Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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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
Nov 9, 2016	2016_210169_0014	028153-16	Resident Quality Inspection

Licensee/Titulaire de permis

MISSISSAUGA LONG TERM CARE FACILITY INC.
26 PETER STREET NORTH MISSISSAUGA ON L5H 2G7

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

MISSISSAUGA LONG TERM CARE FACILITY
26 PETER STREET NORTH MISSISSAUGA ON L5H 2G7

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

YVONNE WALTON (169), BERNADETTE SUSNIK (120), JESSICA PALADINO (586)

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): September 22, 23, 26, 27, 28, 29, 2016

The following inspections were completed as part of this Resident Quality Inspection:
Complaints: 028009-15 related to responsive behaviours and skin and wounds, 028328-15 related to responsive behaviours, complaints management and Resident Bill of Rights
Critical Incident: 019182-16 related to a fall that resulted in an injury
Follow up to previously issued order #001 008978-15 related to lighting

During the course of the inspection, the inspector(s) spoke with the Administrator/Licensee, Assistant to the Administrator and Environmental Manager, Director of Care, Director of Activation, Food Service Manager, Maintenance, President of Residents' Council, Residents, Families, nursing/housekeeping/dietary/laundry staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "All other homes". Measurements were taken of the lux levels of the light fixtures located in various areas of the home using a hand held analog illumination meter held 30 inches above and parallel to the floor. Dining rooms, washrooms, tub/shower rooms, corridors, one three-bed ward (with beds along one wall), one three-bed ward (with beds in two different areas) and one semi-private bedroom was measured.

Each of the resident bedrooms were noted to be repeated throughout the home and were similar in size, shape and layout with the same light fixtures provided and therefore not all rooms were measured. Corridors, private bedrooms, second floor dining room, washrooms and shower rooms were noted to be adequate. Natural light was eliminated as much as possible by using window covers and the lights were allowed to burn for about five minutes prior to measuring. The outdoor condition on the day of the inspection was overcast.

1. Bedrooms

A) Resident room #111 (semi-private) was unique in design from the other semi-private rooms and did not have a light fixture at the entrance. The lux was approximately 20 lux up to and including areas around the first bed which was located along one wall. The over bed light was flickering and did not illuminate the path to the bed or areas around the bed to a minimum of 215.28 lux. The bed located near the window further into the room was several feet from the one ceiling fixture in the room which was 250 lux. With the over bed light on, the bed area was 100 lux.

B) Resident rooms #112, #103, #208 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had three beds, with the heads of the beds along one long wall. Upon entry into the room, the lux was 100 and the lux at beds one and three (door and window side) was 150. The central bed, being the closest to the ceiling light fixture was adequate as long as the over bed light was illuminated.

C) Resident rooms #205 and others similar in shape and layout all had one round light fixture with opaque lens in the center of the room. These rooms all had two beds, with both beds along the same long wall and the room did not have a bulk head. The lux was under 175 upon entry and gradually increased to 250 lux under the ceiling light. However both beds were not under the ceiling light and one side of each bed was under 175 lux which gradually increased to 400 lux at the head of the bed when the over bed light was illuminated. The sides of each bed and path from the entry to each bed was below the required minimum of 215.28 lux.

D) Resident rooms #110, #201 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had two beds, but each bed was against a different wall. The room also had a large bulk head divider along the width of the room. The bulk head blocked out the light for the first bed within

each of these rooms, which was closest to the door. No light fixture was located within the entry or the zone in which the first bed was situated. The lux was 100 in and around the bed with a gradual increase to 400 lux at the head of the bed if the over bed light was illuminated. The path from the entry to each bed and the foot of each bed was below the required minimum of 215.28 lux.

E) Resident rooms #202 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had three beds, but each bed was against a different wall. The room also had a large bulk head divider along the width of the room. The bulkhead blocked out the light for the first bed within each of these rooms, which was closest to the door. No light fixture was located within the entry or the zone in which the first bed was situated. The lux was 100 in and around the bed with a gradual increase to 400 lux if the over bed light was illuminated. The path from the entry to the first bed was below the required minimum of 215.28 lux.

Bedroom lighting levels are required to be a minimum of 215.28 lux in areas where resident activity takes place such as dressing and walking. They key areas for adequate illumination would include areas near dressers and around each bed and along the path of travel from the doorway to the beds. In the above noted bedrooms, the dressers were located at the foot of the beds and within the path of travel to the beds.

2. Common Spaces

A) The dining room on the first floor was equipped with 4 light fixtures equally spaced apart. Each fixture was approximately 150 lux when measured directly underneath them. The spaces between the fixtures, where tables and chairs were placed for meals, was 50 lux. The style of the light fixtures did not adequately provide a general illumination level of 215. 28 lux throughout the space (not including along walls and in corners).

B) The small activity room or lounge located on the second floor was equipped with three light fixtures. Each fixture was approximately 190 lux when measured directly underneath them. The spaces between the fixtures (six to eight feet) was 100 lux. The number of fixtures or the style of the fixtures was inadequate for the size of the room as the illumination level of 215.28 lux could not be achieved throughout the space (not including along walls and in corners). [s. 18.]

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. 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 was provided to resident #021 as specified in their plan of care.

Resident #021 plan of care indicated that they required constant supervision with toileting. Clinical record review and interview with PSW #101, registered staff #102 and the DOC confirmed that the resident was at a high risk for falls. The resident was left alone on the toilet, without supervision and had a fall resulting in an injury and subsequent death. They did not receive care according to their plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

The windows (six in total) located in the dining room on the lowest level of the home were noted to be without any sort of restriction device to prevent them from opening more than 15 centimetres. The windows were tested and could easily slide open. The windows were large enough for a resident to use the window as a form of egress from the building and the windows opened into an outdoor area that was not secured. [s. 16.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was available in every area accessible by residents. The outdoor courtyard did not include an activation station which could be used by staff, residents or family members when necessary. [s. 17. (1) (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for floor care.

The licensee's housekeeping procedure manual included floor cleaning tasks which were to be conducted throughout the home by housekeeping staff. The tasks did not include any specific floor care instructions (procedures) such as how the floors would be maintained if soap and water was not adequate to remove ground in dirt and whether floors needed to be stripped and re-sealed, how often and by whom.

During the inspection on September 23, 2016, the flooring material in the second floor dining room and resident rooms (i.e #108), especially those with light coloured floor tiles, were observed to be dirty in appearance, especially in high traffic areas. These areas appeared black in colour. According to two housekeepers, the floors were cleaned daily with a mop, but no additional deep cleaning methods were employed such as buffing to remove the discolouration which could not be removed with routine mopping. The housekeepers reported that they did not buff, wax or strip the floors. The housekeepers reported that maintenance staff conducted floor stripping and waxing in the past. A review of the maintenance procedures manual revealed no written procedures or tasks regarding floor care. The administrator confirmed that no floor care routine besides routine floor mopping had been implemented over the last four years due to availability of staff and staff willingness to use the home's floor buffer which was stated as being very heavy. [s. 87. (2) (a)]

Issued on this 9th day of November, 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) :	YVONNE WALTON (169), BERNADETTE SUSNIK (120), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2016_210169_0014
Log No. / Registre no:	028153-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 9, 2016
Licensee / Titulaire de permis :	MISSISSAUGA LONG TERM CARE FACILITY INC. 26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7
LTC Home / Foyer de SLD :	MISSISSAUGA LONG TERM CARE FACILITY 26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Novak Bajin

To MISSISSAUGA LONG TERM CARE FACILITY INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_275536_0006, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
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All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

An order (#001) was previously issued for inadequate lighting during an RQI in March 2015. The order required that a plan be submitted, however no plan was received. Regardless of the plan, the lighting upgrades were to be implemented by July 30, 2016.

Based on the current non-compliance, the following order is to be linked to the previous order;

1. The licensee shall consult with a person who has expertise in the field of illumination such as but not limited to, a lighting engineer, to evaluate all resident bedrooms (except private rooms), first floor dining room and decond floor lounge for illumination levels. The illumination values shall be recorded and submitted for review, along with a work plan that identifies how illumination levels will be increased and by whom.

Grounds / Motifs :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "All other homes". Measurements were taken of the lux levels of the light fixtures located in various areas of the home using a hand held analog illumination meter held 30 inches above and parallel to the floor. Dining rooms, washrooms, tub/shower rooms, corridors, one three-bed ward (with beds along one wall), one three-bed ward (with beds in two different areas) and one semi-private bedroom was measured.

Each of the resident bedrooms were noted to be repeated throughout the home and were similar in size, shape and layout with the same light fixtures provided and therefore not all rooms were measured. Corridors, private bedrooms, second floor dining room, washrooms and shower rooms were noted to be adequate. Natural light was eliminated as much as possible by using window covers and the lights were allowed to burn for about five minutes prior to measuring. The outdoor condition on the day of the inspection was overcast.

1. Bedrooms

A) Resident room #111 (semi-private) was unique in design from the other semi-private rooms and did not have a light fixture at the entrance. The lux was

approximately 20 lux up to and including areas around the first bed which was located along one wall. The over bed light was flickering and did not illuminate the path to the bed or areas around the bed to a minimum of 215.28 lux. The bed located near the window further into the room was several feet from the one ceiling fixture in the room which was 250 lux. With the over bed light on, the bed area was 100 lux.

B) Resident rooms #112, #103, #208 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had three beds, with the heads of the beds along one long wall. Upon entry into the room, the lux was 100 and the lux at beds one and three (door and window side) was 150. The central bed, being the closest to the ceiling light fixture was adequate as long as the over bed light was illuminated.

C) Resident rooms #205 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had two beds, with both beds along the same long wall and the room did not have a bulk head. The lux was under 175 upon entry and gradually increased to 250 lux under the ceiling light. However both beds were not under the ceiling light and one side of each bed was under 175 lux which gradually increased to 400 lux at the head of the bed when the over bed light was illuminated. The sides of each bed and path from the entry to each bed was below the required minimum of 215.28 lux.

D) Resident rooms #110, #201 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had two beds, but each bed was against a different wall. The room also had a large bulk head divider along the width of the room. The bulk head blocked out the light for the first bed within each of these rooms, which was closest to the door. No light fixture was located within the entry or the zone in which the first bed was situated. The lux was 100 in and around the bed with a gradual increase to 400 lux at the head of the bed if the over bed light was illuminated. The path from the entry to each bed and the foot of each bed was below the required minimum of 215.28 lux.

E) Resident rooms #202 and others similar in shape and layout all had one round light fixture with opaque lens in the centre of the room. These rooms all had three beds, but each bed was against a different wall. The room also had a large bulk head divider along the width of the room. The bulkhead blocked out

the light for the first bed within each of these rooms, which was closest to the door. No light fixture was located within the entry or the zone in which the first bed was situated. The lux was 100 in and around the bed with a gradual increase to 400 lux if the over bed light was illuminated. The path from the entry to the first bed was below the required minimum of 215.28 lux.

Bedroom lighting levels are required to be a minimum of 215.28 lux in areas where resident activity takes place such as dressing and walking. They key areas for adequate illumination would include areas near dressers and around each bed and along the path of travel from the doorway to the beds. In the above noted bedrooms, the dressers were located at the foot of the beds and within the path of travel to the beds.

2. Common Spaces

A) The dining room on the first floor was equipped with four light fixtures equally spaced apart. Each fixture was approximately 150 lux when measured directly underneath them. The spaces between the fixtures, where tables and chairs were placed for meals, was 50 lux. The style of the light fixtures did not adequately provide a general illumination level of 215. 28 lux throughout the space (not including along walls and in corners).

B) The small activity room or lounge located on the second floor was equipped with three light fixtures. Each fixture was approximately 190 lux when measured directly underneath them. The spaces between the fixtures (six to eight feet) was 100 lux. The number of fixtures or the style of the fixtures was inadequate for the size of the room as the illumination level of 215.28 lux could not be achieved throughout the space (not including along walls and in corners).

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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).

Order / Ordre :

The licensee shall ensure that :
1. all direct care staff that are responsible for supervision during toileting are made aware of the situation and what contributed to the resident's injury
2. all direct care staff are aware of the requirements in the plan of care for all residents requiring supervision during toileting.
3. all residents receive care related to supervision during toileting as per their plan of care.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #021 experienced, the scope of one isolated incident, and the Licensee's history of no non-compliance related to s.6(7) of the Act.

The licensee failed to ensure that the care was provided to resident #021 as specified in their plan of care.

Resident #021 plan of care indicated that they required constant supervision with toileting. Clinical record review and interview with PSW #101, registered staff #102 and the DOC confirmed that the resident was at a high risk for falls. The resident was left alone on the toilet, without supervision and had a fall resulting in an injury and subsequent death. They did not receive care according to their plan of care. [s. 6. (7)] (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YVONNE WALTON

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