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
Apr 14, 2015	2015_312503_0004	H-001940-15	Resident Quality Inspection

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE SUITE 800 LONDON ON N6A 1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST MISSISSAUGA ON L5K 2K7

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

LAURA BROWN-HUESKEN (503), LALEH NEWELL (147), MELODY GRAY (123), VALERIE GOLDRUP (539)

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): February 3, 4, 5, 6, 10, 11, 12, 13 and 17, 2015.

During the course of the inspection, the inspector(s) completed the following follow-up inspections: H-001283-14, H-001284-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Manager/Assistant Director of Care (ADOC), Food Services Manager, Programs Manager, Registered Nursing Staff, Personal Support Workers, Recreation Therapists, and Dietary Aides.

The Inspectors also toured the home, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures, employee records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_265526_0016	147

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. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system includes standardized recipes and production sheets for all menus.

During the lunch meal service for the Sheridan Way on February 12, 2014, the dietary aide serving the meal was observed by the Long-Term Care Inspector to add mashed potatoes to soup prior to serving to specific residents. An interview with the Food Service Manager revealed that it was the home's practice to add mashed potatoes to cream soups to thicken them to an appropriate texture for those residents requiring thickened fluids. The Food Services Manager further confirmed that standardized recipes were not available for the thickening of cream soups. [s. 72. (2) (c)]

2. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

During the lunch meal service for the Sheridan Way on February 12, 2014, the dietary aide serving the meal was observed to take the temperature of the food items without cleaning the thermometer in between different food items. The thermometers used were rinsed in a single glass of water. An interview with the Food Services Manager confirmed that rinsing the thermometers between taking the food temperatures was insufficient to prevent contamination of the food items. [s. 72. (3) (b)]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.

Lunch service was observed by the LTC Inspector in the Sheridan Way dining room on February 3, 2015. The posted menu indicated that the dessert options would be ice cream sundae or fruit cocktail. It was observed that the residents were not offered the ice cream sundae. The dietary aide explained that the sundaes were not provided by the kitchen to the servery and instead the servery was provided vanilla ice cream to serve to the residents. It was also observed that the residents with texture modified diets were not offered fruit cocktail. The dietary aide explained that the fruit cocktail was only available in regular texture. A review of the therapeutic spreadsheet indicated that residents on minced or pureed diets were to be offered minced or pureed fruit salad, respectively. Interview with the Food Service Manager confirmed that the toppings for the sundae and the texture modified fruit salads were not sent to the servery from the kitchen and were not offered to the residents. [s. 71. (4)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 there is a written plan of care for each resident that sets out the planned care for the resident.

Interviews with staff and a review of clinical documentation revealed that resident #107 had bladder incontinence and required the use of continence care products. The resident's written plan of care did not include reference to the use of continence care products. The RAI Manager/Assistant Director of Care confirmed that the resident's written plan of care did not include the planned care for the resident related to continence. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

On an identified date, resident #104 was observed by the LTC Inspector to have scratches on their lower legs. The treatment was outlined on the Treatment Administration Record and was confirmed with a member of the registered staff. On an identified date the written plan of care, which provided direction to the personal support workers, was reviewed. The plan was not updated to identify the open areas and stated only "assess condition of skin Qam and Qhs during care, paying particular attention to pressure areas and bony prominences ie., ears, coccyx, elbow, heels". On February 13, 2015, the Director of Care confirmed that the written plan of care should have been updated to reflect the resident's present skin condition. [s. 6. (1) (c)]

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

The care plan for Resident #107 directed staff to toilet the resident before and after meals and before bed. Interviews with direct care staff revealed that the resident is toileted once between breakfast and lunch. The RAI Manager/Assistant Director of Care confirmed that the resident should be toileted after breakfast and before lunch and that care was not being provided as per 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 there is a written plan of care for each resident that sets out the planned care for the resident, to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

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

A review of the clinical record of Resident #110 and interview with the Food Services Manager revealed that the resident experienced a weight loss of greater than 5 per cent between November and December 2014 and that the weight loss was not assessed. The Food Services Manager indicated a referral was not sent to the home's Registered Dietitian for assessment of the weight loss and confirmed that the significant weight loss was not assessed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with a significant weight change, as defined in the legislation, are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The written plan of care for resident #104 was reviewed on an identified date. The plan identified that the resident was positive for a bacterial infection and that a contact precautions sign should be in place on the door of the room. The sign could not be located. On an identified date, the RAI Manager/ ADOC attended the room with the inspector and confirmed that the sign was missing. They replaced the sign and confirmed the sign should be in place to direct the housekeeping staff and personal support workers. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that,
a) a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker,
b) the resident, the resident's substitute decision-maker, and any person that either of them may direct are given an opportunity to participate fully in the conferences, and
c) a record is kept of the date, the participants and the results of the conferences.

During interview with a family member of resident's #105 on an identified date, the family indicated they were unaware in regards to certain aspects of the resident's care. A review of the clinical records for resident #105 and #111 was completed and a record of the annual care conferences could not be located as having occurred with the interdisciplinary team and the family members.

During interviews with the family members of resident's #105 and #111 on an identified date, the family members noted that they were unable to attend care conferences that were offered as the conferences were only in the daytime when they were unavailable.

An ADOC could not provide documentation of completed care conferences since 2012 for the two residents. The DOC confirmed that the nurse on the unit was to arrange and complete the care conferences and the information could not be located on the paper or electronic chart as completed. [s. 27. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the recreation program provided assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently.

Resident #107 had a disability. The resident's care plan directs staff to remind the resident of programs and to provide cuing before programs. In an interview the resident identified that they had an interest in animals. A review of the resident's clinical record and an interview with a Recreation Therapist revealed that the resident was not assessed for an interest in animals. The Resident and Recreation Therapist revealed that the resident was not offered to be, or involved in, the home's pet therapy program. The Programs Manager further revealed that the pet therapy program does not include a list of interested residents and is based on the therapists knowledge of the home's residents. Due to the resident's disability, the resident is unable to know when the pet therapy program is occurring in the home. The resident was not provided the assistance required to participate in the pet therapy program. [s. 65. (2) (f)]

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

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Issued on this 17th day of April, 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) :	LAURA BROWN-HUESKEN (503), LALEH NEWELL (147), MELODY GRAY (123), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2015_312503_0004
Log No. / Registre no:	H-001940-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 14, 2015
Licensee / Titulaire de permis :	DEVONSHIRE ERIN MILLS INC. 195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7
LTC Home / Foyer de SLD :	ERIN MILLS LODGE NURSING HOME 2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARY WHALEN

To DEVONSHIRE ERIN MILLS INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall implement standardized recipes and production sheets for the preparation of thickened soups including, but not limited to, the development of standardized recipes and production sheets, training of staff in the preparation of the recipes, and processes and schedules for monitoring staff adherence to these recipes.

Grounds / Motifs :

1. During the lunch meal service for the Sheridan Way on February 12, 2014, the dietary aide serving the meal was observed by the Long-Term Care (LTC) Inspector to add mashed potatoes to soup prior to serving to specific residents. An interview with the Food Service Manager revealed that it was the home's practice to add mashed potatoes to cream soups to thicken them to an appropriate texture for those residents requiring thickened fluids. The Food Services Manager further confirmed that standardized recipes were not available for the thickening of cream soups. (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_265526_0016, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee shall ensure that the planned menu items are offered and available at each meal and snack, including but not limited to, retraining of staff and processes and schedules for monitoring staff's compliance with the planned menu.

Grounds / Motifs :

1. Previous non-compliance issued as a Compliance Order in November 2013 and September 2014.

Lunch service was observed by the Long-Term Care (LTC) Inspector in the Sheridan Way dining room on February 3, 2015. The posted menu indicated that the dessert options would be ice cream sundae or fruit cocktail. It was observed that the residents were not offered the ice cream sundae. The dietary aide explained that the sundaes were not provided by the kitchen to the servery and instead the servery was provided vanilla ice cream to serve to the residents. It was also observed that the residents with texture modified diets were not offered fruit cocktail. The dietary aide explained that the fruit cocktail was only available in regular texture. A review of the therapeutic spreadsheet indicated that residents on minced or pureed diets were to be offered minced or pureed fruit salad, respectively. Interview with the Food Service Manager confirmed that the toppings for the sundae and the texture modified fruit salads were not sent to the servery from the kitchen and were not offered to the residents. (503)

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 : Apr 30, 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 14th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Laura Brown-Huesken

Service Area Office /
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