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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 30, 2015	2015_337581_0008	H-002010-15/H-001892-15	Critical Incident System

Licensee/Titulaire de permis

JOHN NOBLE HOME
97 Mt. Pleasant Street BRANTFORD ON N3T 1T5

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

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET BRANTFORD ON N3T 1T5

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

DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 31, April 1, 7, 8 and 9, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurse (RPN), Restorative Care Therapist, Recreation Programmer, Behavioural Supports Ontario (BSO) staff, Personal Support Workers (PSW), residents and families.

During the course of this inspection the inspector toured the home, reviewed clinical health records and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was protected from physical abuse by anyone.

A) Review of the clinical record and interviews with staff identified that on an identified day in January 2015, resident #011 was pushed by resident #010. Resident #010 had been identified as exit seeking, wandered into co-residents' rooms on the unit and had physically aggressive behaviours. This altercation resulted in resident #011 falling and they sustained an injury. The ADOC confirmed that resident #011 was not protected from abuse when resident #010 pushed resident #011.

B) Review of the clinical record indicated that on an identified day in February 2015, resident #010 went into resident #012's room where an altercation occurred. Resident #010 had been identified as exit seeking, wandered into co-residents' rooms on the unit and had physically aggressive behaviours. The plan of care revealed that an alarmed wander guard with large stop signs was on resident's #012 door but was not effective in deterring resident #010 from entering their room on multiple occasions. Resident #010 was physically aggressive towards resident #012, who was struck. The ADOC confirmed that resident #012 was not protected from physical abuse when resident #010 hit resident #012. [s. 19. (1)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

In February 2015, resident #001 fell out of bed while being repositioned with the assistance of one PSW. As a result of the fall the resident sustained an injury. Review of the written plan of care indicated they required extensive assistance of two staff to assist in repositioning and bed mobility. During an interview the PSW stated that the resident was repositioned in bed on the identified day with only one staff at the time of the fall. The PSW verbalized that he was aware of the resident's care requirements of two staff as outlined in the plan of care. The ADOC confirmed that staff did not use safe techniques when assisting resident #001. [s. 36.]

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).

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 failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

Resident #001 fell in February 2015, which resulted in injury. Review of the progress notes indicated that bed rails could be utilized during care. PSW's reported the resident used bed rails only when care was provided in bed to assist in repositioning and turning. Review of the written plan of care did not include the use of bed rails as confirmed by registered staff. [s. 6. (1) (a)]

2. 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.

In February 2015, resident #001 fell out of bed and sustained an injury while being repositioned by one PSW. Review of the written plan of care indicated the resident was extensive assistance by two staff for repositioning and bed mobility. The PSW stated the resident was repositioned with one staff and was aware that the plan of care stated two staff. The ADOC confirmed that the care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that resident was reassessed and the plan of care reviewed and revised at least every six months when, the care set out in the plan had not been effective.

The plan of care for resident #010 identified that they had a history of responsive behaviors, including but not limited to wandering into co-residents rooms and intermittent physical, verbal aggression and causing distress to other residents.

i) In November 2014, it was documented that on multiple occasions that resident #010 attempted to exit seek and wander, of which five caused distress to co-residents. Following the seventh occurrence, an intervention was put in place in attempt to manage the behaviours.

ii) In December 2014, the resident wandered into resident #012's room and attempted to hit them, staff intervened and no injury occurred.

iii) In January 2015, the resident demonstrated multiple incidents of wandering and exit

seeking behaviours. During one occurrence, resident #010 hit resident #012 on the hand, with no injury noted. On another occurrence, resident #010 wandered into resident #011's room, where resident #010 pushed resident #011 and an injury was sustained.

iv) In February 2015, resident #010 wandered into resident #012's room which resulted in a physical altercation.

Resident #010's clinical record was reviewed and did not include new interventions or revisions to the plan of care to manage behaviours after November 19, 2014. Registered staff confirmed that the plan of care was not reviewed and revised when care set out in the plan was not effective. [s. 6. (10) (c)]

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 sets out planned care for the resident, that the care set out in the plan of care was provided to the resident as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months when, the care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation required the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with.

A) The licensee did not ensure that the policy "Falls Assessment" # 3-I-30, revised on December 2014, was complied with.

The policy stated that the registered staff would perform a head to toe assessment of every resident after they had fallen and before moving the resident. On an identified day in February 2015, resident #001 fell and sustained an injury. Review of the clinical records indicated that a head to toe assessment was not completed post fall. This was confirmed by the ADOC.

B) The licensee did not ensure that the policy "Head Injury Routine" # 3-I-40, revised on December 2014, was complied with.

The policy stated that a head injury routine would be carried out for 24 hours and the result of the assessment would be documented on the Glasgow Coma Scale (GCS) form when a resident reported they had been struck in the head. On an identified day in February 2015, resident #001 fell and verbalized they hit their head. Review of the clinical records indicated that a GCS was started on the day of the fall, but was not completed as per the home's policy which required every four hours for sixty minutes and a minimum of every four hours for the next twenty hours, as confirmed by the ADOC.

C) The licensee did not ensure that the policy "Pain Assessment and Management Program" #3-A-30 was complied with.

The policy stated that each resident must have a pain assessment on admission and be reassessed on readmission, quarterly which was embedded in the Resident Assessment Instrument assessment, at significant condition changes and be screened during the provision of care or at least once a day. On an identified day in February 2015, resident #001 fell, sustained an injury and complained of increased pain. Review of the clinical records indicated that a pain assessment was not completed by registered staff until eight days post fall. The ADOC confirmed the pain assessment was not completed post fall and with a significant change as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 and ensuring that all policies and procedures are complied with, to be implemented voluntarily.

WN #5: 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 was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A review of resident #001's progress notes indicated they could use two quarter bed rails in the raised position to assist in repositioning and turning only when care was provided. Review of the written plan of care did not include an assessment of the bed rails and this was confirmed by the ADOC. [s. 15. (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 where bed rails are used, residents are assessed in accordance with evidence-based practices or prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Review of the progress notes indicated that two quarter bed rails could be used when resident #001 was provided care in bed. Staff confirmed that the bed rails were being used for safety and to assist in turning and repositioning in bed only when care was provided. Review of the written plan of care did not include an assessment to determine the reason for the use of the bed rails, nor any documented approvals or consent for its use. The ADOC and registered staff confirmed the resident was not assessed to determine if the bed rails were being used as a PASD or a restraint nor did they have a documented consent or approval for the device in place. [s. 33. (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 the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in a resident's plan of care only if the following are satisfied, alternatives to the use of a PASD are considered and tried where appropriate, the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario and the use of the PASD has been consented to by the resident or substitute decision-maker, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that behavioural triggers where identified for residents demonstrating responsive behaviours.

A review of the resident's clinical record indicated that resident #010 demonstrated wandering, exit seeking and physically, verbally aggressive behaviors. These behaviours increased over a three month period of time. The resident's plan of care did not to identify the possible triggers for these behaviours. The DOC and registered staff confirmed there had not been a reassessment completed to identify possible behavioural triggers for these behaviours being demonstrated. [s. 53. (4) (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 behavioural triggers are identified for residents demonstrating responsive behaviors, to be implemented voluntarily.

Issued on this 3rd day of June, 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) :	DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2015_337581_0008
Log No. / Registre no:	H-002010-15/H-001892-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 30, 2015
Licensee / Titulaire de permis :	JOHN NOBLE HOME 97 Mt. Pleasant Street, BRANTFORD, ON, N3T-1T5
LTC Home / Foyer de SLD :	JOHN NOBLE HOME 97 MOUNT PLEASANT STREET, BRANTFORD, ON, N3T-1T5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelly Proulx

To JOHN NOBLE HOME, 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that all residents including but not limited to resident #012 are protected from abuse by resident #010.
The staff shall review and revise resident #010's care related to responsive behaviors to ensure that interventions and strategies are in place to minimize the risk of opportunities of negative resident interactions.
All revisions to the plan of care shall be communicated to staff as changes occur.

Grounds / Motifs :

1. The licensee failed to ensure that every resident was protected from physical abuse by anyone.

A) Review of the clinical record and interviews with staff identified that on an identified day in January 2015, resident #011 was pushed by resident #010. Resident #010 had been identified as exit seeking, wandered into co-residents' rooms on the unit and had physically aggressive behaviours. This altercation resulted in resident #011 falling and they sustained an injury. The ADOC confirmed that resident #011 was not protected from abuse when resident #010 pushed resident #011.

B) Review of the clinical record indicated that on an identified day in February 2015, resident #010 went into resident #012's room where an altercation occurred. Resident #010 had been identified as exit seeking, wandered into co-residents' rooms on the unit and had physically aggressive behaviours. The plan of care revealed that an alarmed wander guard with large stop signs was on resident's #012 door but was not effective in deterring resident #010 from entering their room on multiple occasions. Resident #010 was physically aggressive towards resident #012, who was struck. The ADOC confirmed that resident #012 was not protected from physical abuse when resident #010 hit resident #012. (581)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning techniques with all residents as identified in their written plan of care.
Education to all direct care staff on safe transferring and positioning techniques for all residents.
Develop a process to ensure that all staff are following the plan of care especially in relation to bed mobility, positioning and the required number of staff to perform the task safely.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

In February 2015, resident #001 fell out of bed while being repositioned with the assistance of one PSW. As a result of the fall the resident sustained an injury. Review of the written plan of care indicated they required extensive assistance of two staff to assist in repositioning and bed mobility. During an interview the PSW stated that the resident was repositioned in bed on the identified day with only one staff at the time of the fall. The PSW verbalized that he was aware of the resident's care requirements of two staff as outlined in the plan of care. The ADOC confirmed that staff did not use safe techniques when assisting resident #001.
(581)

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 : Jun 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 30th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dianne Barsevich

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