



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

**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**

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 12, 2014	2014_182128_0007	L-001391-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF HURON
c/o Huronlea HFA, 820 Turnberry Street South, BRUSSELS, ON, N0G-1H0

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

HURONLEA HOME FOR THE AGED
820 TURNBERRY STREET SOUTH, BRUSSELS, ON, N0G-1H0

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

RUTH HILDEBRAND (128), JUNE OSBORN (105)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): October 27-31 and November 3-5, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Administrative Assistant, RAI Coordinator, 3 Registered Nurses, 8 Registered Practical Nurses, 12 Personal Support Workers/Health Care Aides, Registered Dietitian, Nutrition Care Manager, 2 Dietary Aides, Coordinator of Programs and Social Services, 2 Activation Aides, Maintenance Engineer, Handy Person, 40+ Residents and 3 Family Members.

During the course of the inspection, the inspector(s) conducted a tour of common areas, observed residents and the care provided to them and observed meal service. Medication administration and storage were observed and the clinical records for identified residents were reviewed. The inspectors reviewed records, policies and procedures, as well as minutes of meetings pertaining to the inspection. Posting of required information was confirmed.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails Specifically failed to comply with the following:

- s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
 - (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
 - (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**



Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, each resident was assessed and his or her bed system was evaluated and steps were taken to prevent resident entrapment, taking into consideration all the potential zones of entrapment, as evidenced by:

Observations of beds, October 27-29, 2014, revealed that there were entrapment concerns noted in four identified rooms where four beds, using bed rails, had no corner guards.

The Administrator and Director of Care verified that these beds had entrapment concerns after observing the beds on October 28-29, 2014.

The Administrator reported that the home had done an audit this year of all the beds but they have determined that there was a "glitch" in how they were testing the entrapment risk. [s. 15. (1)]

Additional Required Actions:

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

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17.
Communication and response system**



Specifically failed to comply with the following:

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
 - (b) is on at all times; O. Reg. 79/10, s. 17 (1).
 - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
 - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
 - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
 - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
 - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents, as evidenced by:

Observation of the Chapel and the Tuck Shop areas, on October 27, 2014, revealed there was no call bell available in either area.

A Dietary Aide verified there was no call bell in the Tuck Shop area.

The Director of Care verified there was no call bell in the Chapel, and confirmed both areas should have one. [s. 17. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.



WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized plan of care to promote and manage bladder continence based on the assessment was available for an identified resident as evidenced by:

A review of the plan of care for Resident # 006 revealed that an individualized plan of care to promote bladder continence had not been developed and that there were discrepancies within the plan of care.

Interviews with a Personal Support Worker and the RAI Coordinator confirmed that the home had not established an individualized plan for the resident's continence care.

The RAI Coordinator indicated that the home was re-vamping the continence care program and the expectation would be that individualized plans to manage continence were available for each resident. [s. 51. (2) (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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council



Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, as evidenced by:

A review of minutes of Residents' Council meetings revealed that residents had requested at the February 10, March 10, August 7 and September 8, 2014 meetings that a list of names of Department Heads in the home be posted so that they knew who to contact if they had an issue that they wanted resolved.

Additionally, residents expressed concerns about chairs soiled in the T.V. room and main lobby on July 14, 2014 and flies in the dining room August 7, 2014.

Despite these concerns being expressed there was no documented evidence to demonstrate that written responses were provided to the Residents' Council.

The Administrator acknowledged that no responses to the concerns or recommendations had been provided in writing. [s. 57. (2)]

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 ensure that if the Residents' Council has advised the licensee of concerns or recommendations, the licensee, within 10 days of receiving the advice, responds to the Residents' Council in writing, to be implemented voluntarily.



WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attended a Residents' Council meeting, only if invited, as evidenced by:

A review of minutes of Residents' Council meetings revealed that the assistant for Residents' Council was approached, by the Administrator, after the July 14, 2014 meeting and the Administrator requested that she be able to attend the next meeting. The assistant agreed that the Administrator could attend without an invitation from Residents' Council.

The Administrator confirmed that she also attends the Residents' Council meetings as part of a standing invitation to report quarterly regarding Administrator updates and quarterly regarding Quality Improvement updates.

The Administrator indicated that the home needed to review this practice to ensure that staff attend meetings by invitation, only. [s. 64.]

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, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of Residents' Council, only if invited, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services



Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance, as evidenced by:

Observations throughout the RQI revealed the following maintenance concerns:

The spindles of the railing in the main hallway, near the lounge and dining room, were scraped and had paint chipped off them;

Damage was noted on the wooden legs and arms of 9/10 (90%) dining room chairs in the large 300 wing dining room. Additionally, 5/6 (83%) dining room table legs had paint chipped off them. The wall under the menu board had a gouge with peeling paint in 3 places and the dining room baseboard of the servery wall had the finish worn off of it. The window frame to the hallway was scraped and the dining room door was damaged at the bottom;

In the 100, 200 and 300 wing, resident bedroom and bathroom walls, window frames, door frames and doors were noted to be scraped and had chipped paint with 26/33 identified rooms (79%) needing repair;

The 200 wing tub room radiator was very paint chipped and had rust on it. It was also noted that the floor was lifting around the drain, near the tub.

These maintenance issues were confirmed by the Maintenance Engineer and the Handy Person. They acknowledged that the home does not have a preventative maintenance &/or painting schedule in place to ensure that routine maintenance is done. [s. 90. (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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times, as evidenced by:

On October 27, 2014, three bottles of Virox disinfectant were found under sink in an unlocked cupboard in the Activation Room which was accessible to residents. This finding was verified by an Activation Aide.

The Director of Care confirmed the expectation was to keep chemicals inaccessible to the residents at all times. [s. 91.]

2. The servery in the large dining room was observed open and unattended at 14:35, October 30, 2014. Residents had potential access to hazardous chemicals in the dishmachine area.

The Administrator confirmed that the dining room was unlocked providing potential access to the servery and acknowledged the potential safety risk to residents. [s. 91.]



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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, as evidenced by:

The servery in the large dining room was observed open and unattended at 14:35, October 30, 2014. Residents had potential access to a rotary toaster, hot water urn/coffee machine as well as 4 sharp knives.

The Administrator confirmed that the dining room was unlocked providing potential access to the servery and acknowledged the potential safety risk to residents.

The risk was mitigated while inspectors were on-site in the home as locks were installed on the dining room doors. [s. 5.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :



1. The licensee has failed to ensure that the care set out in the plan of care was provided to an identified resident as specified in the plan, as evidenced by:

[REDACTED]

Review of the plan of care revealed the resident was to have facial hairs shaved.

A Personal Support Worker verified the resident was to have facial hairs shaved when they were visible, and this had not been done and the plan of care was not followed.

[s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, as evidenced by:

Observation of Resident #005 November 4, 2014 revealed she/he had greasy hair.

A record review revealed that the Care Plan and Kardex used by staff indicated this resident was to have hair washed at the time of being showered. Showers were provided four times in eleven days with only one hair wash documented.

A Registered Nurse verified this information and confirmed the care set out in the plan was not followed. [s. 6. (7)]

Issued on this 12th day of November, 2014

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



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*

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) : RUTH HILDEBRAND (128), JUNE OSBORN (105)

Inspection No. /

No de l'inspection : 2014_182128_0007

Log No. /

Registre no: L-001391-14

Type of Inspection /

Genre

d'inspection:

Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Nov 12, 2014

Licensee /

Titulaire de permis : CORPORATION OF THE COUNTY OF HURON
c/o Huronlea HFA, 820 Turnberry Street South,
BRUSSELS, ON, N0G-1H0

LTC Home /

Foyer de SLD : HURONLEA HOME FOR THE AGED
820 TURNBERRY STREET SOUTH, BRUSSELS, ON,
N0G-1H0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Jolanta Linde-Martinsons

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



**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

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

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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
- (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
- (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must ensure that where bed rails are used, each resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and that steps are taken to prevent resident entrapment and minimize the risk to residents.

Grounds / Motifs :



**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*

1. The licensee has failed to ensure that where bed rails were used, each resident was assessed and his or her bed system was evaluated and steps were taken to prevent resident entrapment, taking into consideration all the potential zones of entrapment, as evidenced by:

Observations of beds, October 27-29, 2014, revealed that there were entrapment concerns noted in four identified rooms where four beds, using bed rails, had no corner guards.

The Administrator and Director of Care verified that these beds had entrapment concerns after observing the beds on October 28-29, 2014.

The Administrator reported that the home had done an audit this year of all the beds but they have determined that there was a "glitch" in how they were testing the entrapment risk. (128)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2015



**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

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



**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*

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.



**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*

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, 11^e 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.



**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*

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 12th day of November, 2014

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : RUTH HILDEBRAND

Service Area Office /

Bureau régional de services : London Service Area Office