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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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
Dec 21, 2016	2016_303563_0040	031052-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

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

LAMBTON MEADOWVIEW VILLA
3958 PETROLIA LINE R. R. #4 PETROLIA ON N0N 1R0

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

MELANIE NORTHEY (563), DONNA TIERNEY (569), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 15, 16, 17, 18, and 21, 2016

The following intakes were completed within the RQI:
019806-16 - IL-45342-LO - Complaint related to nursing shortages
021103-16 - M547-000009-16 - Critical Incident related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Personal Care, the Quality Improvement Coordinator, the Environmental Services Manager, the Resident Assessment Instrument Coordinator, the Registered Dietitian, the Ward Clerk, one Registered Nurse, nine Registered Practical Nurses, six Personal Support Workers, a representative of Residents' Council, 20 residents, and three family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

5 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 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 has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations during stage 1 of the Resident Quality Inspection documented 10 of 20 residents had one or more bed rails in use. Record review of the residents' clinical records revealed the absence of a documented resident assessment for the use of bed rails.

Record review of the "Lambton Meadowview Villa Care Plan Item/Task Listing Report" documented that 22 bed systems have been audited for entrapment. The report indicated that first floor North wing was completed and all 22 beds tested identified a fail, and the fail was between the headboard and rails on most bed systems.

Inspector #563 and Environmental Service Manager (ESM) toured first floor North wing to review bed systems. Multiple beds were noted to have the mattress keepers absent from the foot of the bed. The ESM shared that the bed keepers collapse and fall down automatically when the foot of the mattress was raised and keepers needed to be manually put in place by the Personal Support Workers (PSWs) when they make the beds. The ESM acknowledged there had been fails identified on multiple beds at the head of the bed between the headboard and the rails and that no corrective action was put in place for any bed with an identified fail.

The Director of Nursing and Personal Care (DONPC) shared that the Bed System Assessment had not been completed for any resident who used bed rails. The DONPC shared that the Bed System Assessment had not been created, and there was no start date for its completion or implementation.

The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. The home has not completed a bed assessment for any resident using bed rails, all bed systems were not evaluated to minimize risk and steps were not taken to prevent resident entrapment where failed zones of entrapment were identified.

The severity was determined to be a level 3 as there was potential for actual harm/risk to all residents who used bed rails. Although the home had no previous history of noncompliance, the scope of this issue was widespread to all residents using one or more bed rails during the course of this inspection. [s. 15. (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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A Critical Incident Systems Report was submitted to the Ministry of Health and Long Term Care related to alleged staff abuse by a staff member towards a resident.

Record review of the incident note in PointClickCare (PCC) and the home's investigation notes indicated that a staff member had physically assisted the resident with personal care, despite the resident's refusal.

Interview with the resident verified that the resident did not want the particular personal care offered by the staff member.

Interview with the Administrator verified that the home's expectation was not to use a physical approach to provide care and that the resident had a right to be treated with respect and dignity and was not.

The licensee has failed to ensure that the resident was treated with courtesy, respect and dignity when the resident refused the personal care.

The severity was determined to be a level 2 as there was minimal harm to the resident. The scope of this issue was isolated to one resident, however there was a compliance history of this legislation being issued in the home on September 29, 2014 as a Voluntary Plan of Correction (VPC) in the Resident Quality Inspection (RQI) # 2014_260521_0043. [s. 3. (1) 1.]

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 every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: 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 has failed to ensure that for each resident actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Critical Incident Systems Report was submitted to the Ministry of Health and Long Term Care related to the alleged staff abuse towards a resident that had demonstrated responsive behaviours.

Record review of the plan of care indicated that the resident had demonstrated responsive behaviours. The progress notes in PCC and the 30 day look-back in Point of Care (POC) verified that the resident had repeated behaviours over the course of several weeks.

Record review of the current care plan and Kardex did not include strategies that responded to the resident's responsive behaviours.

Interview with the RPN and Administrator agreed that although the resident sustained no injuries, a physical approach to providing care was not the home's mission or policy.

Interview with the Quality Improvement Coordinator (QIC) verified that all resident care refusals were tracked for patterns and the care plan for the resident should have been

updated with strategies for staff and was not.

Interview with the Behavioural Supports Ontario (BSO) RPN indicated that the resident was assessed with responsive behaviours and the care plan should have been updated with effective interventions and was not.

Interview with the RN, DONPC and Administrator verified that all registered staff were responsible to keep the resident care plans current with strategies and interventions for staff to respond to the resident's responsive behaviours previous to the critical incident that occurred and should have been documented.

The licensee has failed to ensure that strategies were developed, implemented and documented for the resident that demonstrated responsive behaviours.

The severity was determined to be a level 1 as there was minimal harm to the resident. The scope of this issue was widespread and there was no compliance history of this legislation being issued in the home within the last three years. [s. 53. (4) (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 to ensure that for each resident that demonstrates responsive behaviours, strategies are developed and implemented to respond to these behaviours and documented, to be implemented voluntarily.

WN #4: 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. (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 resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Record review of the current care plan for the resident documented the use of multiple Personal Assistance Service Devices (PASDs) in PointClickCare (PCC).
The resident was observed using a PASD.

Record review of the "Consent to Personal Assistance Service Device (PASD)" stated the resident used a PASD. There was no documentation that a particular PASD was used for this resident as a PASD or restraint.

Record review of the Physician's Orders in PCC documented only the use of one PASD.

Interview with two Personal Support Workers (PSWs) shared that the resident does not use a particular PASD and neither PSW could recall a time when the resident did use it.

The Director of Nursing and Personal Care (DONPC) agreed the particular PASD was not in use for the resident. The DONPC shared that the plan of care should updated when the particular PASD was no longer used.

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 and the PASD was no longer necessary.

The severity was determined to be a level 1 as there was minimal harm to the resident. The scope of this issue was isolated and there was no compliance history of this legislation being issued in the home within the last three years. [s. 6. (10) (b)]

WN #5: 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 failed to ensure that the use of a PASD to assist a resident with a routine activity of daily living was included in a resident’s plan of care only if alternatives to the use of a PASD had 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.

During stage one of the Resident Quality Inspection (RQI), three residents were observed to have a PASD in use.

A review of the clinical records on PointClickCare (PCC) showed there was a physician order for a PASD for the three residents.

Record review of the "Personal Assistance Service Device (PASD) - V 1" assessments in PCC for these residents documented the assessments were completed and under the assessment heading “Alternative treatments that were tried / considered and why they were not suitable” the documentation stated that all three residents used a PASD without listing any alternative treatments.

The home’s policy "Restraints/Personal Assistance Service Devices (PASDs)" index No. 3-5-18-4, last reviewed July 2016, stated that a PASD assessment will identify alternative treatment options tried prior to the use of a PASD.

The Director of Nursing and Personal Care shared that the alternatives for PASDs were to be documented in the PASD-V1 assessment and there were none listed for the three residents.

The licensee failed to ensure that the use of a PASD was included in a resident’s plan of care only if alternatives to the use of a PASD had been considered.

The severity was determined to be a level 1 as there was minimal harm to the residents. The scope of this issue was a pattern and there was no compliance history of this legislation being issued in the home within the last three years. [s. 33. (4) 1.]

Issued on this 21st day of December, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), DONNA TIERNEY (569), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_303563_0040
Log No. / Registre no:	031052-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF LAMBTON 789 Broadway Street, WYOMING, ON, N0N-1T0
LTC Home / Foyer de SLD :	LAMBTON MEADOWVIEW VILLA 3958 PETROLIA LINE, R. R. #4, PETROLIA, ON, N0N-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeff Harvey

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must achieve compliance to ensure when bed rails are used,
(a) the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident and
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. O.Reg. 79/10, s. 15 (1) (a) (b).

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s. 15 (1) (b). The plan must include immediate and long term actions to be implemented to ensure resident risk of entrapment is assessed for all residents who use one or more bed rails. All resident bed systems where bed rails are used pass all zones of entrapment and the actions taken to correct the identified deficiencies, who will be responsible to correct the deficiencies and the dates for completion.

The bed system audit must specify the following for all beds audited for bed entrapment:
a) Pass or fail for all zones
b) Corrective action taken to address fails and date
c) Re-evaluation of any bed system that has been modified in any way and date

Please submit the plan, in writing, to Melanie Northey, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email to melanie.northey@ontario.ca by January 3, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations during stage 1 of the Resident Quality Inspection documented 10 of 20 residents had one or more bed rails in use. Record review of the residents' clinical records revealed the absence of a documented resident assessment for the use of bed rails.

Record review of the "Lambton Meadowview Villa Care Plan Item/Task Listing Report" documented that 22 bed systems have been audited for entrapment.

The report indicated that first floor North wing was completed and all 22 beds tested identified a fail, and the fail was between the headboard and rails on most bed systems.

Inspector #563 and Environmental Service Manager (ESM) toured first floor North wing to review bed systems. Multiple beds were noted to have the mattress keepers absent from the foot of the bed. The ESM shared that the bed keepers collapse and fall down automatically when the foot of the mattress was raised and keepers needed to be manually put in place by the Personal Support Workers (PSWs) when they make the beds. The ESM acknowledged there had been fails identified on multiple beds at the head of the bed between the headboard and the rails and that no corrective action was put in place for any bed with an identified fail.

The Director of Nursing and Personal Care (DONPC) shared that the Bed System Assessment had not been completed for any resident who used bed rails. The DONPC shared that the Bed System Assessment had not been created, and there was no start date for its completion or implementation.

The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. The home has not completed a bed assessment for any resident using bed rails, all bed systems were not evaluated to minimize risk and steps were not taken to prevent resident entrapment where failed zones of entrapment were identified.

The severity was determined to be a level 3 as there was potential for actual harm/risk to all residents who used bed rails. Although the home had no previous history of noncompliance, the scope of this issue was widespread to all residents using one or more bed rails during the course of this inspection. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 21st day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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