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 prévue le Loi de 2007 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2017;	2017_607523_0002 (A1) (Appeal\Dir#: DR#072)	003496-17	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF MIDDLESEX
c/o Strathmere Lodge 599 Albert Street, P.O. Box 5000 STRATHROY ON N7G 3J3

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

STRATHMERE LODGE
599 Albert Street Box 5000 STRATHROY ON N7G 3J3

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

ALI NASSER (523) - (A1)(Appeal\Dir#: DR#072)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

This report has been revised to reflect a decision of the Director on a review of the Inspector's order. The Director's review was completed on 2017/06/07. The Order was rescinded to reflect the Director's review.

Issued on this 13 day of June 2017 (A1)(Appeal\Dir#: DR#072)

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

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

ALI NASSER (523) - (A1)(Appeal/Dir# DR#072)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 13, 14 and March 2, 2017.

This Complaint was related to alleged staff to resident abuse and neglect, resident care concerns and informing Substitute Decision Makers about incidents involving a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Staff Educator, the RAI Coordinator, five Registered staff members and six Personal Support Workers.

The inspector(s) also reviewed clinical records, internal incident reports, relevant policies and procedures, observed residents and staff/residents interactions.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Skin and Wound Care

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

- **6 WN(s)**
- **5 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 #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff involved in the different aspects of care of the resident collaborated with each other in the development of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Two RNs and three PSWs said in interviews that a resident was known to have a certain medical condition and the resident was to have a certain protective aide.

Plan of care did not identify this specific condition and did not include any interventions or direction to apply the protective aide.

Acting Director of Care (ADOC) reviewed the plan of care and acknowledged that it did not identify this specific condition and did not include any interventions or direction to apply the protective aide.

ADOC said that staff should have collaborated with each other in the development of the plan of care so that the different aspects of care were integrated, consistent and complemented each other.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Clinical record review for a resident showed that the resident had a certain responsive behaviour. The plan of care intervention included certain intervention for this behaviour.

The resident sustained altered skin integrity on a certain date while care was being provided to them at a certain time.

Two Registered Nurses (RN) acknowledged in interviews that the resident had this specific responsive behaviour.

A Personal Support Worker (PSW) said in an interview that the resident could exhibit a specific responsive behaviour and the staff would usually implement the intervention that was documented in the plan of care.

A PSW said in an interview that the alteration in the skin integrity occurred when they were trying to provide care to the resident and the resident exhibited a certain behaviour. The PSW said that they did not implement the specific intervention in the plan of care and continued providing care.

The RN was made aware of the alteration in skin integrity that occurred and treatment was given.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan as staff did not implement specific interventions related to a specific responsive behaviour. [s. 6. (7)]

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 staff involved in the different aspects of care of the resident collaborated with each other in the development of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other and to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's diagnosis.

Clinical record review for a resident showed that the resident had a certain medical diagnosis.

In an interview three RNs said the resident had this medical condition and was at a certain risk associated with this diagnosis.

ADOC acknowledged that there were no interventions in the plan of care for this specific medical condition.
ADOC said that it was their expectation that the plan of care would be based on an assessment of the resident diagnosis and would include interventions to address this medical diagnosis.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for an actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 26. (3) 9.]

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 the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's diagnosis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

A clinical record review for a resident showed that the resident's physician ordered a specific PASDs to be used. The Substitute Decision Maker (SDM) signed a consent form for the use of the PASDs.

A clinical record review for the resident showed that the plan of care had no interventions for the use of the specific PASDs.

Three registered staff members and three personal support workers stated that the resident used the PASDs.

ADOC acknowledged in an interview that the PASDs were used for the residents and that the PASDs were not included in the plan of care.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD was included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

A clinical record review for a resident showed that the plan of care stated that the resident had certain restraints and interventions included specific directions.

Four staff members stated in interviews that restraints were applied.
A clinical record review showed no restraint order for specific restraints that were used.

ADOC acknowledged in an interview that there was no order for the use of restraints.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for an actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 33. (4) 3.]

3. The licensee has failed to ensure that the use of a PASD was in a resident's plan of care only if the use of the PASD has been consented to by the resident or,

if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A clinical record review for a resident showed that the plan of care stated that the resident had certain restraints and interventions included specific directions.

Four staff members stated in interviews that those restraints were applied.
A clinical record review showed that there was no consent by the resident or the substitute decision-maker for the use of specific restraints.

ADOC acknowledged in an interview that the use of restraints were not consented to by the SDM before the PASDs were in the resident's plan of care.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for an actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 33. (4) 4.]

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 :
1) The PASD that was used to assist a resident with a routine activity of living would be included in the residents' plan of care.

2) The use of a PASD was included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

3) The use of a PASD was in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that when an incident occurs that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee shall:
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection.

Clinical record review for a resident showed that on a certain date and time the resident sustained an injury that resulted in an altered skin integrity, the resident was transferred to hospital on the next day.

Progress note stated that on the same day staff called the hospital and were told that the resident was to be admitted for the night.
The resident was readmitted to the home 10 days later. During the time the resident was in hospital there was no documented evidence that the hospital was contacted by the home to determine whether the injury had resulted in a significant change in the resident's health condition.

Seven business days after the occurrence of the incident, ADOC said that the home did not report the incident to the Director.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for an actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 107. (3.1)]

2. The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

A) Clinical record review for a resident showed that the resident sustained an injury that resulted in an altered skin integrity while care was being provided to them and RN was notified about this.

The RN said in an interview that they planned to call the family but it was busy. Clinical record review for the resident showed that staff noted more effects to the altered skin integrity.

B) Clinical record review for the resident showed that they sustained an alteration to their skin integrity while care was being provided to them. RN was notified about this.

The RN said in an interview that they were informed about the incident on the morning of that day. RN said that they called the substitute decision-maker (SDM) and left a voice mail. The RN said that they did not attempt to call the SDM's cell

phones to inform them of the incident.

ADOC reviewed home's policy named Resident Accident/Injury-Reporting Policy with inspector and said in an interview that their expectations would be that every effort would be made to inform SDMs as soon as possible of any injury to the resident.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for an actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 107. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
1) when an incident occurs that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee shall:
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection.

2) The resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A) Clinical record review for a resident showed that the print out care plan in the resident paper chart had handwritten updates that were not dated and signed.
In an interview, ADOC said that it was the process for staff to update the care plan as needed and they said it was the expectation that every change or update would be dated and signed.
ADOC acknowledged that the care plan changes were not signed and dated.

B) A review of the internal Incident Summary Reports showed that RN had spoken with the physician on a certain date regarding an incident involving the resident.
In an interview RN said that they informed the physician about the incident.
A Clinical record review showed no documentation in the resident's record related to this communication with the physician.
ADOC acknowledged in an interview that the resident's record did not have documentation that the physician was informed of incident.

C) Clinical record review for the resident showed that the Task Flow sheet had a significant number of missing signatures. ADOC acknowledged that signatures were missing for the tasks.

ADOC stated in an interview the expectation that staff would need to complete documentation as required and ensure the resident's written record was kept up to date at all times.

During this inspection, this non-compliance was found to have a severity of minimal harm/risk or potential for actual harm/risk, it was isolated and there was a previous non-compliance issued in a similar area. [s. 231. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's written record was kept up to date at all times, to be implemented voluntarily.

(A1)(Appeal/Dir#DR#072)
The following Non-Compliance has been Revoked: WN #1

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

Additional Required Actions:

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

(A1)(Appeal/Dir# DR#072)
The following order(s) have been rescinded:CO# 001

Issued on this 13 day of June 2017 (A1)(Appeal/Dir# DR#072)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALI NASSER (523) - (A1)(Appeal/Dir# DR#072)

Inspection No. / No de l'inspection : 2017_607523_0002 (A1)(Appeal/Dir# DR#072)

Appeal/Dir# / Appel/Dir#: DR#072 (A1)

Log No. / Registre no. : 003496-17 (A1)(Appeal/Dir# DR#072)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 13, 2017;(A1)(Appeal/Dir# DR#072)

Licensee / Titulaire de permis : THE CORPORATION OF THE COUNTY OF MIDDLESEX
c/o Strathmere Lodge, 599 Albert Street, P.O. Box 5000, STRATHROY, ON, N7G-3J3

LTC Home / Foyer de SLD : STRATHMERE LODGE
599 Albert Street, Box 5000, STRATHROY, ON, N7G-3J3

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Brent Kerwin

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To THE CORPORATION OF THE COUNTY OF MIDDLESEX, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR#072)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. Duty to protect

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 13 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ALI NASSER

Service Area Office /
Bureau régional de services : London