Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Feb 3, 2017	2016_434631_0012	024810-16	Resident Quality Inspection

Licensee/Titulaire de permis

1365853 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

MAPLE PARK LODGE
6 Hagey Avenue Fort Erie ON L2A 5M5

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

KERRY ABBOTT (631), KELLY CHUCKRY (611)

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): August 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 2016

During the course of the inspection, the following inspections were conducted simultaneously with this RQI: Critical Incident (CI) #010983-16 related to alleged abuse and neglect, CI #006243-16 related to responsive behaviours, Complaint # 018127-16 related to plan of care and CI #016819-16 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Nursing Clinical Support, registered staff, personal support workers (PSW), President of Residents' Council, President of Family Council, residents and families. During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

5 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #004	2015_323130_0028	611
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_323130_0028	631
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2015_323130_0028	631
O.Reg 79/10 s. 73. (2)	CO #005	2015_323130_0028	611
O.Reg 79/10 s. 8. (1)	CO #003	2015_323130_0028	611

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. 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place were complied with.

A) On an identified date, resident #003 was observed to have a device in place. This had been classified by the home as a Personal Assistive Safety Device (PASD), and the resident utilized this device for support and to assist them with activities of daily living.

On two separate observations during this inspection, resident #003 was not able to remove the device. An interview with Personal Support Worker (PSW) staff confirmed the resident was not able to remove the device on their own.

The home had a policy in place entitled Restraints (CN-R-05-1). This policy reviewed the home’s requirements for the use of a PASD with restraining properties, and further specified that a restraint/PASD with restraining properties flow sheet was to be used.

Interviews with four PSW staff confirmed that this document was not completed for this resident, and that it was only utilized for restraints.

An interview with the Administrator and the RAI-Coordinator confirmed that the home only utilized the above noted flow sheet for restraints and that the Restraint policy had not been complied with.

B) A review of resident #018’s record indicated that the resident suffered a fall on an identified date. A review of the resident’s Safety Assessment, indicated that the resident was a “medium” risk for falls. A review of the resident’s Safety Assessment, indicated that the resident was a “high” risk for falls. A review the licensee’s policy titled “Fall Prevention and Management Program”, (CN-F-05-1) under the heading “Objectives”, stated that a “resident identified as significant fall risk (moderate-high) will have care plans that include interventions to reduce fall risk factors and hazards”. A review of the resident's most recent care plan, indicated that there were no interventions to reduce fall risk factors or hazards.

An interview with the Administrator and the RAI Co-ordinator confirmed that for the purpose of interpretation, the level of risk on the Safety Assessment, the word “medium” or "moderate" were interchangeable. The Administrator further confirmed that according

to the above mentioned policy, the care plan for resident #018 did not include interventions to reduce fall risk factors and hazards.

C) A review of resident #008's record indicated that the resident suffered a fall on an identified date. A review of the resident's Safety Assessment, indicated that the resident was a "medium" risk for falls. A review of the resident's Safety Assessment, indicated that the resident was a "high" risk for falls. A review the licensee's policy titled "Fall Prevention and Management Program", under the heading "Objectives", stated that a "resident identified as significant fall risk (moderate-high) will have care plans that include interventions to reduce fall risk factors and hazards". A review of the resident's most recent care plan, did not include interventions to reduce fall risk factors and hazards.

An interview with the Administrator and the RAI-Coordinator confirmed that for the purpose of interpretation, related to the level of risk on the Safety Assessment, the word "medium" or "moderate" are interchangeable. The Administrator further confirmed that according to the above mentioned policy, the care plan for resident #008 did not include interventions to reduce fall risk factors and hazards. [s. 8. (1) (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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy was complied with.

The home had a policy entitled Abuse-Prevention, Reporting and Elimination of Abuse and Neglect (CA-05-37-1). This policy was part of the home's abuse and neglect prevention program. The policy stated that the home has “A zero-tolerance policy that allows no exceptions; tolerates no abusive or neglectful behaviour; requires strict compliance and enforcement” and “Conmed Health Care Group shall neither abuse nor allow the abuse of any resident in our homes by anyone at our home”. The definition of emotional abuse as per this policy stated, “Any threatening, insulting or humiliating gestures, actions, behaviour or remarks including imposed isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident”.

On an identified date, an incident of verbal abuse occurred by a PSW staff towards resident #030. This incident was witnessed by three (3) PSW staff members. The impact of the comments on the resident was unable to be determined.

During an interview with the Administrator on August 24, 2016, it was confirmed that the actions of the staff member involved with this incident were abusive in nature.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

On an identified date, resident #018 had a Minimum Data Set, Resident Assessment Instrument (MDS-RAI) quarterly assessment completed. This assessment indicated that resident #018 was incontinent of bladder. It was noted that this was a deterioration for this resident since the last MDS assessment.

A review of the clinical record for resident #018 indicated that an assessment was not completed when this resident had a change in their bladder continence status.

The home had a policy in place entitled “Continence Care and Bowel Management Program, (CN-C-32-1). This policy stated that all residents will be assessed within seven (7) days of admission, at least quarterly, and with any change in health status that affects continence, using MDS-RAI assessment initially. It also indicated that if further assessment was required then the continence assessment tool was to be completed.

An interview with a registered staff member confirmed that Bowel and Bladder Assessments were completed yearly in the home, and when there was a change in health status. It was further confirmed this assessment was not completed for this resident after the noted change in their bladder continence status. The registered staff member also indicated that the home does not use a continence assessment tool as

identified in their policy.

An interview with the Administrator and the RAI Co-ordinator confirmed that a bowel and bladder continence assessment was not completed for resident #018 when there was a change in their health status, that the home no longer used the continence assessment tool identified in their policy and quarterly assessments are not being completed. [s. 51. (2) (a)]

2. On an identified date, resident #014 had a MDS-RAI annual assessment completed. During this annual assessment, a Bowel and Bladder Assessment was completed.

On an identified date, a quarterly MDS-RAI assessment was completed for this resident. A Bowel and Bladder Assessment was not completed.

The home had a policy in place entitled "Continence Care and Bowel Management Program, (CN-C-32-1). This policy stated that all residents will be assessed within seven (7) days of admission, at least quarterly, and with any change in health status that affects continence, using MDS-RAI assessment initially. It also indicated that if further assessment was required then the continence assessment tool was not completed.

An interview with registered staff confirmed that Bowel and Bladder Assessments were completed yearly in the home, and when there is a change in health status. The interview further confirmed that a Bowel and Bladder Assessment was not completed for this resident in conjunction with the MDS-RAI quarterly assessment. Registered staff also indicated that the home does not use a continence assessment tool as identified in their policy.

An interview with the Administrator and the RAI Co-ordinator confirmed that a bowel and bladder continence assessment was not completed for resident #014 when the quarterly MDS-RAI assessment was completed, and that the home is no longer using the continence assessment tool identified in their policy. [s. 51. (2) (a)]

3. On an identified date, resident #020 had a (MDS-RAI) annual assessment completed. During this annual assessment, a Bowel and Bladder Assessment using a clinically appropriate assessment instrument was completed.

Resident #020 had three quarterly MDS-RAI assessments completed. A Bowel and Bladder Assessment was not completed with each of those quarterly assessments.

The home had a policy in place entitled "Continence Care and Bowel Management Program, (CN-C-32-1). This policy stated that all residents will be assessed within seven (7) days of admission, at least quarterly, and with any change in health status that affects continence, using MDS-RAI assessment initially. It also indicated that if further assessment was required then the continence assessment tool was not completed.

An interview with registered staff confirmed that Bowel and Bladder Assessments were completed yearly in the home, and when there is a change in health status. The interview further confirmed that a Bowel and Bladder Assessment was not completed for this resident in conjunction with the MDS-RAI quarterly assessments.

An interview with the Administrator and the RAI Co-ordinator confirmed that bowel and bladder continence assessments were not completed quarterly for resident #020 and that the home is no longer using the continence assessment tool identified in their policy. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident requires, an assessment is to be conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Resident #029 was a resident residing in the long term care home. On an identified date, a registered staff member was administering medication during the morning medication pass. During this medication pass, resident #029 was administered medication that was intended to be administered to resident #040. A total of twelve (12) medications were administered to resident #029, and all with the exception of one (1) medication was not prescribed for resident #029.

This incorrect medication administration resulted in resident #029 receiving medications that were not appropriate for this resident.

Resident #029 experienced adverse effects as a result of receiving medication that was not prescribed for them and was transferred to hospital for treatment. This resident returned to the home from the hospital once the adverse effects were stabilized.

The home has a policy in place entitled Administration of Medications, (CN-M-01-1). This policy stated that the nurse must follow the five (5) rights when administering medications, including the right dose, drug, route, resident and time.

An interview with registered staff confirmed medication was administered to resident #029 that was not prescribed for this resident. The Administrator confirmed the incident occurred, and further confirmed the staff did not follow the home's Administration of Medications policy. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A review of resident #015's progress notes indicated that the resident has sustained four falls on identified dates between July, 2016 and August, 2016. A review of resident #015 care plan under "Safety: potential for falls" indicated that resident #015 was to have an intervention implemented daily.

Two observations were completed on resident #015 in their bedroom in wheelchair.The Inspector observed that the resident did not have the intervention that was to be implemented daily on either occasion.

The Inspector conducted an interview with PSW staff. Staff stated that to the best of their knowledge, this intervention was never used for this resident. An interview with another PSW staff confirmed that resident did not have the intervention implemented and that the intervention was not implemented at all for this resident. Both staff PSW staff confirmed that they refer to the resident's Kardex or care plan for interventions related care. [s. 6. (7)]

Issued on this 14th day of February, 2017

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

Original report signed by the inspector.

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) :	KERRY ABBOTT (631), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2016_434631_0012
Log No. / Registre no:	024810-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 3, 2017
Licensee / Titulaire de permis :	1365853 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MAPLE PARK LODGE 6 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carole Jukosky

To 1365853 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

This Order is being issued based on the application of the factors of severity (2), scope (2), and compliance history (4), in keeping with r.299 of the Regulations. This is in respect to the severity of minimal harm or potential for actual harm, the scope of a pattern and the home's history of noncompliance that included a Written Notification in January, 2015.

The licensee shall prepare, submit and implement a plan that ensures any plan, policy, protocol, procedure, strategy or system is complied with, including but not limited to: Restraints, Policy CN-R-05-1, Skin and Wound Care Program, Policy CN-S-13-7, Continence Care and Bowel Management Program, Policy CN-C-32 -1 and Falls Prevention and Management Program, CN-F-05-1.

The plan shall include education for relevant staff and identify quality monitoring activities to ensure ongoing compliance.

The plan shall be submitted via email by February 24, 2017, to Kelly Chuckry at kelly.chuckry@ontario.ca.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place were complied with.

A) On an identified date, resident #003 was observed to have a device in place.

This had been classified by the home as a Personal Assistive Safety Device (PASD), and the resident utilized this device to assist with activities of daily living.

On two separate observations during this inspection, resident #003 was not able to remove the device. An interview with personal support worker (PSW) confirmed the resident did not have the ability to remove the device on their own.

The home had a policy in place entitled Restraints (CN-R-05-1). This policy reviewed the home's requirements for the use of a PASD with restraining properties, and further specified that a restraint/PASD with restraining properties flow sheet was to be used.

Interviews with four (4) PSW staff confirmed that this document was not completed for this resident, and that it was only utilized for restraints.

An interview with the Administrator and the RAI Co-ordinator confirmed that the home only utilized the above noted flow sheet for restraints and that the Restraint policy had not been complied with.

B) A review of resident #018's record indicated that the resident suffered a fall on an identified date. A review of the resident's Safety Assessment indicated that the resident was a “medium” risk for falls. A review of the resident's Safety Assessment indicated that the resident was a “high” risk for falls. A review the licensee's policy titled “Fall Prevention and Management Program”, (CN-F-05-1) under the heading “Objectives”, stated that a “resident identified as significant fall risk (moderate-high) will have care plans that include interventions to reduce fall risk factors and hazards”. A review of the resident's most recent care plan, indicated that there were no interventions to reduce fall risk factors or hazards.

An interview with the Administrator and the RAI Co-ordinator confirmed that for the purpose of interpretation, the level of risk on the Safety Assessment, the word “medium” or "moderate" are interchangeable. The Administrator further confirmed that according to the above mentioned policy, the care plan for resident #018 did not include interventions to reduce fall risk factors and hazards.

C) A review of resident #008's record indicated that the resident suffered a fall

on an identified date. A review of the resident's Safety Assessment indicated that the resident was a "medium" risk for falls. A review of the resident's Safety Assessment indicated that the resident was a "high" risk for falls. A review the licensee's policy titled "Fall Prevention and Management Program", under the heading "Objectives", stated that a "resident identified as significant fall risk (moderate-high) will have care plans that include interventions to reduce fall risk factors and hazards". A review of the resident's most recent care plan did not include interventions to reduce fall risk factors and hazards.

An interview with the Administrator and the RAI-Coordinator confirmed that for the purpose of interpretation, related to the level of risk on the Safety Assessment, the word "medium" or "moderate" are interchangeable. The Administrator further confirmed that according to the above mentioned policy, the care plan for resident #008 did not include interventions to reduce fall risk factors and hazards. (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 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 3rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kerry Abbott

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