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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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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
Jul 17, 2015	2015_391603_0022	014993-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 29, 2015

During the course of the inspection, the inspector (s) reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a walk-through of the home, observed the delivery of resident care and staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Restorative Care Assistant, Registered Nurses, and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 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. 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 has failed to ensure that the plan of care was provided to resident #001 as specified in the plan.

On June 29, 2015, Inspector #603 reviewed a Critical Incident Report, which was reported to the Director. The Critical Incident Report identified that on a certain date, resident #001 was found lifeless in their room, half slid out of their wheelchair, their restraint under their chin. The Critical Incident Report indicated that the resident's responsive behaviors had decreased, however the behaviors had not stopped altogether. On a certain date, S#101 provided resident #001's morning care and according to the CI, S#101 got the resident up in their wheelchair. The resident wore a restraint for positioning and if not, would slide out of their wheelchair. The resident had a history of throwing themselves onto the floor. On that morning, when resident #001 was positioned in their wheelchair with a restraint on, they were exhibiting behaviors. Because the resident was exhibiting behaviors, S#101 left the resident in their room until the staff would bring them for breakfast. Later, S#101 went into the resident's room to bring them for breakfast, and found the resident half slid out of their wheelchair with their restraint under their chin. Staff #101 called for help and S#103 and S#104 entered the room later. Staff #103 released the restraint and S#101, #103, #104 lowered resident #001 to the floor. Staff #104 checked for vital signs and found none and began CPR. Staff #103 called 911 and once the paramedics arrived, and checked for heart rhythm, it showed asystole.

On June 29, 2015, Inspector #603 reviewed resident #001's plan of care, which indicated that while the resident was sitting in a wheelchair, the staff were to ensure that their restraint was on and slightly tilt wheelchair back. Inspector #603 interviewed S#101 who explained that the morning in question, they had positioned resident #001 in a wheelchair in their room, applied a restraint and did not tilt the wheelchair back. Staff #101 explained that they did not tilt the wheelchair back as they "were not aware of this direction". Staff #101 also explained that when they found resident #001 lifeless, they yelled for help and when S#104 arrived, they communicated to S#101 "You should have tilted the wheelchair back" and they continued repeating this to S#101. Staff #104 also stated to S#101, "How many times did I tell you to tilt the chair back?" Staff #101 explained to Inspector #603 that they had never been told to tilt the wheelchair back when using a restraint until the morning of June, 21st, after the incident.

On review of the resident's health care record, Inspector #603 noted on the daily Safety Restraint Record checklist for June, 2015 that a circle had been placed around the restraint and not around the tilted chair. On interview with S#101, they explained that this form was utilized for documenting hourly checks and the circles around the type of restraint was the method utilized for selecting which restraint was to be used and documented. In this case, S#101 explained that this form was one way of

communicating the type of restraint utilized for the resident.

On June 30, 2015, Inspector #603 received a Staff Incident Report from S#100 which indicated that on June 29, 2015, S#101 was disciplined for "failing to slightly tilt resident #001's wheelchair back, as stated in the resident's plan of care". This report referred to the incident in question, related to resident #001. [s. 6. (7)]

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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the "Use of Restraints" policy was complied with.

On June 29th, 2015, Inspector #603 reviewed the home's policy related to the Use of Restraints which was dated March, 2014. The policy indicated that all direct care staff who apply and monitor restraints &/or PASDs shall receive training upon hiring and thereafter, annually.

On June 29, 2015, Inspector #603 interviewed S#101 who explained that they has previously received training on restraints but did not remember when the last time was, as "it was years ago". Inspector #603 interviewed S#100 who explained that every year, all staff receive training on restraints. Staff #100 also explained that S#101 missed the annual restraint training for 2014 and was not able to find the last time S#101 had previously received training on restraints. [s. 29. (1)]

2. The licensee has failed to ensure that the "Use of Restraints" policy was complied with.

On June 29, 2015, Inspector #603 reviewed the Use of Restraints policy which indicated that a physical restraint may only be utilized on the written order of a physician. The policy also indicated that before a restraint is applied, a written consent must be obtained using the form "Consent for Restraint Use". The policy indicated that the resident's care plan must contain information on the frequency of checks, repositioning and the assessment dates.

On review of resident #001's health care record, there was a written physician order dated September 23, 2014 which indicated to use a restraint for safety while in wheelchair. Inspector #603 did not find a written physician order for a tilted wheelchair as a form of physical restraint. Staff #100 reviewed resident's health care record and confirmed that there was no physician order for a tilted wheelchair. On review of the resident's health care record, there was a written consent for the restraint while in wheelchair dated March 12, 2015. Inspector #603 did not find a written consent for a tilted wheelchair as a form of physical restraint. Staff #100 reviewed the resident's health care record and confirmed that there was no written consent for a tilted wheelchair. On review of the care plan, there was no information on the frequency of checks and repositioning and the assessment dates.

On interview with S#100, they explained that resident #001 had been regularly restrained by a specific restraining device and a tilted wheelchair in order to prevent from sliding out their chair. Inspector interviewed S#102 who explained that resident #001 needed to be restrained by a specific restraining device and a tilted wheelchair in order to prevent them from slipping out of the wheelchair. [s. 29. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

On June 29, 2015, Inspector #603 reviewed the home's "Use of Restraints" policy which indicated that a physical restraint may only be utilized on the written order of a physician.

On June 29, 2015, Inspector #603 reviewed resident #001's care plan which indicated a focus on "Risk for falls characterized by history of falls/injury and will allow self to fall to buttocks when having behaviors". The interventions included that when the resident was sitting in wheelchair, to ensure that their restraint is on and slightly tilt wheelchair back".

On review of resident #001's health care record, there was a written physician order dated September 23, 2014 which indicated to use a restraint for safety while in wheelchair. Inspector #603 did not find a written physician order for a tilted wheelchair as a form of physical restraint. Staff#100 reviewed the resident's health care record and confirmed that there was no physician order for a tilted wheelchair. [s. 31. (2) 4.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no staff performs their responsibilities before receiving training or retraining on an annual interval, specifically related to Use of Restraints.

On June 29th, 2015, Inspector #603 reviewed the home's policy related to the "Use of Restraints", dated March 2014. The policy indicated that all direct care staff who apply and monitor restraints &/or PASDs shall receive training upon hiring and thereafter, annually.

On June 29, 2015, Inspector #603 interviewed S#101 who explained that they had previously received training on the use of restraints but did not remember when the last time was "it was years ago". Inspector #603 interviewed S#100 who explained that every year, all staff receive training on the use of restraints. The Administrator also explained that S#101 missed the annual restraint training for 2014 and was not able to find the last time they had received training. [s. 76. (2) 6.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report included a description of the individuals involved in the incident, including: iii. names of staff members who responded or are responding to the incident.

On June 29, 2015, Inspector #603 reviewed a Critical Incident Report, which was reported to the Director. The Critical Incident Report identified that on a certain date, resident #001 was found lifeless in their room, half slid out of their wheelchair, their restraint under their chin. The Critical Incident Report indicated that the resident's responsive behaviors had decreased, however the behaviors had not stopped altogether. On a certain date, S#101 provided resident #001's care and got the resident up in their wheelchair. The resident wore a restraint for positioning and if not, would slide out of their wheelchair. According to the CI, the resident had a history of throwing themselves onto the floor. On that morning, when resident #001 was positioned in their wheelchair with the restraint on, they were exhibiting behaviors. Because the resident was exhibiting behaviors, S#101 left the resident in their room until the staff would get them for breakfast. Later, S#101 went into the resident's room to bring them for breakfast, and found the resident half slid out of their wheelchair with their restraint under their chin. Staff #101 called for help and S#103 and S#104 entered the room later. Staff #103 released the restraint and S#101, #103, #104 lowered resident #001 to the floor. Staff #104 checked for vital signs and found none and began CPR. Staff #103 called 911 and once the paramedics arrived, and checked for heart rhythm, it showed asystole.

On review of the written Critical Incident Report, it included a description of S#104 but not a description of S#103 who both had responded to the incident. [s. 107. (4) 2.]

Issued on this 17th day of July, 2015

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

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) :	SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2015_391603_0022
Log No. / Registre no:	014993-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 17, 2015
Licensee / Titulaire de permis :	CORPORATION OF THE TOWN OF KIRKLAND LAKE 3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4
LTC Home / Foyer de SLD :	TECK PIONEER RESIDENCE 145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Loach

To CORPORATION OF THE TOWN OF KIRKLAND LAKE, 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 :

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 prepare, submit, and implement a plan to ensure that all residents are provided the care set out in the plan of care related to the use of restraints, which includes the following:
1. A process to ensure that the care set out in the plans of care is clearly communicated to and understood by all staff who provide direct care to residents.
2. An auditing process to ensure that the care set out in the plans of care is provided to all residents.
3. Steps the licensee will take to ensure the policy related to Use of Restraints is complied with, specifically related to physician's orders for restraints, written consent for restraints, and that the care plans contain direction regarding the frequency of checks, repositioning, and assessment by registered staff.
4. Education for all staff who provide direct care to the residents on the Use of Restraint Policy, including the risks to residents when restraints are applied, Responsive Behaviors Policy, and Risk Management Policy.
5. Education and retraining on safe use of restraints, monitoring of residents who are restrained, and restraint documentation.
6. An auditing process to ensure that all residents, especially residents who display responsive behaviors and who are restrained are being monitored and that there is documentation which meets legislative requirements.
7. A multidisciplinary process to ensure clear communication between RNs, RPNs, and PSWs regarding resident care.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email sylvie.lavictoire@ontario.ca . This plan must be submitted by July 31, 2015 with full compliance by August 28, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was provided to resident #001 as specified in the plan.

On June 29, 2015, Inspector #603 reviewed a Critical Incident Report, which was reported to the Director. The Critical Incident Report identified that on a certain date, resident #001 was found lifeless in their room, half slid out of their wheelchair, their restraint under their chin. The Critical Incident Report indicated that the resident's responsive behaviors had decreased, however the behaviors

had not stopped altogether. On a certain date, S#101 provided resident #001's morning care and according to the CI, S#101 got the resident up in their wheelchair at 08:05. The resident wore a restraint for positioning and if not, would slide out of their wheelchair. The resident had a history of throwing themselves onto the floor. On that morning, when resident #001 was positioned in their wheelchair with the restraint on, they were exhibiting behaviors. Because the resident was exhibiting behaviors, S#101 left the resident in their room until the staff would bring them for breakfast. Later, S#101 went into the resident's room to bring them out for breakfast, and found the resident half slid out of their wheelchair with their restraint under their chin. Staff #101 called for help and S#103 and S#104 entered the room later. Staff #103 released the restraint and S#101, #103, #104 lowered resident #001 to the floor. Staff #104 checked for vital signs and found none and began CPR. Staff #103 called 911 and once the paramedics arrived, and checked for heart rhythm, it showed asystole.

On June 29, 2015, Inspector #603 reviewed resident #001's plan of care, which indicated that while the resident was sitting in a wheelchair, the staff were to ensure that their restraint was on and slightly tilt wheelchair back. Inspector #603 interviewed S#101 who explained that on the morning in question, they had positioned resident #001 in a wheelchair in their room, applied a restraint and did not tilt the wheelchair back. Staff #101 explained that they did not tilt the wheelchair back as they "were not aware of this direction". Staff #101 also explained that when they found resident #001 lifeless, they yelled for help and when S#104 arrived, they communicated to S#101 "You should have tilted the wheelchair back" and they continued repeating this to S#101. Staff #104 also stated to S#101, "How many times did I tell you to tilt the chair back?" Staff #101 explained to Inspector #603 that they had never been told to tilt the wheelchair back when using a restraint until the morning of June, 21st, after the incident.

On review of the resident's health care record, Inspector #603 noted on the daily Safety Restraint Record checklist for June, 2015 that a circle had been placed around the restraint and not around the tilted chair. On interview with S#101, they explained that this form was utilized for documenting hourly checks and the circles around the type of restraint was the method utilized for selecting which restraint was to be used and documented. In this case, S#101 explained that this form was one way of communicating the type of restraint utilized for the resident.

On June 30, 2015, Inspector #603 received a Staff Incident Report from the home's Administrator which indicated that on June 29, 2015, S#101 was disciplined for "failing to slightly tilt resident #001's wheelchair back, as stated in the resident's plan of care". This report referred to the incident that occurred on June 21, 2015, related to resident #001.

(603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2015

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 and the Director

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

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.

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 17th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Lavictoire

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