



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**

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**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

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2014	2014_226192_0015	L-000444-14	Complaint

Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES
200 Boullee St., New Hamburg, ON, N3A-2K4

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

NITHVIEW HOME
200 Boullee Street, New Hamburg, ON, N3A-2K4

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

DEBORA SAVILLE (192)

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): April 30, May 1, 2, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Staffing Clerk, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

During the course of the inspection, the inspector(s) reviewed medical records, schedules, staff issues on shift records, shift routines, unit daily records and policy and procedure.

The following Inspection Protocols were used during this inspection:



Contenance Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. Legend includes WN, VPC, DR, CO, WAO. Legendé includes Avis écrit, Plan de redressement volontaire, Aiguillage au directeur, Ordre de conformité, Ordres : travaux et activités. The table also contains detailed descriptions of non-compliance with LTCHA requirements and their French equivalents.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act



Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**
-

Findings/Faits saillants :

1. The licensee failed to ensure that a reported allegation of abuse and neglect was immediately investigated.

In 2014 the Assistant Director of Care received information indicating that resident #003, who is identified to be at risk of altered skin integrity and according the plan of care, required the assistance of two staff to turn every two hours while in bed, had been left in one position in bed for a period of nine hours.

On the same date in 2014, the Assistant Director of Care was informed of an allegation of abuse, where the staff approached a resident without speaking to them and proceeded with care. A staff member was heard to be yelling at the resident. The person reporting the incident indicated that the resident was fearful of staff.

Interview with the Assistant Director of Care confirmed that the allegations of neglect and abuse had been received verbally and that no investigation had been completed into either incident. [s. 23. (1) (a)]

Additional Required Actions:

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



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WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :



1. The licensee failed to ensure that residents who are dependent on staff for repositioning, are repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Resident #003 is identified in the plan of care to be at risk of altered skin integrity and under Bed Mobility to require turning and repositioning every two hours by two staff; the resident was unable to assist.

Interview with the Substitute Decision Maker (SDM) and staff confirmed that in 2014, resident #003 was put to bed at a specified time and was not repositioned for a period of nine hours.

Review of the shift routine and staff interview confirm that resident #003 and other residents of the home requiring assistance to turn are routinely turned twice on the night shift. A round is conducted at 2315 hours and again at 0430 hours without consideration of the assessed needs of the residents. Residents #003 and #002 are identified in their plan of care and through interview to require turning and repositioning every two hours and are at risk of altered skin integrity.

Resident #003 was not turned and positioned every two hours as required in 2014. Resident #002 and other residents of the home are not turned and repositioned every two hours as required during the night shift.

Interview and record review confirmed that resident #003 required the assistance of two staff for turning and repositioning. Interview confirmed that the evening routine was for resident #003 to be assisted into bed at a specified time and that resident #003 routinely does not receive further turning and positioning on the evening shift. The next turning and repositioning would occur on the night shift.

The licensee failed to ensure that residents #003 and #002, who are at risk of altered skin integrity and are dependent on staff for bed mobility are turned and repositioned every two hours as assessed. [s. 50. (2) (d)]



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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :



1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director.

In 2014 a Substitute Decision Maker (SDM) observed resident #003 allegedly neglected and resident #002 allegedly abused by staff of the home.

The SDM reported to the Assistant Director of Care (ADOC) the allegation of abuse and neglect. The SDM alleged that resident #003 was not turned or repositioned for a nine hour period and that resident #002 was not awakened before being provided care and when the resident resisted assistance they were yelled at by staff. The SDM also reported that resident #002 appeared fearful of staff.

Interview in 2014 with the ADOC confirmed that she had received the information from the SDM and that the reported information constituted reasonable grounds to suspect that neglect and abuse may have occurred.

Interview confirmed that the reported incidents of alleged abuse and neglect were not reported to the Director. [s. 24. (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 ensuring that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours



Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

- 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
 - 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
 - 3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
 - 4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**
-

Findings/Faits saillants :

1. The licensee failed to ensure that there are written approaches to care developed to meet the needs of resident #002 who demonstrated responsive behaviours and included screening protocols, assessment, reassessment, and the identification of behavioural triggers that may result in responsive behaviours.

Resident #002 was identified in interview to have been provided care on a specified date in 2014 without being spoken to. When resident #002 demonstrated responsive behaviours during the provision of care, staff yelled at the resident.

Interview with staff confirmed that resident #002 demonstrated responsive behaviours when awakened for care.

Review of the plan of care and interview with the Director of Care and Administrator confirmed that the plan of care does not include screening protocols, assessment or identification of triggers for this responsive behaviour.

Interview with staff and the DOC confirmed that interventions to manage responsive behaviours had not been identified for resident #002. [s. 53. (1) 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 ensuring that there are written approaches to care developed to meet the needs of residents who demonstrate responsive behaviours and include screening protocols, assessment, reassessment, and the identification of behavioural triggers that may result in responsive behaviours, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

Interview with the Substitute Decision Maker (SDM) for resident #003 and confirmed by the Director of Care indicated that the lift used for resident #003 caused injury to the resident. The SDM provided a device to be applied to the resident prior to transfer in order to prevent injury.

The plan of care indicated that the resident required the use of the lift for all transfers and that two staff are to be present but does not address the use of the device to be applied to the resident.

Interview with the DOC confirmed that the plan of care does not address use of the device that is to be applied during transfers. [s. 6. (1) (a)]



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Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 8th day of May, 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) : DEBORA SAVILLE (192)

Inspection No. /

No de l'inspection : 2014_226192_0015

Log No. /

Registre no: L-000444-14

Type of Inspection /

Genre

Complaint

d'inspection:

Report Date(s) /

Date(s) du Rapport : May 8, 2014

Licensee /

Titulaire de permis : TRI-COUNTY MENNONITE HOMES
200 Boulée St., New Hamburg, ON, N3A-2K4

LTC Home /

Foyer de SLD : NITHVIEW HOME
200 Boulée Street, New Hamburg, ON, N3A-2K4

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Elizabeth Klassen

To TRI-COUNTY MENNONITE HOMES, 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**

**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*

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. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall complete an investigation into the reported incident of alleged abuse and neglect that occurred on March 24, 2014.

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
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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 failed to ensure that a reported allegation of abuse and neglect was immediately investigated.

In 2014 the Assistant Director of Care received information indicating that resident #003, who is identified to be at risk of altered skin integrity and according the plan of care, required the assistance of two staff to turn every two hours while in bed, had been left in one position in bed for a period of nine hours.

On the same date in 2014, the Assistant Director of Care was informed of an allegation of abuse, where the staff approached a resident without speaking to them and proceeded with care. A staff member was heard to be yelling at the resident.

Interview with the Assistant Director of Care confirmed that the allegations of neglect and abuse had been received verbally and that no investigation had been completed into either incident. (192)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

Order(s) of the InspectorPursuant 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 :** 002**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that resident #003 and all other residents assessed to require assistance with repositioning every two hours or more frequently are turned and repositioned every two hours.



**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
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**Ministère de la Santé et
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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

Grounds / Motifs :



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*

1. The licensee failed to ensure that residents who are dependent on staff for repositioning, are repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Resident #003 is identified in the plan of care to be at risk of altered skin integrity and under Bed Mobility to require turning and repositioning every two hours by two staff; the resident was unable to assist.

Interview with the Substitute Decision Maker (SDM) and staff confirmed that in 2014, resident #003 was put to bed and was not repositioned for a period of nine hours.

Review of the shift routine and staff interview confirm that resident #003 and other residents of the home requiring assistance to turn are routinely turned twice on the night shift. A round is conducted at 2315 hours and again at 0430 hours. Residents #003 and #002 are identified in their plan of care and through interview to require turning and repositioning every two hours and are at risk of altered skin integrity.

Resident #003 was not turned and positioned every two hours as required in 2014.

Resident #002 and other residents of the home are not turned and repositioned every two hours as required during the night shift.

Interview and record review confirmed that resident #003 required the assistance of two staff for turning and repositioning. Interview confirmed that the evening routine was for resident #003 to be assisted into bed at a specified time and that resident #003 routinely does not receive further turning and positioning on the evening shift. The next turning and repositioning would occur on the night shift.

The licensee failed to ensure that residents #003 and #002, who are at risk of altered skin integrity and are dependent on staff for bed mobility are turned and repositioned every two hours as assessed. (192)



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Order(s) of the Inspector

Pursuant to section 153 and/or
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Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
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**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

May 30, 2014



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

**Ministère de la Santé et
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Order(s) of the Inspector

Pursuant to section 153 and/or
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Ordre(s) de l'inspecteur

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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
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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*

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Ordre(s) de l'inspecteur

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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.



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Order(s) of the Inspector
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Aux termes de l'article 153 et/ou
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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.



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Order(s) of the Inspector

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section 154 of the *Long-Term Care
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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 8th day of May, 2014

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** DEBORA SAVILLE

**Service Area Office /
Bureau régional de services :** London Service Area Office