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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Jan 27, 2015	2014_247508_0036	H-001649-14	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 16, 17, 18, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nutrition Manager, registered staff, Personal Support Workers (PSW), residents and family.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

Resident #001 was cognitively impaired and exhibited verbal and physical responsive behaviours. The resident was ordered a medication to be administered three times a day as required (PRN), in January, 2014, to manage these behaviours. Since this time, the resident's responsive behaviours which included being resistive to care, gradually became more intense and frequent.

In October, 2014, resident #001 was assessed by a team of health care professionals, including a Physician due to an increase in the resident's behaviours. The Physician had recommended that if behavioural approaches and the use of analgesics were not sufficient to manage the resident's responsive behaviours, then to trial an anti-psychotic.

In November, 2014, resident #001's health declined and the resident was transferred to hospital. In December, 2014, the resident's weight had decreased from the previous month. Due to the resident's weight loss, the resident was assessed by the Registered Dietician and identified as a high nutritional risk due to poor intake.

During this inspection, it was observed by the inspector that the resident demonstrated responsive behaviours while staff attempted to assist the resident with eating, transferring and personal hygiene care for three consecutive days.

During an interview with staff, staff indicated that the resident was combative and resistive to care. Staff also indicated that the care the resident required, including bathing, continence care and assistance with eating, could not always be provided to the resident due to these responsive behaviours.

An interview with registered staff and the Director of Care confirmed that the recommendation from the Physician to trial an anti-psychotic medication had not been followed up with when the resident continued to demonstrate responsive behaviours. Resident #001 was not cared for in a manner consistent with their needs when the care resident #001 required could not be provided due to their responsive behaviours. [s. 3. (1) 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

Resident #001 was reassessed by the Registered Dietician (RD) in December, 2014, due to a significant weight loss. The RD changed the resident's diet order. On December 16, and 17, 2014, it was observed by the inspector that dietary staff were referring to a diet list to direct them on the type of diet to serve to the residents.

The resident's dietary care plan had been updated with the new diet and new interventions by the RD in December, 2014. The dietary list that the Dietary Aides (DA) refer to when serving the resident's meals, had not been updated with the new diet order.

On December 16, and 17, 2014, resident #001 received the incorrect diet. It was confirmed by the DA's that they served the resident the diet according to the diet list provided, however, this list had not been updated with the new diet order.

It was confirmed by the Nutrition Manager that the diet list had not been updated to the current diet order. [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 care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A) In November, 2014, resident #001's family met with the Administrator, the Director of Care (DOC) and other staff from the home to discuss care concerns. These concerns included the resident's weight loss, pain management, continence care, the lack of communication and documentation of incidents including a medication error that had occurred earlier in the year.

The home's Complaint policy, #09-04-06, in the Administration manual, states that 'verbal complaints that can be resolved within 24 hours do not require a written investigation report; however if the verbal complaint can not be resolved within 24 hours a written record of the complaint as well as the investigation and outcome will be retained by the home'.

A review of the home's 2014 Complaint Log, the Medication Incident Tracking Tool and the resident's clinical records indicated that these concerns, investigations and outcomes had not been documented. During an interview with the Administrator and the DOC, it was confirmed that they did not document these concerns or the medication error and had no records related to these resident care concerns.

B) Resident #001 was ordered a routine medication for agitation and also had an additional order to administer more doses of this medication, if required (PRN).

A review of the homes's PRN Medications policy, #11-22 in the Clinical Procedures manual states that 'In addition to all of the normal requirements in a physician order, PRN orders must also contain the reason when the order may be followed or utilized. This reason for use should also be documented on the Medication Administrator Record (MAR)'.

A review of the Physician's order and the Medication Administration Record's (MAR) for September, October, November and December, 2014, which included the order for the PRN medication did not indicate the reason for when the medication could be utilized.

The policy also stated that 'If there is a regular or routine use of PRN medications this should be flagged for the physician with the goal of converting the PRN order into a scheduled medication/treatment order'.

In addition to the resident's regularly scheduled medication, staff administered the additional PRN medication 11 times in July, 4 times in August, 2 times in September and 6 times in October until the order was changed to a routine order in October, 2014.

It was confirmed by the Director of Care that staff did not follow the PRN Medications policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff were using safe transferring and positioning techniques when assisting resident #001.

In December, 2014, after the lunch meal service, staff were observed by the inspector taking resident #001 out of the dining room and into the resident's room. The inspector entered the resident's room while two staff were attempting to transfer resident #001 using a mechanical lift.

It was observed that the staff had the sling around the resident, however, it was not fully supporting the resident. Staff re-adjusted the sling to secure the resident, however, the brakes had not been applied while the staff were securing and raising the resident in the lift. [s. 36.]

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 are using safe transferring and positioning techniques when assisting residents, including resident #001, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours.

Resident #001 had cognitive impairment and exhibited verbal and physical responsive behaviours. The resident was ordered a medication to be administered three times a day as required (PRN), in January, 2014, to manage these behaviours. Since this time, the resident's responsive behaviours which included being resistive to care, gradually became more intense and frequent.

In October, 2014, resident #001 was assessed by a team of health care professionals, including a Physician due to an increase in the resident's behaviours. The Physician had recommended that if behavioural approaches and the use of analgesics were not sufficient to manage the resident's responsive behaviours, then to trial an anti-psychotic. This recommendation had not been followed up with or implemented.

During this inspection, it was observed by the inspector that the resident demonstrated responsive behaviours while staff attempted to assist the resident with eating, transferring and personal hygiene care for three consecutive days.

During an interview with staff, staff indicated that the resident's responsive behaviours were not managed. Staff also indicated that the care the resident required, including bathing, continence care and assistance with eating, could not always be provided to the resident due to their responsive behaviours.

An interview with registered staff and the Director of Care confirmed that strategies had not been implemented when the recommendation from the Physician to trial an anti-psychotic had not been followed up with or implemented when the resident continued to demonstrate responsive behaviours. [s. 53. (4) (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 strategies are developed and implemented to respond to residents, including resident #001 demonstrating responsive behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident that involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the residents' health.

In April, 2014, the Physician ordered supplements, two tablets daily for resident #001. The pharmacy that services the home, sent the resident's medication, however, a different medication was sent in the medication pouches instead of supplements.

Resident #001 was already taking this medication and due to this error, the resident was taking double the dose of this medication for several days. The resident had symptoms of diarrhea after several days of taking the additional medication. The resident then had excoriation of their skin which required treatment.

This error had been identified by registered staff and reported to the resident's Power of Attorney (POA). In May, 2014, the resident's family requested a meeting to discuss care concerns which included this medication error. A meeting was held with the Administrator and the Director of Care present. An interview with the Director of Care confirmed that she had been made aware of this medication incident.

An interview with the Administrator and the Director of Care confirmed that this meeting, and the medication incident, that involved resident #001, including immediate actions taken, should have been documented, however, no documentation had been completed. [s. 135. (1) (a)]

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 every medication incident that involves a resident, including resident #001, and every adverse drug reaction is documented, together with a record of the immediate action taken to assess and maintain the resident's health, to be implemented voluntarily.

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

Issued on this 6th day of February, 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) :	ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_247508_0036
Log No. / Registre no:	H-001649-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 27, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HALTON HILLS 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANDRE' SPEKKENS

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall review resident #001's plan of care, including medications and recommendations from the Senior's Mental Health Outreach Program to manage resident #001's responsive behaivours to ensure that the resident is cared for in a manner consistent with their needs.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

Resident #001 was cognitively impaired and exhibited verbal and physical responsive behaviours. The resident was ordered a medication to be administered three times a day as required (PRN), in January, 2014, to manage these behaviours. Since this time, the resident's responsive behaviours which included being resistive to care, gradually became more intense and frequent.

In October, 2014, resident #001 was assessed by a team of health care professionals, including a Physician due to an increase in the resident's behaviours. The Physician had recommended that if behavioural approaches and the use of analgesics were not sufficient to manage the resident's responsive behaviours, then to trial an anti-psychotic.

In November, 2014, resident #001's health declined and the resident was transferred to hospital. In December, 2014, the resident's weight had decreased

from the previous month. Due to the resident's weight loss, the resident was assessed by the Registered Dietician and identified as a high nutritional risk due to poor intake.

During this inspection, it was observed by the inspector that the resident demonstrated responsive behaviours while staff attempted to assist the resident with eating, transferring and personal hygiene care for three consecutive days.

During an interview with staff, staff indicated that the resident was combative and resistive to care. Staff also indicated that the care the resident required, including bathing, continence care and assistance with eating, could not always be provided to the resident due to these responsive behaviours.

An interview with registered staff and the Director of Care confirmed that the recommendation from the Physician to trial an anti-psychotic medication had not been followed up with when the resident continued to demonstrate responsive behaviours. Resident #001 was not cared for in a manner consistent with their needs when the care resident #001 required could not be provided due to their responsive behaviours. [s. 3. (1) 4.]

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 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 27th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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