Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016	2016_250511_0013	023706-16	Complaint

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT HAMILTON ON L8V 4V5

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

ROBIN MACKIE (511)

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): October 25, 27, 28, 2016.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Physiotherapist, Restorative Aide, Registered Nurse, Personal Support Worker (PSW), family members and identified residents.
During the course of this inspection the Inspector observed the provision of resident care, reviewed clinical records, applicable policies, practices and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that everyone hired as an Administrator after the coming into force of this section, (d) had successfully completed or, subject to subsection (6), was enrolled in, a program in long-term care home administration or management that was a minimum of 100 hours in duration of instruction time.

The licensee became aware of the Administrator's absence from the home on September 9, 2016. A review of the home's internal communication to staff indicated the home's Director of Care (DOC) accepted an Acting Administrator's position on September 14, 2016. There was no documentation to confirm there had been an Administrator, onsite, at the home from September 9-14, 2016. The Administrator had resigned, effective October 17, 2016. Interview with the Acting Administrator confirmed that on October 27, 2016, they had not successfully completed or, subject to subsection (6), was enrolled in, a program in long-term care home administration or management. The Acting Administrator confirmed they had not intended to enroll in a program in long-term care home administration or management. The Acting Administrator confirmed the home's CEO had indicated the home was still actively interviewing and a further interviews would be set up on an undetermined date in November. The Acting Administrator confirmed there was no confirmed start date for an Administrator that completed or was enrolled in, a program in long-term care home administration or management that was a minimum of 100 hours in duration of instruction time. [s. 212. (4) (d)]

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 O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee of a 184 bed long-term care home failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for the following amount of time per week: 5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

Interview with the Acting Administrator confirmed that they had been the DOC in the home working full-time, greater than 35 hours per week, prior to September 14, 2016. They confirmed they had accepted the Acting Administrator position on September 14, 2016, when the home's Administrator had gone off work on September 9, 2016. The Acting Administrator stated there had been no other DOC or Acting DOC in the home since September 14, 2016, when they had accepted the Acting Administrator position. Interview with the Acting Administrator confirmed they had been working 'longer' hours but not worked an additional 35 hours per week, as required in their previous DOC position, in addition to the 35 hours per week, as required in the Acting Administrator position.

The Acting Administrator confirmed the licensee of the 184 bed long-term care home failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for the following amount of time per week: 5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. [s. 213. (1) 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 used safe transferring and positioning devices or techniques when assisting residents.

Resident #001's Resident Assessment Protocol (RAP) indicated the resident

experienced both long and short term memory loss and required assistance to make adequate decisions. The resident was described as being at a risk for altered skin integrity due to their skin being described as being very fragile and was on a medication that made them susceptible to bruising.

A) A review of the resident's Safe Ambulation Lift and Transfer (SALT) assessment, completed in March 2016, indicated the resident required the use of a specialized lift, with two persons, for transfers. A review of the plan of care for the same period indicated the resident was to be assessed for stability prior to each transfer as the specialized lift required the resident to follow direction, weight bear on one leg and be able to hold the arm of the lift securely with at least one arm for a safe transfer. A review of the progress notes indicated that in April 2016, resident #001 sustained an injury, when they had been transferred using the lift. Interview with staff #101 indicated the resident was often unpredictable and inconsistent with their ability to follow instructions and weight bear. Staff #101 indicated the resident may have moved their body part during the transfer when it was struck by the lift. The home completed an internal Client Service Response form of the incident in April 2016 and determined the two staff, involved in the incident, required additional training for safe transfers.

The Acting Administrator confirmed the PSW staff members had completed an unsafe transfer which resulted in harm to the resident. The Acting Administrator confirmed further education was required and completed in April 2016.

B) A request for a change in transfer assessment was completed in April, 2016. A review of the resident's Safe Ambulation Lift and Transfer (SALT) assessment indicated the resident now required the use of a different specialized lift, with two persons, for transfers and no longer could weight bear or follow directions on a consistent basis. A review of the resident's plan of care indicated the resident required extensive assistance for transfers, related to their lack of strength and cognitive defect and required the use of this different lift, with two staff in attendance, for the safe transfer of the resident. A progress note completed by a Registered Practical Nurse (RPN) in June 2016, described that the resident sustained an injury during a transfer with one PSW during care. A review of the home's internal investigation records for the July 2016, incident indicated the PSW had completed a one person transfer that resulted in the resident's injury. The resident required nursing interventions for the injury.

The Acting Administrator confirmed the licensee failed to ensure the staff had used safe transferring and positioning devices or techniques when they assisted resident #001 from

their bed to their wheelchair which resulted in an injury to resident #001. [s. 36.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of the clinical record indicated that in July 2016, resident #001 sustained an injury during a transfer. The registered staff was notified and immediately contacted the Nurse Practitioner (NP) who came to the home 30 minutes later. The NP documented their interventions to treat the injury. The Substitute Decision Maker (SDM) was notified after the resident was treated in the home. The SDM had issued a letter of complaint to the home in August 2016 asking why they had not been notified earlier on the day of the injury and given the opportunity to decide if they had wanted their family member to receive treatment at the hospital or, at a minimum, be in attendance when the resident

received treatment in the home. The family member voiced that they could have came over and provided comfort and reassurance to their family member. Interview with the Acting Administrator confirmed the home's practice was to give the SDM the opportunity to participate fully in the resident's plan of care. The Acting Administrator confirmed that in July 2016, the licensee failed to ensure the SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, (b) if the plan of care was being revised because care set out in the plan had not been effective, the licensee failed to ensure that different approaches were considered in the revision of the plan of care.

A review of the clinical record for resident #001 identified during their Resident Assessment Instrument Minimum Data Set quarterly review from April to June 2016, the resident was at a high risk for altered skin integrity. The resident required extensive assistance for transferring related to their lack of strength, cognitive deficit and required two staff with a mechanical lift for transfers. Resident #001's plan of care documented they had sustained multiple altered levels of skin integrity in March, April, May and June 2016. Interventions in the plan of care included but were not limited to: the staff to use the palms of their hands for care and transfers, assess conditions of skin in the morning and at night during personal care and to massage skin with moisturizing lotion.
The resident continued to experience further altered levels in their skin integrity in June, July and September 2016.
There were no changes or different approaches documented in the revision of the plan of care, with the last care plan review, completed in September 2016.

Interview with the ADOC confirmed resident #001 continued to experience areas of altered skin integrity over a six month period (March-September 2016) and that different approaches were not considered in the revision of the plan of care when the strategies in the resident's plan of care had not been effective. [s. 6. (11) (b)]

Issued on this 14th day of December, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2016_250511_0013
Log No. / Registre no:	023706-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 25, 2016
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Spretnall

To GRACE VILLA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration;
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d);
(c) has demonstrated leadership and communications skills; and
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Order / Ordre :

The Licensee shall ensure that everyone hired as an Administrator, (a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; (b) has at least three years working experience, (i) in a managerial or supervisory capacity in the health or social services sector, or (ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); (c) has demonstrated leadership and communications skills; and (d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

Grounds / Motifs :

1. The licensee failed to ensure that everyone hired as an Administrator after the coming into force of this section, (d) had successfully completed or, subject to subsection (6), was enrolled in, a program in long-term care home administration or management that was a minimum of 100 hours in duration of instruction time.

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (2) in keeping with r. 229 of the Regulation. This is in respect to the severity of potential for minimal Harm/Risk or Potential for Actual Harm/Risk that the identified resident experienced, the scope of pattern and the home's history of on or more unrelated non-compliances in the previous three years

The licensee became aware of the Administrator's absence from the home on September 9, 2016. A review of the home's internal communication to staff indicated the home's Director of Care (DOC) accepted an Acting Administrator's position on September 14, 2016. There was no documentation to confirm there had been a full time Administrator, onsite, at the home from September 9-14, 2016. The Administrator had resigned, effective October 17, 2016. Interview with the Acting Administrator confirmed that on October 27, 2016, they had not successfully completed or, subject to subsection (6), was enrolled in, a program in long-term care home administration or management. The Acting Administrator confirmed they had not intended to enroll in a program in long-term care home administration or management. The Acting Administrator confirmed the home's CEO had indicated the home was still actively interviewing and a further interviews would be set up on an undetermined date in November. The Acting Administrator confirmed there was no confirmed start date for an Administrator that had completed or was enrolled in, a program in long-term care home administration or management that was a minimum of 100 hours in duration of instruction time. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The Licensee shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for at least 35 hours per week.

Grounds / Motifs :

1. The licensee of a 184 bed long-term care home failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for the following amount of time; 5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (2) in keeping with r. 229 of the Regulation. This is in respect to the severity of potential for minimal Harm/Risk or Potential for Actual Harm/Risk that the identified resident experienced, the scope of pattern and the home's history of on or more unrelated non-compliances in the previous three years

Interview with the Acting Administrator confirmed that they had been the DOC in the home working full-time, greater than 35 hours per week, prior to September 14, 2016. They confirmed they had accepted the Acting Administrator position on September 14, 2016, when their Administrator had gone off work on September 9, 2016. The Acting Administrator stated there had been no other DOC or Acting DOC in the home since September 14, 2016, when they had accepted the Acting Administrator position. Interview with the Acting Administrator confirmed they had been working 'longer' hours but not worked an additional 35 hours per week, as required in their previous DOC position, in addition to the 35 hours per week, as required in the Acting Administrator position.

The Acting Administrator confirmed the licensee of the 184 bed long-term care home failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for the following amount of time per week: 5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall that staff use safe transferring and positioning devices or techniques when assisting resident #001.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #001's Resident Assessment Protocol (RAP) indicated the resident experienced both long and short term memory loss and required assistance to make adequate decisions. The resident was described as being at a risk for altered levels of skin integrity due to their skin being described as being very fragile and was on a medication that made them susceptible to bruising.

A) A review of the resident's Safe Ambulation Lift and Transfer (SALT) assessment, completed in March 2016, indicated the resident required the use of a specialized lift, with two persons, for transfers. A review of the plan of care for the same period indicated the resident was to be assessed for stability prior to each transfer as the specialized lift required the resident to follow direction, weight bear on one leg and be able to hold the arm of the lift securely with at least one arm for a safe transfer. A review of the progress notes indicated that in April 2016, resident #001 sustained an injury, when they had been transferred using the lift. Interview with staff #101 indicated the resident was often unpredictable and inconsistent with their ability to follow instructions and weight bear. Staff #101 indicated the resident may have moved their body part during the transfer when it was struck by the lift. The home completed an internal Client Service Response form of the incident in April 2016 and determined the two staff, involved in the incident, required additional training for safe transfers.

The Acting Administrator confirmed the PSW staff members had completed an unsafe transfer which resulted in harm to the resident. The Acting Administrator confirmed further education was required and completed in April 2016.

B) A request for a change in transfer assessment was completed in April 2016. A review of the resident's Safe Ambulation Lift and Transfer (SALT) assessment indicated the resident now required the use of a different specialized lift, with two persons, for transfers and no longer could weight bear or follow directions on a consistent basis. A review of the resident's plan of care indicated the resident required extensive assistance for transfers, related to their lack of strength and cognitive defect and required the use of this different lift, with two staff in attendance, for the safe transfer of the resident. A progress note completed by a Registered Practical Nurse (RPN) in June 2016, described that the resident sustained an injury during a transfer with one PSW during care. A review of the home's internal investigation records for the July 2016, incident indicated the PSW had completed a one person transfer that resulted in the resident's injury. The resident required nursing interventions for the injury.

The Acting Administrator confirmed the licensee failed to ensure the staff had used safe transferring and positioning devices or techniques when they assisted resident #001 from their bed to their wheelchair which resulted in an injury to resident #001. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Robin Mackie

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