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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2014	2014_217137_0011	L-000150-14	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

THE MAPLES HOME FOR SENIORS
94 William Street South, P.O. Box 400, Tavistock, ON, N0B-2R0

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

MARIAN MACDONALD (137), CHRISTINE MCCARTHY (568), RAE MARTIN (515)

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): April 14-17 and April 22-24, 2014

Critical Incident L-000149-14 and Critical Incident L-000323-14 were inspected in conjunction with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Activation Manager, Nutrition Manager, Maintenance Manager, Regional Manager, RAI-MDS Coordinator, 1 Attending Physician, 2 Registered Nurses, 1 Registered Practical Nurse, 9 Nurses' Aides/Personal Support Workers, 2 Dietary Aides, 1 Housekeeping Aide, 4 Family Members and 40 Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas and common areas, medication room, observed resident care provision, resident-staff interactions, dining service, recreational activities, medication administration, medication storage areas, infection prevention and control practices, reviewed residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 failed to ensure 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 as evidenced by:

Motion Specialties conducted a "Bed System Inventory and Bed Audit" on February 10, 2014.
A review of the audit results indicated 29/41 (70.07%) of bed systems failed, 7/41 (17.07%) bed systems passed and 5/41 (12.20%) bed systems were not tested, as they contained air mattresses and they are unable to be formally tested using the bed safety and entrapment tool due to components of the bed make it difficult for testing.

The report was forwarded to Caressant Care Nursing and Retirements Homes Ltd. and the Administrator, Director of Care and Regional Manager confirmed that, to date, no interventions have been implemented to mitigate risks to residents that use one or more bed rails, for beds that failed any zone of entrapment. [s. 15. (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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents as evidenced by:

A) Observations, during the initial tour of the home on April 23, 2014, between 0937 - 1030h am, revealed two windows in the main floor sun room each opened 27 centimetres and one window on the second floor, to the left of the elevator, opened 51 centimetres.

The Administrator confirmed the three windows opened more than 15 centimetres, are accessible to residents, and the expectation that the windows cannot open more than 15 centimetres.

B) Observations of the Resident Upper Lounge, Resident Lower Lounge and Sun Room revealed there was no resident/staff communication and response system available in every area accessible by residents.

A review of the monthly call bell audits from July 2013 to March 2014, revealed there was documented evidence of no call bells in the Resident Upper Lounge and Resident Lower Lounge.

A Registered Nurse, Director of Care, Administrator and Regional Manager confirmed there is no resident/staff communication and response system available in these identified areas. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

On April 23, 2014, at 0937h, the door handle and lock on the sun room door was in disrepair, whereby inspectors were locked inside the sun room and unable to exit the sun room.

The Administrator and Maintenance Manager both confirmed the lock was in disrepair and the expectation is the home be maintained in a safe condition and a good state of repair. [s. 15. (2) (c)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Observations, throughout the RQI, revealed:

Main Level
a) Main dining room has a hole in the drywall above the baseboard and beside the electrical outlet, paint chipping on window frames and baseboards scuffed with white marks.
b) Small dining room has paint chips on wall with clock at chair height and above baseboard.
c) Paint chipping on door frame on top of linen storage room.
d) Stained ceiling tiles in hallway outside of the Resource Room and Bathroom B, as well as sagging ceiling tiles across from an identified room.
e) Drywall patched and unpainted in hallway beside an identified room.
f) Two Turbo-Aire Hallway fans, attached to the wall, are visibly dusty.
Blades of the floor fan, in large dining room, were dusty.

g) Damaged ceiling tile in the hallway, outside main floor clean utility room.
h) Damaged ceramic tile in the clean utility room and the inside door frame had chipped paint.
i) Several damaged floor tiles in main floor hallways and large dining room.
j) A crack in the upholstery, left arm of a burgundy armchair, in the main floor small dining room.
k) Two wooden pillars, in large dining room, damaged and with chipped paint.
l) Clean utility room has a cracked tile behind the door and a missing ceiling light cover.
m) In an identified room, the corner of the bathroom door was damaged. The screen in the bedroom window was ill-fitting and causing a draft.
n) In an identified room, the bathroom door and bathroom ceramic tiles were damaged. The corner of the wall, to the left of the bathroom door entrance, was damaged.
o) In an identified room, the bathroom door was damaged and had a hole in it. The bathroom radiator cover was scraped.
p) In an identified room, the bedroom wall, near the foot of the bed, on the left side of the bed, was damaged. A strip of the baseboard was missing, below the damaged wall surface. The radiator cover was damaged and had chipped paint. The radiator, to the left of the bed, was pulled away from the wall. The wall, to the right of the bedroom door entrance, had a crack in the plaster, approximately 6 inches long, as well as superficial damage above it. The ceiling, above the bed, was damaged and cracked, the entire length of the ceiling. The ceiling, above the wardrobe, was observed cracked, approximately 18-24 inches in length.
q) Scuffed cabinet doors in Washroom A

Lower Level
r) In an identified room, radiator has paint chipped and scraped in the shared bathroom, missing tile on the wall behind the toilet, baseboard in the bedroom on the wall of bathroom is lifting away from the wall.
s) In an identified room, bathroom door is patched but not painted and the radiator has chipped paint.
t) In an identified room, radiator is broken and has a sharp edge of metal where the end section is pulled away and down from the side end of the radiator. Window has a metal lever on one side not functioning and no handle on the other side to enable the window to open.
u) Baseboards have white scuff marks, paint scuffed at bottom of wainscotting.

v) Wallpaper border is lifting along the bottom in many sections, throughout the hallway
w) Resident Lounge has one window with a note attached indicating the mechanism is stripped and do not open, parts of radiator are not painted and paint is chipped, radiator is separating in two places behind a chair and at the end by the exit door, paint above wainscotting is chipped.
x) Activity room work table is chipped and has sharp edges, the corner of the wall is gouged at chair height and there are 4 stained ceiling tiles in one corner.
y) A hole above baseboard across from the elevator.
z) Tub room floor is visibly soiled and there are broken and missing floor tiles under the head of the bathtub.

The Administrator confirmed the identified deficiencies and the expectation is the home be maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services, the licensee has failed to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance as evidenced by:

There is no documented evidence that there are schedules and procedures in place for routine, preventative and remedial maintenance.

The Administrator confirmed there are no schedules and procedures in place for routine, preventative and remedial maintenance and the expectation is there be schedules and procedures in place. [s. 90. (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 to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1)(a), and every action taken under clause (1)(b), related to reporting and complaints, as evidenced by:

During a family interview, it was revealed that a concern was reported to the management of the home, related to care provision by an identified staff member. An investigation was completed by the home, the outcome was unfounded and the complainant was satisfied with the investigation.

There was no documented evidence that the results of the complaint investigation was reported to the Director and the Administrator confirmed the results of the complaint investigation was not reported to the Director. [s. 23. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked as evidenced by:

During medication administration, the medication cart was observed unlocked, unattended and the eMAR terminal unlocked.
A registered staff member confirmed the medication cart was unlocked, unattended and the terminal unlocked and the expectation is that the cart be locked when unattended and not in visual proximity of a registered staff member. [s. 129. (1) (a) (ii)]

Issued on this 1st day of May, 2014

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

Marian C. Mac Donald

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) :	MARIAN MACDONALD (137), CHRISTINE MCCARTHY (588) (), RAE MARTIN (515)
Inspection No. / No de l'inspection :	2014_217137_0011
Log No. / Registre no:	L-000150-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 1, 2014
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	THE MAPLES HOME FOR SENIORS 94 William Street South, P.O. Box 400, Tavistock, ON, N0B-2R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOAN HERGOTT

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

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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 take immediate action to achieve compliance to ensure 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. O.Reg. 79/10, s.15(1)(a)(b)

1. Immediate interventions must be implemented to mitigate risks to residents that use one or more bed rails, for beds that failed any zone of entrapment. This includes all beds, whether the mattress is foam based or not.
2. Assessments of residents must be completed to determine if their bed system (rail, mattress, frame) are appropriate for their needs.

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.15(1)(a)(b). The plan shall:

1. Include dates when assessments will be completed and care plans updated.
2. Include how education will be provided, to all direct care staff, with respect to bed safety, including who will be responsible.
3. Include a copy of the home's bed safety policy and procedures.
4. Identify what long-term actions will be implemented to ensure beds continue to pass all zones of entrapment and how ongoing resident assessments will be completed, including who will be responsible and time frames.

Please submit the plan, in writing, to Marian C. Mac Donald, Long-Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email, at Marian.C.Macdonald@ontario.ca by May 13, 2014.

Grounds / Motifs :

1. The licensee failed to ensure 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 as evidenced by:

Motion Specialties conducted a "Bed System Inventory and Bed Audit" on February 10, 2014.
A review of the audit results indicated 29/41 (70.07%) of bed systems failed, 7/41 (17.07%) bed systems passed and 5/41 (12.20%) bed systems were not tested, as they contained air mattresses and they are unable to be formally tested using the bed safety and entrapment tool due to components of the bed make it difficult for testing.

The report was forwarded to Caressant Care Nursing and Retirements Homes Ltd. and the Administrator, Director of Care and Regional Manager confirmed that, to date, no interventions have been implemented to mitigate risks to residents that use one or more bed rails, for beds that failed any zone of entrapment.
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2014

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

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.

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

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 1st day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Marian C. MacDonald

Name of Inspector / Nom de l'inspecteur : MARIAN MACDONALD

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