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

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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
Dec 15, 2016	2016_554541_0035	013558-16	Resident Quality Inspection

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH P.O. BOX1510 PRESCOTT ON K0E 1T0

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

AMBER LAM (541), ANANDRAJ NATARAJAN (573), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 22-25 and November 28-December 1, 2016

A follow-up inspection was conducted concurrently

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered Nurses, Registered Practical Nurses, the RAI Co-ordinator, the Maintenance Supervisor, the Program Manager, Personal Support Workers, Dietary Aides, the President of the Resident Council and the President of the Family Council, residents and families. In addition the inspectors reviewed relevant health care records, conducted a tour of the home, observed a meal service, observed medication administration and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Safe and Secure Home
Skin and Wound Care

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

7 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Compliance Order #001 was issued in September 2016 with a compliance date of October 31, 2016 under LTCHA 2007 s. 19 Duty to Protect (Inspection #2016_347197_0021). The licensee failed to comply with the order to ensure "all staff receive re-education on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03".

CO #001 had ordered the licensee to ensure:
- All staff receive re-education on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03

During the follow-up inspection, the Administrator confirmed that the home is using an online education program called Surge Learning to educate all staff on the 3 policies related to abuse identified in CO #001. When Inspector #541 requested confirmation that this training was completed, it was noted the re-education did not begin until November 2016. At the time of the inspection, according to the Surge Learning completion statistics, approximately 30-35% of staff had not completed the education.

Compliance Ordered #001 will be re-issued as the home did not ensure all staff were re-educated on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03 by the compliance date of October 31, 2016. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with 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 failed to ensure that the equipment: specifically resident's mobility equipment, was kept clean and sanitary.

On November 23, 24 and 30, 2016, Inspector #573 observed that resident #007 and resident #020's wheelchair frames under the seat and side of the brakes had a heavy accumulation of dirt and debris. There was also unidentified debris and white color stains on the frame and wheels of the wheel chair and padding of the leg rest behind the foot petals.

On November 30, 2016, Inspector #573 spoke with PSW #108 and PSW #110, both indicated that the PSWs who works on nights are responsible for the cleaning of all resident mobility equipment. Inspector #573 observed resident's #007 and #020's wheelchair in the presence of the PSW #108 and #110, both the staff members agreed that the wheelchairs were unclean. Further PSW #108 indicated to inspector that resident #020's wheel chair was scheduled to be cleaned that night.

On November 30, 2016, during an Interview, RN #107 indicated that every resident mobility equipment are to be cleaned on regular basis by the night PSW staff members as outlined in the home's weekly cleaning schedule. Further RN #107 indicated that resident wheelchairs and walkers are to be spot cleaned by the PSWs whenever they were observed to be unclean. The RN #107 confirmed with the inspector that resident #020's wheelchair was scheduled to be cleaned that night.

On December 01, 2016, Inspector #573 observed resident #020's wheelchair in the presence of the RN #107, who indicated to inspector that resident #020's wheelchair was observed to be unclean. Further the RN #107 indicated that the resident #020's wheelchair should be kept clean as per the cleaning schedule. [s. 15. (2) (a)]

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.

On November 28, 2016, the following observations were made by Inspector #573:

Resident #015 bed system – In the middle of the bed frame, a rail deflector measuring four inches in width and extending out by two inches with sharp and uneven edges on the corners.

Resident #011 bed system – In the middle of the bed frame, a rail deflector measuring four inches in width and extending out by one inch with sharp and uneven edges on the corners.

Resident #007 bed system - In the middle of the bed frame, a rail deflector measuring four inches in width and extending out by two inches with sharp and uneven edges on the corners.

Resident #002 bed system – Resident bed frame with the mattress platform board that was not in alignment with the mattress and bed frame. In the middle of the bed frame, a mattress platform board measuring 14 inches wide and extending out by one and half inches with sharp edges on the corners was observed.

Resident #007 bed system – Resident bed frame with the mattress platform board that was not in alignment with the mattress and bed frame. In the middle of the bed frame, a mattress platform board measuring 14 inches wide and extending out by two inches with sharp edges on the corners was observed.

Resident #016 bed system – Resident bed frame with the mattress platform board that was not in alignment with the mattress and bed frame. In the middle of the bed frame, a mattress platform board measuring 14 inches wide and extending out by one inch with sharp edges on the corners was observed.

In resident #001's washroom, an electric metal base board heater with sharp edges on

the corners was observed next to the toilet bowel.

In resident #015's bed room, an electric metal base board heater with sharp edges on the corners was observed next to the resident's lazy boy chair.

On November 28, 2016, during an interview with Maintenance Supervisor, he indicated to the Inspector #573 that all the three quarter bed rails were removed on all the bed systems in the home including the above identified resident beds. The Maintenance Supervisor indicated that the rail deflectors that were installed on the bed frames were used to prevent the bed rails from hitting the mattress, when the rails were raised. He added that the rail deflectors no longer had a purpose when the bed rails were removed from the bed system.

On November 28, 2016, Inspector #573 and the home's Maintenance Supervisor observed the above identified resident bed systems and the metal base board heater. Maintenance Supervisor indicated to the inspector that there were about approximately 40 bed systems similar to the identified specific bed systems in the home. The Maintenance Supervisor stated to the inspector that he will rectify the resident's mattress platform board and the metal base board heater that was observed with the sharp edges. He further indicated that the rail deflectors on the bed system would be removed. [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, specifically the beds and baseboard heaters, are maintained in a safe condition and in a good state of repair and that the equipment, specifically resident's mobility equipment, is kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

For resident #028 on a specified date it is recorded in the Minimum Data Set (MDS) that the resident presents with a wound.
The resident's care plan specified that the resident required increased nutritional requirements, related to skin and wound management, in addition to specific nursing interventions.

An assessment was conducted on a specified date on the Skin -Weekly Impaired Skin Integrity Assessment tool indicating the the resident had a reddened area. There are no other assessments conducted specific to the compromised area.

On November 30, 2016 during an interview with RN #107, she indicated that resident's presenting with a reddened area are to be assessed weekly using a clinically indicated skin assessment tool. The RN #107 provided examples of the Weekly Impaired Skin Integrity Assessment tool to the inspector. The RN #107 went on to add that the clinical assessment tools are used for the management, communication and nursing assessment of the current treatment and interventions.

On November 30, 2016 during an interview, RPN #102 indicated that she is aware that the weekly skin assessments for the reddened area were not being conducted, as required. As per the home’s expected practice and policy, skin and wound assessments are to be completed weekly. RPN #102 further indicated that treatment was provided and the wound has now healed.

On November 30, 2016 the Administrator indicated that altered skin integrity requires weekly assessments and, later that day a progress note entry by RPN #102 indicated that the affected area is pink and healed for the past month. [s. 50. (2) (b) (iv)]

2. On a specified date, resident #041 was identified as being at risk for altered skin integrity as recorded on the Skin-Braden Risk Assessment.
On a specified date, it is recorded in the Minimum Data Set (MDS) that resident #041 presents with a stage 2 pressure ulcer. The wound was treated and the same treatment was scheduled to be completed every 5 days.

Resident’s #041 care plan specified that the resident required increased nutritional requirements, to promote wound healing as well as additional specified nursing interventions.

On November 30, 2016 during an interview the Administrator indicated that the home has a tool specific to the assessment of wounds that is to be conducted weekly by registered nursing staff. The Administrator indicated that the home had transitioned from one method of assessment to another this past Fall, 2016.

From the review of resident’s #041 health care record there is no wound assessment conducted for resident’s #041 since the specified date it was first noted. During an interview the Administrator acknowledged that wound assessments are to be conducted, however, they were not done. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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 failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Resident #007 has a history of high risk for falls and is not able to leave his/her chair without assistance. On November 23, 2016 at 1345 hours, the resident was observed sitting in a lazy boy chair watching TV in the resident's room. The resident-staff communication system panel for this resident is located on the wall adjacent to the head of bed and is not accessible to the resident due to bed placement. The call bell cord leading to the panel was observed to be placed on the head board of the resident's bed frame and would not be accessible to the resident while seated in the chair. In order for the resident to reach the call bell, the resident would have to get up from the chair and go to the head of the bed to reach it. When asked by Inspector #573, how he/she would call for assistance the resident indicated that he/she would use the call bell for assistance. Further, resident #007 indicated to inspector that the staff did not place the call bell within the resident's reach when they transferred the resident to the chair. Inspector #573 spoke with the PSW #100, who indicated that she transferred the resident from wheelchair to the lazy boy chair and failed to ensure that the resident's call bell was within reach. Upon review by the Inspector, the plan of care for Transfers and Falls for resident #007 indicates 'staff to encourage resident to ring the call bell when the resident needs assistance.

On November 24, 2016 at 1015 hours, resident #007 was observed sitting in a lazy boy chair with the call bell not within reach/nor easily accessed by the resident. Inspector #573 observed the call bell cord was placed on the resident's bed side table, which was a few feet behind the resident's chair. Interview with the PSW #101 who provides direct care to resident #007 indicated that the call bell cord should always be placed near the resident #007 so that it was easily accessible by the resident. [s. 17. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee consult regularly with the Residents' Council, and in any case, at least every three months.

On November 29, 2016, Inspector #573 spoke with the President of the Residents' Council, who indicated to the Inspector that the licensee does not consult regularly with the Residents' Council.

On November 30, 2016, during an interview with the Home's Program Manager, she indicated to Inspector that she was assigned to assist the Residents' Council, and she does not represent for licensee. Further she indicated that the home's Administrator who represents the licensee will consult with the Residents' Council.

On November 30, 2016, the Home's Administrator indicated to Inspector #573 that she was designated to represent the licensee. Further she indicated that she had not consulted with the Residents' Council since April 2016. [s. 67.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that drugs acquired, received or stored by or in the home or kept by a resident, have been prescribed for a resident.

On November 23, 2016 at approximately noon, inspector #573 observed a tube of medicated gel labelled with the resident’s name #011. There was no label from the pharmacy provider affixed on the tube.

From the review of resident’s #011 health record there is no physician order for the medicated gel.

On November 30, 2016 during an interview, the Director of Care confirmed that there was no physician order for the medication.

At the time of the inspection, it was not conclusive how the medicated gel was acquired and stored in the resident’s room. [s. 122. (1)]

WN #7: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The Licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On November 30, 2016 RPN #102 showed the inspector a tube of used medicated gel with the name of resident #046 written on it with a black marker. She indicated that a tube of medicated gel was brought in by the resident's #046 SDM and was left at the resident's bedside.

On the same day, during an interview resident #046 indicated that he/she was applying the gel whenever his/her had pain in a specified area, on a regular basis, throughout the day.

The Physician orders on a specified date indicated that medicated gel to specified areas as needed.

The resident's #046 November 2016 Medication Administration Record was reviewed in the presence of RN #106. There is no record of the administration of the medicated gel although the resident indicated its use for his/her discomfort.

On November 30, 2016 RPN #102 and the DOC both indicated that no resident has been assessed to self-administer medications at the home. [s. 131. (5)]

Issued on this 19th day of December, 2016

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) : AMBER LAM (541), ANANDRAJ NATARAJAN (573), RUZICA SUBOTIC-HOWELL (548)

Inspection No. / No de l'inspection : 2016_554541_0035

Log No. / Registre no: 013558-16

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 15, 2016

Licensee / Titulaire de permis : DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

LTC Home / Foyer de SLD : WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Julie Streska

To DEEM MANAGEMENT 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)

Linked to Existing Order / Lien vers ordre existant: 2016_347197_0021, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to ensure:

- That all staff who have not received re-education on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03, complete this training by the compliance date.

Grounds / Motifs :

1. Compliance Order #001 was issued in September 2016 with a compliance date of October 31, 2016 under LTCHA 2007 s. 19 Duty to Protect (Inspection #2016_347197_0021). The licensee failed to comply with the order to ensure "all staff receive re-education on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03".

CO #001 had ordered the licensee to ensure:
- All staff receive re-education on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03

During the follow-up inspection, the Administrator confirmed that the home is using an online education program called Surge Learning to educate all staff on the 3 policies related to abuse identified in CO #001. When Inspector #541 requested confirmation that this training was completed, it was noted the re-education did not begin until November 2016. At the time of the inspection, according to the Surge Learning completion statistics, approximately 30-35% of staff had not completed the education.

Compliance Ordered #001 will be re-issued as the home did not ensure all staff were re-educated on the home's prevention of abuse and neglect policies #RC-02-01-01, #RC-02-01-02 and #RC-02-01-03 by the compliance date of October 31, 2016. (541)

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
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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 15th day of December, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amber Lam

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