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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2017_457630_0003	025794-16, 028031-16, 029712-16	Complaint

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

peopleCare Hilltop Manor Cambridge
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 25, 26 and 27, 2017.

The following inspections were conducted as part of this Complaints Inspection:
Complaint Log #025794-16/IL-462840-LO related to personal support services, laundry services and eating assistance;
Complaint Log #028031-16 related to personal support services and alleged staff to resident abuse;
Complaint Log #029712-16 related to personal support services and complaints process.

Inspector #680 (Tracy Richardson) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Executive Director of Nursing Care, Director of Resident Quality Outcomes, the Nutrition Manager, the Registered Dietitian (RD), two Registered Nurses (RN), three Personal Support Workers (PSWs), one Behavioural Supports Ontario (BSO) PSW, one Dietary Aide, two family member and more than three residents.

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed complaint record for an identified resident, reviewed policies and procedures of the home and reviewed staff education records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident related to continence care.

During interviews with multiple staff members during the inspection it was reported that an identified resident often refused continence care from staff and required a specified level of assistance with care.

Review of the clinical record for the identified resident found that the most recent continence assessments did not match the plan of care in terms of the level of assistance required for continence care. The clinical record also showed that the family for the identified resident had requested specific interventions related to refusal of care and this was not included in the plan of care.

During an interview with the Executive Director of Nursing Care (EDNC) it was reported that this identified resident refused care. EDNC indicated it was the expectation in the home that the plan of care related to continence care would be based on an assessment

of the resident and would reflect the needs of that resident including direction for staff regarding refusal of care. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan for nutritional care.

Multiple observations over the course of the inspection found an identified resident was served a food item that was not within the resident's documented diet order or plan of care for food texture.

Review of the clinical record for the specified resident found the resident had been assess by the Registered Dietitian (RD) as requiring a specific food texture.

During an interview with an identified staff member it was reported that the identified resident was served different food textures from the documented plan of care as they thought this resident was allowed to pick their own food items.

During an interview with the Nutrition Manager (NM) and the RD it was reported that this identified resident required a specific food texture. The NM and RD said it was the expectation in the home that staff would follow the diet order and corresponding therapeutic menu for that texture. NM said that resident should not have been served the the specific food item as it was not part of this resident's plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed for eating assistance.

Multiple observations over the course of the inspection found an identified resident required variable levels of assistance with eating at meals.

During interviews with multiple staff members during the inspection it was reported that an identified resident often refused care and required variable types of assistance with eating.

Review of the clinical record for the specified resident found the resident had been assessed as requiring a different level of assistance with eating than was identified in the plan of care.

During an interview with the Executive Director of Nursing Care (EDNC) it was reported that this identified resident refused care. The EDNC indicated it was the expectation in the home that the plan of care related to eating assistance would be based on an assessment of the resident and would reflect the needs of that resident including direction for staff regarding refusal of care. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care revised at anytime when the resident's care needs changed regarding responsive behaviours.

During interviews with multiple staff members during the inspection it was reported that an identified resident refused care and that staff needed to reapproach and use specific techniques when providing care.

Review of the clinical record for the specified resident found the resident had not had a recent assessment of responsive behaviours and the plan of care had not been updated since 2015 related to refusal of care.

During and interview with the Executive Director (ED) and the Executive Director Nursing Care (EDNC) it was reported this specified resident had a history of refusing care and it was the approach that staff took with the resident that at times would affect whether care was accepted. ED and EDNC said they would expect the plan of care to reflect assessments and the care needs of the resident relating to refusal of care. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care revised at anytime when the resident's care needs changed regarding eating assistance and nutritional care.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced a change in the type of care assistance needed for eating and nutrition.

Review of the clinical record for the specified resident found the resident had not had an assessment documented related to the change in eating and nutritional care. Review of the plan of care identified it had not been updated to reflect the change in eating and nutritional care.

During an interview with the RD it was reported that they had not received a referral

regarding the change in eating and nutritional care.

During an interview with the NM and RD it reported that it was the expectation in the home that residents would be re-assessed when there was a change and the plan of care would be reviewed and revised to reflect the change in care needs for eating assistance and nutritional care. [s. 6. (10) (b)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed or the care set out in the plan was no longer necessary for personal care.

Multiple observations during the inspection found an identified resident did not have a specific device in place.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced a change and no longer used the specific device that was identified in the plan of care. The staff members reported that the resident regularly refused the specific device or the staff did not offer the specific device as they felt it was no longer appropriate for the resident.

Review of the clinical record for the specified resident found the resident had not had an assessment documented related to the change in their needs related to the specific device. Review of the plan of care identified it had not been updated to reflect the change in the resident's needs related to the specific device.

During an interview with the Executive Director (ED) and the Executive Director Nursing Care (EDNC) it was reported this specified resident had a history of refusing care. ED and EDNC said they would expect the plan of care to reflect assessments and the care needs of the resident relating to the specific device. [s. 6. (10) (b)]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed for continence care.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced a change in the type of care assistance needed for continence care.

Review of the clinical record for the specified resident found the resident had not had an assessment documented related to the change in their needs related to continence care. Review of the plan of care identified it had not been updated to reflect the change the resident's needs related to continence care.

During an interview the Director Resident Quality Outcomes (DRQO) said a change in continence would be assessed using the bowel and bladder continence assessment form in the electronic documentation system. DRQO reviewed the clinical record for this identified resident and said this assessment had not been completed.

During an interview the EDNC said it was the expectation in the home that residents would be reassessed and the plan of care revised for continence care if there was a change in a resident's care needs.

The scope of this issue was a pattern. The severity of the issue was determined to be level two with potential harm to residents. It was previously issued as a Voluntary Plan of Correction (VPC) with Written Notification (WN) on May 3, 2016; as a VPC with WN on March 16, 2016; and as a Compliance Order (CO) with WN on February 27, 2015 which was complied on March 30, 2015. [s. 6. (10) (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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced pain.

During an interview with an identified staff member it was reported that staff varied in the approaches used to monitor this identified resident's pain and that the pain assessment in the electronic documentation system had not been completed for this resident.

Review of clinical record for this identified resident showed the resident had expressed that they were having pain and there was no documented pain assessment in the electronic documentation system.

During an interview with the Director Resident Quality Outcomes (DRQO) it was reported that it was the expectation in the home that pain would be assessed by registered staff using a pain scale which would be documented in the electronic documentation system. The DRQO reviewed the clinical record for this identified resident and acknowledged there was no documented assessment using their clinically appropriate assessment instrument when the resident's pain was not relieved by initial interventions.

The scope of this issue was isolated. The severity of the issue was determined to be level two with potential harm to residents. It was previously issued as a Written Notification (WN) on June 17, 2014. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included (a) the nature of each verbal or written complaint (b) the date the complaint was received, (c) the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow-up action required, (d) the final resolution if any (e) every date on which a response was provided to the complainant and a description of the response and (f) any response made in turn by the complainant.

During multiple interviews over the course of the inspection the ED and the EDNC said there had been concerns raised to the management in the home by the family members for an identified resident.

Review of the records provided by the home showed a "Complaint Record Form" had been used on a specified date to document complaints that had been verbally expressed about the care provided to this identified resident. This form did not include documentation of the date of actions taken, time frames for actions, any follow-up action required, the final resolution and every date or the response made by the complainant.

Review of the home's policy titled "Response to Complaints" with reference number "004100.00" included the "Complaint Record" which stated "name of person making the

complaint/bringing the concern to your attention" and "describe in detail the complaint/concern".

During an interview the EDOC it was acknowledged that this documented record did not include all required information.

Further review of correspondence between a family member for an identified resident and management of the home identified concerns had been expressed regarding the care provided to the resident in the home. Review of the records provided to the inspectors showed no evidence that the home had documented the nature of each written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which a response was provided to the complainant and a description of the response and any response made in turn by the complainant.

During an interview with Vice President Clinical Operations (VPCO) they reported they had a process in the home for dealing with verbal and written complaints. The VPCO said that the process for documenting the actions taken within the home to deal with complaints included completing the "Complaint Record Form". The VPCO acknowledged that a complaint form was not completed in the home for all the complaints raised by the this family and therefore there was no documented evidence that met the required legislation for complaints made within the home.

The scope of this issue was isolated. The severity of the issue was determined to be level two with potential harm to residents. There was no history of related non-compliance. [s. 101. (2)]

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 a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

Issued on this 8th day of March, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2017_457630_0003
Log No. / Registre no:	025794-16, 028031-16, 029712-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 9, 2017
Licensee / Titulaire de permis :	PEOPLECARE Inc. 28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0
LTC Home / Foyer de SLD :	peopleCare Hilltop Manor Cambridge 42 ELLIOTT STREET, CAMBRIDGE, ON, N1R-2J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna Michaels

To PEOPLECARE 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee will ensure each resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change.

The licensee will also specifically ensure:

a) That an identified resident is reassessed and the plan of care reviewed and revised related to eating assistance, nutritional care and continence care.
b) That an identified resident is reassessed and the plan of care reviewed and revised related to eating assistance, nutritional care, denture care, and responsive behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed for continence care.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced a change in the type of care assistance needed for continence care.

Review of the clinical record for the specified resident found the resident had not had an assessment documented related to the change in their needs related to

continence care. Review of the plan of care identified it had not been updated to reflect the change the resident's needs related to continence care.

During an interview the Director Resident Quality Outcomes (DRQO) said a change in continence would be assessed using the bowel and bladder continence assessment form in the electronic documentation system. DRQO reviewed the clinical record for this identified resident and said this assessment had not been completed.

During an interview the EDNC said it was the expectation in the home that residents would be reassessed and the plan of care revised for continence care if there was a change in a resident's care needs.
(630)

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed or the care set out in the plan was no longer necessary for personal care.

Multiple observations during the inspection found an identified resident did not have a specific device in place.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced a change and no longer used the specific device that was identified in the plan of care. The staff members reported that the resident regularly refused the specific device or the staff did not offer the specific device as they felt it was no longer appropriate for the resident.

Review of the clinical record for the specified resident found the resident had not had an assessment documented related to the change in their needs related to the specific device. Review of the plan of care identified it had not been updated to reflect the change in the resident's needs related to the specific device.

During an interview with the Executive Director (ED) and the Executive Director Nursing Care (EDNC) it was reported this specified resident had a history of refusing care. ED and EDNC said they would expect the plan of care to reflect assessments and the care needs of the resident relating to the specific device.

(630)

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed for eating assistance.

Multiple observations over the course of the inspection found an identified resident required variable levels of assistance with eating at meals.

During interviews with multiple staff members during the inspection it was reported that an identified resident often refused care and required variable types of assistance with eating.

Review of the clinical record for the specified resident found the resident had been assessed as requiring a different level of assistance with eating than was identified in the plan of care.

During an interview with the Executive Director of Nursing Care (EDNC) it was reported that this identified resident refused care. The EDNC indicated it was the expectation in the home that the plan of care related to eating assistance would be based on an assessment of the resident and would reflect the needs of that resident including direction for staff regarding refusal of care. (630)

4. The licensee has failed to ensure that the resident was reassessed and the plan of care revised at anytime when the resident's care needs changed regarding responsive behaviours.

During interviews with multiple staff members during the inspection it was reported that an identified resident refused care and that staff needed to reapproach and use specific techniques when providing care.

Review of the clinical record for the specified resident found the resident had not had a recent assessment of responsive behaviours and the plan of care had not been updated since 2015 related to refusal of care.

During and interview with the Executive Director (ED) and the Executive Director Nursing Care (EDNC) it was reported this specified resident had a history of refusing care and it was the approach that staff took with the resident that at times would affect whether care was accepted. ED and EDNC said they would

expect the plan of care to reflect assessments and the care needs of the resident relating to refusal of care.
(630)

5. The licensee has failed to ensure that the resident was reassessed and the plan of care revised at anytime when the resident's care needs changed regarding eating assistance and nutritional care.

During interviews with multiple staff members during the inspection it was reported that an identified resident had experienced a change in the type of care assistance needed for eating and nutrition.

Review of the clinical record for the specified resident found the resident had not had an assessment documented related to the change in eating and nutritional care. Review of the plan of care identified it had not been updated to reflect the change in eating and nutritional care.

During an interview with the RD it was reported that they had not received a referral regarding the change in eating and nutritional care.

During an interview with the NM and RD it reported that it was the expectation in the home that residents would be re-assessed when there was a change and the plan of care would be reviewed and revised to reflect the change in care needs for eating assistance and nutritional care.

The scope of this issue was a pattern. The severity of the issue was determined to be level two with potential harm to residents. It was previously issued as a Voluntary Plan of Correction (VPC) with Written Notification (WN) on May 3, 2016; as a VPC with WN on March 16, 2016; and as a Compliance Order (CO) with WN on February 27, 2015 which was complied on March 30, 2015.
(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 03, 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 9th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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