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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2015	2015_277538_0033	026856-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens 710 Southdale Road East LONDON ON N6E 1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST LONDON ON N6E 1R8

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

NANCY JOHNSON (538), MELANIE NORTHEY (563), RHONDA KUKOLY (213)

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): November 16, 17, 18, 19, 20, 23, 24, 2015.

Complaint Log#025796-15/CI#000042-15 related to a discharge was completed during the Resident Quality Inspection(RQI).

The following Critical Incidents were inspected with the RQI:
Log#025256-15/CI#000040-15, Log#022779-15/CI#000035-15, Log#026069-15/CI#000044-15, related to abuse,
Log#024108-15/CI#000037-15, related to a fall,
Log#030854-15/CI#000046-15, related to improper resident care,
Log#030131-15/CI#000045-15, related to an outbreak,
Log#022391-15/CI#000032-15 related to improper resident care,

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, two Resident Assessment Instrument (RAI) Coordinators, the Manager of Dietary and Environmental Services, one Maintenance staff, the Manager of Compliance and Education, the Regional Consultant, one Staffing Coordinator, one Dietary Aide, one Housekeeping staff, one Health Care Aide, five Personal Support Workers, eight Registered Practical Nurses (RPN), three Registered Nurses (RN), one Client Services Manager, forty plus Residents, and three Family members.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Training and Orientation

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

- **5 WN(s)**
- **2 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practice, and if there are none, in accordance with prevailing practices to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations of specific resident rooms, revealed 29 of 40 residents had one or more bed rails in use.

Record review of specific residents' clinical records, revealed the absence of a documented resident bed rail risk assessment for the use of bed rails.

Record review of the bed entrapment audit, revealed it was completed December 19, 2014, by Joerns Health Care Canada. There were 29 bed systems identified with failed zones of entrapment. Two of 29 bed systems had failed zone three and 27 of the 29 bed systems had failed zones two and three. Joern's recommendation for corrective action was to replace the mattresses for 28 of the 29 bed systems and to tighten the rails on one of the bed systems to pass zone two and/or three.

Interview with the Educator and the Director of Care confirmed the home had not completed a bed rail risk assessment for any resident using bed rails and confirmed there was no formal assessment in Point Click Care (PCC) to assess a resident where bed rails were used.

Staff interview with Director of Care (DOC) confirmed that the failed zones identified in the last bed entrapment assessment done in December 2014, by Joerns have not been addressed or fixed to date. Therefore, although the home had been aware of potential entrapment risk, steps had not been taken to prevent resident entrapment in these 29 beds. The DOC also confirmed that they had not completed resident assessments related to use of bed rails for any residents. [s. 15. (1)]

Additional Required Actions:

CO # - 901, 902 were served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 plan of care set out clear directions to staff and others who provided direct care to the resident.

Observations of a specified resident, revealed the left side rail was in use.

Record review of the resident's plan of care revealed, "One half bed rail in the raised position when (the resident) is in bed, to prevent falls out of bed" and "One bed rail used for positioning and safety".

Staff interview with the Assistant Director of Care confirmed that the plan of care should have indicated on which side the rail was to be in use to direct staff. (213) [s. 6. (1) (c)]

2. Observation of a specified resident's bed, revealed one half rail in use while the resident was in bed.

Record review of the resident's plan of care, under the bed mobility section revealed, "participates by using the bed rails and with one staff providing weight bearing assistance with turning, and repositioning." There was no documented evidence indicating which bed rails were used.

Staff interview with the Director of Care (DOC) confirmed that it was the home's

expectation that the plan of care set out clear direction to staff who provide direct care to the resident. (538) [s. 6. (1) (c)]

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

Record review of the home's internal investigation notes revealed that the Personal Support Workers (PSW) confirmed that they were providing care to a specified resident that was not set out in the plan of care.

Record review of the resident's plan of care, revealed no documentation and interventions giving direction to the PSW's to provide the care.

Interview with the Director of Care (DOC) and the Administrator confirmed that the care provided to the resident was not set out in the plan of care. The Administrator confirmed that it was an expectation of the home that care only be provided to residents if it was in the care plan. [s. 6. (7)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal care items labeled within 48 hours of admission and of acquiring in the case of new items.

Observations of the home's tub and shower rooms, revealed one or more of the following:

Second floor Walnut Court tub and shower room: one half used, unlabeled jar of Vitarub.

Interview with a personal support worker confirmed that the jar of Vitarub should have been labeled.

First Floor Oak Dale unit tub and shower room: four half used, unlabeled jars of Vitarub; one unlabeled; one used (hair observed in the bristles) hair brush; and two unlabeled used (debris observed between the blades) razors.

Interview with a Registered Nurse confirmed that these items should have been labeled.

Fourth Floor Willow Way unit tub and shower room: one unlabeled, more than half used, without a cap, tube of Anusol cream; one partially used, unlabeled tube of toothpaste; one unlabeled, used (debris noted) set of nail clippers; and one partially used (hair observed on it), unlabeled stick of Secret deodorant.

Interview with a health care aide confirmed all personal care items should have been labeled.

Third Floor Poplar Green tub and shower room: one unlabeled, partially used tube of

pain reliever cream; one unlabeled tin of used hair elastics with hair observed on the elastics; one half used bar of soap; two sets of unlabeled, used (debris noted) nail clippers; and one open used (discolored), unlabeled catheter plug.

Interview with a health care aide confirmed all personal care items should have been labeled.

Interview with the Administrator and the Director of Care, confirmed that the home's expectation was that all personal care items including jars of cream, nail clippers, brushes, razors, etc. were to be labeled with resident names to be used individually by residents and not shared. They confirmed that this labeling was to be done by direct staff to prevent shared use of personal care items.[s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal care items labeled within 48 hours of admission and of acquiring in the case of new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Record review of the home's policy "Resident Abuse - Staff to Resident" dated March 2013, indicated:
"Procedures. Responding/Reporting - suspected or witnessed abuse. All staff:
1. If the abuse was witnessed, separate the resident from the alleged perpetrator (if safe to do so).
2. Stay at the scene to provide comfort and reassurance to the resident as needed.
3. Immediately report (verbally) any suspected or witnessed abuse:
- to the Administrator, Director of Care, or their designate (e.g. supervisor, department head)
Note: Staff failure to report verbally the incident to the Administrator, Director of Care or their designate immediately could result in disciplinary action."

Record review of the home's internal investigation records related to a critical incident #M514-000040 by a staff member revealed an incident of witnessed alleged verbal abuse toward a specified resident by a staff member on a specified date. The incident was reported by another staff member, at a later date.

Interview with the Director of Care confirmed that a staff member witnessed an incident of alleged abuse, and that the staff member who witnessed the incident did not report this incident until a later date. The Director of Care confirmed that the staff member who witnessed the incident did not follow the home's policy or the home's expectation to report any witnessed alleged abuse immediately to a manager. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Findings/Faits saillants :

1. The licensee failed to discharge a resident only when the licensee was informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident.

Record review of a Critical Incident (CI) #M514-000042-15 revealed that a specified resident's requirements for care changed, and the resident was subsequently discharged from the home. The home did not follow the proper procedure to discharge the specified resident and discharged the resident without viable alternative accommodation.

Interview with the Director of Care (DOC) confirmed that the resident's physician or registered nurse in the extended class attending the specified resident at the time of discharge did not inform the licensee of the resident's requirements for care as per legislation.

Interview with the DOC confirmed the decision to discharge the resident from the home was made without viable alternative accommodation.[s. 145. (1)]

Issued on this 18th day of December, 2015

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

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) :	NANCY JOHNSON (538), MELANIE NORTHEY (563), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2015_277538_0033
Log No. / Registre no:	026856-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 17, 2015
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF LONDON c/o Dearness Home for Senior Citizens, 710 Southdale Road East, LONDON, ON, N6E-1R8
LTC Home / Foyer de SLD :	DEARNESS HOME FOR SENIOR CITIZENS 710 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angie Heinz

To THE CORPORATION OF THE CITY OF LONDON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan to achieve compliance with O.Reg. 79/10, s.15 (1) (a).

The plan must include the following:
- a full bed rail risk assessment for all residents.
- the plan will include the home's time line and the person(s) responsible to achieve compliance.
- the long term action plan for tracking and updating bed rail risk assessments to ensure information is accurate and current at all times.

Please submit the plan in writing to Nancy Johnson, Long Term Care Homes, Inspector-Nursing, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin, 4th Avenue, 4th floor, London, Ontario, N6A 5R2, by email, nancy.johnson@ontario.ca by December 31, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practice, and if there are none, in accordance with prevailing practices to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations revealed 29 of 40 residents had one or more bed rails in use.

Record review of the residents' clinical records revealed the absence of a documented resident bed rail risk assessment for the use of bed rails.

Record review of the bed entrapment audit, revealed it was completed December 19, 2014, by Joerns Health Care Canada. There were 29 bed systems identified with failed zones of entrapment. Two of 29 bed systems had failed zone three and 27 of the 29 bed systems had failed zones two and three. Joern's recommendation for corrective action was to replace the mattresses for 28 of the 29 bed systems and to tighten the rails on one of the bed systems to pass zone two and/or three.

Interview with the Educator and the Director of Care, confirmed the home had not completed a bed rail risk assessment for any resident using bed rails.

Staff interview with Director of Care (DOC), confirmed that the failed zones identified in the last bed entrapment assessment done in December 2014, by Joerns have not been addressed or fixed to date. Therefore, although the home have been aware of potential entrapment risk, steps have not been taken to prevent resident entrapment in these 29 beds. The DOC also confirmed that they have not completed resident assessments related to use of bed rails for any residents.

The scope of this issue was widespread, the severity was determined to be a level 2 minimal harm/potential for actual harm, and there was previous noncompliance related to this regulation. A VPC was issued on December 14, 2014, as a result of the home's Resident Quality Inspection.
(563)

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 : Jan 29, 2016

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee shall ensure that corrective action is immediately taken for all bed systems that failed the December 19, 2014, bed entrapment audit, and any other bed system identified to have failed zones of entrapment.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations revealed 29 of 40 residents had one or more bed rails in use.

Record review of the residents' clinical records revealed the absence of a documented resident bed rail risk assessment for the use of bed rails.

Record review of the bed entrapment audit revealed it was completed December 19, 2014, by Joerns Health Care Canada. There were 29 bed systems identified with failed zones of entrapment. Two of 29 bed systems had failed zone 3 and 27 of 29 bed systems had failed zones 2 and 3. Joern's recommendation for corrective action was to replace the mattresses for 28 of the 29 bed systems and to tightened the rails on one of the bed systems to pass zone 2 and/or 3.

Interview with the Educator and the Director of Care, confirmed the home has not completed a bed rail risk assessment for any resident using bed rails and confirmed there was no formal assessment in Point of Care (PCC) to assess a resident where bed rails are used.

The Director of Care, confirmed that the fails identified in the last bed entrapment assessment done in December 2012, by Joerns had not been addressed or fixed to date. Threfore, although the homes had been made aware of potential entrapment risk, steps had not been taken to prevent resident entrapment in these 29 beds. The DOC also confirmed that the home had not completed resident assessments related to use of bed rails for any residents.

The scope of this issue was widespread, the severity was determined to be a level 2 minimal harm/potential for actual harm, and there was previous noncompliance related to this regulation. A VPC was previously issued on December 14, 2014, as a result of the home's Resident Quality Inspection.

(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 17th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nancy Johnson

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