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
Facsimile: (905) 546-8255

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2017	2017_482640_0003	024039-16, 028051-16, 029664-16, 001847-17	Complaint

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH HAMILTON ON L8N 2A7

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

QUEEN'S GARDEN
80 Queen Street North HAMILTON ON L8R 3P6

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

HEATHER PRESTON (640)

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): February 3, 7, 8, 9 and 10, 2017

The following complaint intakes were included in this inspection;
024029-16 related to resident care,
028051-16 related to plan of care,
029664-16 related to plan of care,
001847-17 related to neglect,
and 003772-17 related to all previous intakes.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Director Professional Development, Resident Assessment Instrument (RAI) Coordinator, Environmental Services Supervisor, Food Service Manager, Registered Dietitian, Social Worker, Activities Director, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Housekeeping

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence

Resident #001 was assessed as incontinent of bladder and continent of bowel. Interview of RN #100 confirmed when a resident was admitted to the home and was incontinent, a clinically appropriate instrument specific to continence was to be completed in Point Click Care(PCC). Review of the clinical record by the Long Term Care Home(LTCH) Inspector revealed there was no clinically appropriate instrument for continence completed during the admission process for resident #001. Interview with the RAI Coordinator revealed there was no clinically appropriate instrument for continence completed upon admission of resident #001. The RAI Coordinator confirmed it was the expectation of the home that a complete assessment of bladder continence, using the Bladder Continence Assessment tool found in PCC, which was a clinically appropriate assessment tool, was to be completed for resident #001 upon admission. Interview with the Assistant Director of Care confirmed there was no clinically appropriate assessment instrument completed upon admission of resident #001. [s. 51. (2) (a)]

2. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence

Resident #002 was assessed during admission as continent of bladder and bowel. Review of the clinical record by the LTCH Inspector revealed a significant change and the resident had become incontinent. There was no clinically appropriate bladder assessment instrument completed for resident #002 related to this decline. Since the date of decline, there were no clinically appropriate assessment instruments completed. Interview with the RAI Coordinator revealed there was no clinically appropriate bladder assessment instrument completed with the change of status of resident #002 or at any time since the change in status. The RAI Coordinator confirmed it was the expectation of

the home that a complete assessment of bladder continence, using the Ont - Bladder Continence Assessment was to be completed for any resident who was incontinent. Interview with the Assistant Director of Care confirmed there was no clinically appropriate assessment instrument completed for resident #002 related to the change in continence or any time after. [s. 51. (2) (a)]

3. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence

Resident #003 was assessed as incontinent of bladder and bowel. Review of the clinical record by the LTCH Inspector revealed there were no clinically appropriate bladder and bowel continence assessment instruments completed upon admission or any time thereafter. Interview with the RAI Coordinator revealed there was no clinically appropriate bladder or bowel assessment instrument completed at any time for resident #003. The RAI Coordinator confirmed it was the expectation of the home that a complete assessment of bladder and bowel continence, using the Bladder Continence Assessment tool, was to be completed for any resident who was assessed to be incontinent of bladder or bowel upon admission. Interview with the Assistant Director of Care confirmed there was no clinically appropriate bladder or bowel continence assessment instrument completed for resident #003 for the assessed bowel and bladder incontinence upon admission and any time thereafter. [s. 51. (2) (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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 was a written plan of care for each resident that set out the planned care for the resident.

Resident #001 was observed to have a health condition. Review of the clinical record failed to identify the planned care for the resident related to the health condition. During interview with Personal Support Worker (PSW) #106 stated that the resident was to receive oral care at specified intervals when they were assisted with toileting. Interview with PSW #102 revealed that staff provided oral hygiene to resident #001 in the morning and at bed time. During interview the Resident Assessment Instrument (RAI) Coordinator confirmed that resident #001 was to receive oral care twice daily, morning and evening and that the plan of care did not include the required care for the resident. The Director of Care stated that the expectation was that the plan of care would include the required needs of resident #001 and that the resident was to receive oral care. [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6(1) where 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, as part of the organized program of laundry services under clause 15 (1)(b) of the Act, that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

Resident #003's clothing item went missing. Policy, "Personal Clothing - Missing" and issued February 2015, directed staff to document all information on the missing clothing report form. An immediate search of the resident area was to be initiated followed by an immediate search of the laundry room. If not found, the Environmental Services Manager (ESM), was to post the missing clothing report in the laundry room for three consecutive days. Review of the resident record revealed that staff were aware that the resident was missing a clothing item. The Program and Support Service Manager was notified. During an interview with the Program Support and Services Manager, the LTCH Inspector was told that the process was not implemented as per the policy. In fact, the form had not been filled out and no one was directed to search for the clothing item. Interview with the ESM revealed a review of the contents of the policy and that the process to report and locate the missing item was not followed. During interview of the Director of Care(DOC), the DOC told the LTCH Inspector that when an resident item is missing, it is the expectation of the home that staff immediately start the search and follow the written policy for missing laundry. [s. 89. (1) (a) (iv)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after an occurrence of an incident, followed by the report required under subsection (4) for an incident that caused injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

In January 2017, resident #003 sustained a fall with injury. The resident was assessed and was sent to hospital for further assessment. Interview with the Director of Care and the Assistant Director of Care confirmed that the Director was not informed of the injury resulting in a significant change in condition for resident #003 and that a Critical Incident Report was not submitted to the Director. [s. 107. (3)]

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

Resident #003 sustained a fall that resulted in an injury. RN #113 assessed the resident and determined there were injuries. The residents' substitute decision-maker(SDM) was not notified for approximately four hours on the date of the injury. Policy "Critical Incident Report (CIS), policy number LTC-CA-ON-100-05-04 and revised January 2016, stated "The purpose of this policy is to provide home staff with operational guidelines regarding ministry defined critical incidents and the associated reporting system and requirements." And policy "Resident Falls", policy number LTC-CA-WQ-200-07-08 and revised May 2016, directed staff to notify the residents' SDM of the incident. The resident subsequently was sent to hospital and it was determined there were injuries. Interview of RN #100 revealed that staff was expected to notify the residents' SDM as soon as possible after a fall with injury. The Administrator confirmed with the LTCH Inspector, the expectation of the home was for immediate notification of the SDM when a resident falls and sustains an injury. [s. 107. (5)]

Issued on this 8th day of May, 2017

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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2017_482640_0003
Log No. / Registre no:	024039-16, 028051-16, 029664-16, 001847-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 13, 2017
Licensee / Titulaire de permis :	LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION 44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7
LTC Home / Foyer de SLD :	QUEEN'S GARDEN 80 Queen Street North, HAMILTON, ON, L8R-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah DiMauro

To LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(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;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that;
1. Resident #001, 002 and 003 have a continence assessment completed to include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
2. All residents demonstrating incontinence or a change in continence have an assessment or reassessment completed to include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
3. All registered staff are trained on the use of the home's designated continence assessment instrument, including when the assessment and reassessments are to be initiated and action to be taken following the assessment.
4. There is an auditing process in place to ensure that all resident who are incontinent or experience a change in continence have an assessment completed using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is widespread (3), the severity of the non-compliance is minimal harm or potential for actual harm (2), three incontinent residents were not assessed using a clinically appropriate assessment tool and the history of non-compliance under LTCHA, 2007, section s. 19 is previous related (3) with a VPC issued previously in March 2016.

The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #003 was assessed as incontinent of bladder and bowel. Review of the clinical record by the LTCH Inspector revealed there were no clinically appropriate bladder and bowel continence assessment instruments completed upon admission or any time thereafter. Interview with the RAI Coordinator revealed there was no clinically appropriate bladder or bowel assessment instrument completed at any time for resident #003. The RAI Coordinator confirmed it was the expectation of the home that a complete assessment of bladder and bowel continence, using the Bladder Continence Assessment tool, was to be completed for any resident who was assessed to be incontinent of bladder or bowel upon admission. Interview with the Assistant Director of Care confirmed there was no clinically appropriate bladder or bowel continence assessment instrument completed for resident #003 for the assessed bowel and bladder incontinence upon admission and any time thereafter. [s. 51. (2) (a)] (640)

2. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #002 was assessed during admission as continent of bladder and bowel. Review of the clinical record by the LTCH Inspector revealed a significant change and the resident had become incontinent. There was no clinically appropriate bladder assessment instrument completed for resident #002 related to this decline. Since the date of decline, there were no clinically appropriate assessment instruments completed. Interview with the RAI Coordinator revealed there was no clinically appropriate bladder assessment instrument completed with the change of status of resident #002 or at any time since the change in status. The RAI Coordinator confirmed it was the expectation of the home that a complete assessment of bladder continence, using the Ont - Bladder Continence Assessment was to be completed for any resident who was incontinent. Interview with the Assistant Director of Care confirmed there was no clinically appropriate assessment instrument completed for resident #002 related to the change in continence or any time after. [s. 51. (2) (a)] (640)

3. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #001 was assessed as incontinent of bladder and continent of bowel. Interview of RN #100 confirmed when a resident was admitted to the home and was incontinent, a clinically appropriate instrument specific to continence was to be completed in Point Click Care (PCC). Review of the clinical record by the Long Term Care Home (LTCH) Inspector revealed there was no clinically appropriate instrument for continence completed during the admission process for resident #001. Interview with the RAI Coordinator revealed there was no clinically appropriate instrument for continence completed upon admission of resident #001. The RAI Coordinator confirmed it was the expectation of the home that a complete assessment of bladder continence, using the Bladder Continence Assessment tool found in PCC, which was a clinically appropriate assessment tool, was to be completed for resident #001 upon admission. Interview with the Assistant Director of Care confirmed there was no clinically appropriate assessment instrument completed upon admission of resident #001. [s. 51. (2) (a)] (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 24, 2017

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 13th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

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