Inspection de soins de longue durée
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 3rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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