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 prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2016;	2015_264609_0059 (A1)	016215-15	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date has been updated to February 29, 2016.

Issued on this 22 day of January 2016 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 17, 18, 21, 22, 2015

This inspection was a result of a Critical Incident submission to the Director related to responsive behaviours.

Four other Critical Incident inspections were also completed concurrently related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), two Registered Nurses (RN), one Social Worker (SW), two Personal Support Workers (PSW) and one Housekeeper.

The inspector(s) also reviewed plans of care, clinical records, internal investigations, components of human resource files, the home's policies and procedures and training logs.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
4 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any potential behavioural triggers.

A Critical Incident Report (CI) was submitted to the Director which indicated that an identified resident had responsive behaviours towards another specified resident.

A review of the clinical record for the identified resident revealed multiple responsive behaviour episodes directed towards the specified resident.

An interview with registered staff revealed they knew the two residents proximity to each other was a trigger for responsive behaviours.

A review of the plan of care for the identified resident revealed no mention or any interventions to manage this established trigger.

An interview with the DOC confirmed that it was the expectation of the home that any potential behavioural triggers were identified in the plan of care, that in the case of the known responsive behaviours of the identified resident this did not occur and should have. [s. 26. (3) 5.]

2. A CI was submitted to the Director which indicated that an identified resident had responsive behaviours directed towards another specified resident.

A review of the clinical record revealed multiple episodes of responsive behaviour between the two residents.

An interview with registered staff revealed they knew that a responsive behaviour trigger for the identified resident was proximity to the specified resident.

A review of the plan of care for the identified resident revealed no mention or any interventions to managed this established trigger.

An interview with the DOC confirmed that it was the expectation of the home that any potential behavioural triggers were identified in the plan of care, that in the case of the known responsive behaviours of the identified resident this did not occur and should have.[s. 26. (3) 5.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs.

A CI was submitted to the Director which indicated that an identified resident had responsive behaviours directed towards a specified resident. The CI indicated that to prevent future incidents a specified intervention was to be utilized.

The CI occurred in the afternoon yet the specified intervention outlined in the plan of care was to be utilized in the nighttime only to protect the specified resident.

An interview with registered staff confirmed that it was the expectation of the home that the plan of care was based on the resident's needs, that in the case of the identified resident and the specified intervention to protect the resident this did not occur and should have. [s. 6. (2)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

a) A review of the plan of care for an identified resident revealed a specified intervention was to be performed by staff.

An interview with registered staff revealed that the specified intervention was being performed yet not documented as there was no task generated in the clinical record to enable staff to document that the specified intervention was completed.

A review of clinical record revealed no documentation that the specified intervention was performed by any staff member.

b) A review of the plan of care for an identified resident revealed that a specified intervention was to be completed by staff.

A review of the clinical record for an identified resident revealed no documentation that the specified intervention was performed by any staff member.

An interview with the DOC confirmed that it was the expectation of the home that the provision of care set out in the plan of care was to be documented, that in the case of the specified interventions cited this did not occur and should have. [s. 6. (9) 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 plan of care is based on an assessment of the resident and the resident's needs and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the long-term care home to have, institute or otherwise put in place any policy that the policy was complied with.

A CI was submitted to the Director which indicated that an identified resident had responsive behaviours directed towards another specified resident.

A second CI was submitted to the Director which alleged staff to resident physical abuse.

A review of the home's policy titled "Zero Tolerance for Abuse and Neglect" last revised September 14, 2015, indicated that staff were to conduct a head-to-toe physical assessment on the alleged victim and document findings if physical abuse was alleged.

A review of the clinical record for the two identified residents revealed no head-to-toe assessment was conducted by staff following the allegations of physical abuse.

An interview with the DOC confirmed that it was the expectation of the home that staff were to comply with the "Zero Tolerance for Abuse and Neglect" policy and conduct a head-to-toe assessment and document findings, that in the case of no head-to-toe physical assessments after the alleged and partially witnessed abuses towards two identified residents this did not occur and should have. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy on zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report was submitted to the Director four days after the allegations of abuse were known by the home.

An interview with the DOC revealed that all critical incidents were to be immediately reported by the RN in charge to the home's management in order to complete the reports to the Ministry and that this did not occur.

An interview with the DOC confirmed that it was the expectation of the home that abuse of a resident by anyone was to be immediately reported to the Director that in the case of the CI cited this did not occur and should have. [s. 24. (1)]

2. A Critical Incident Report (CI) was submitted to the Director 2.5 days after the allegations of abuse were known by the home.

An interview with the DOC revealed that all critical incidents were to be immediately reported by the RN in charge to the home's management in order to complete the reports to the Ministry and that this did not occur.

An interview with the DOC confirmed that it was the expectation of the home that abuse of a resident by anyone was to be immediately reported to the Director that in the case of the CI cited this did not occur and should have. [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 to ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including:

i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

A Critical Incident Report (CI) was submitted to the Director which implicated and verified abuse by staff towards an identified resident.

A review of the home's policy titled "Zero Tolerance for Abuse and Neglect" issue date September 14, 2015, revealed no mention of the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

A review of the Regulation was conducted with the DOC who confirmed that it was the expectation of the home to be in compliance with the Regulation that in the case of no mention of the training and retraining requirements for all staff on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care within the home's written policy, this did not occur and should have. [s. 96. (e) (i)]

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's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:

i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record relating to each annual evaluation of the responsive behaviour program that included:

• date of the evaluation
• names of the persons who participated
• summary of the changes made, and
• date that those changes were implemented.

A Critical Incident Report (CI) was submitted to the Director which indicated that an identified resident had responsive behaviour directed towards another specified resident.

The home was unable to provide a written record of the responsive behaviour program annual evaluation for the 2014 year.

An interview with the ADOC confirmed that to reflect the Regulation a responsive behaviour program annual written evaluation would be completed for the 2015 calendar year before December 31, 2015.

An interview with the DOC confirmed that monthly evaluations of responsive behaviours were performed by the home.

A review of the Regulation was conducted with the DOC who confirmed it was the expectation of the home that a written record of an annual evaluation of the responsive behaviours program should have been completed, that in the case of the 2014 annual written evaluation this did not occur and should have. [s. 53. (3) (c)]

Issued on this 22 day of January 2016 (A1)

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

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHAD CAMPS (609) - (A1)

Inspection No. / No de l'inspection : 2015_264609_0059 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 016215-15 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jan 22, 2016;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

LTC Home / Foyer de SLD : ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0

Ontario

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Ray Ingriselli

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To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

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

(A1)
The licensee shall:

1) Perform an audit of all residents of the home experiencing responsive behaviours to ensure that all potential behavioural triggers are identified in each of the resident s plan of care by January 29, 2016.

2) Maintain a record of the required audit that includes when the audit was completed, who performed the audit, what residents were identified in the audit as well as when and what interventions and changes to the plans of care were implemented.

3) Identify additional training and retraining needs of staff related to behavioural triggers to ensure behavioural triggers are clearly identified and documented in resident plans of care as well as maintain a record of the additional training and retraining and which staff completed the education.

Grounds / Motifs :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any potential behavioural triggers.

A Critical Incident Report (CI) was submitted to the Director which indicated that an identified resident had responsive behaviours towards another specified resident.

A review of the clinical record for the identified resident revealed multiple responsive behaviour episodes directed towards the specified resident.

An interview with registered staff revealed they knew the two residents proximity to each other was a trigger for responsive behaviours.

A review of the plan of care for the identified resident revealed no mention or any interventions to manage this established trigger.

An interview with the DOC confirmed that it was the expectation of the home that any potential behavioural triggers were identified in the plan of care, that in the case of the known responsive behaviours of the identified resident this did not occur and should have. [s. 26. (3) 5.] (609)

2. A second CI was submitted to the Director which indicated that an identified resident had responsive behaviours directed towards another specified resident.

A review of the clinical record revealed multiple episodes of responsive behaviour between the two residents.

An interview with registered staff revealed they knew that a responsive behaviour trigger for the identified resident was proximity to the specified resident.

A review of the plan of care for the identified resident revealed no mention or any interventions to manage this established trigger.

An interview with the DOC confirmed that it was the expectation of the home that any potential behavioural triggers were identified in the plan of care, that in the case of the known responsive behaviours of the identified resident this did not occur and should have.[s. 26. (3) 5.] (609)

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

Feb 29, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 22 day of January 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHAD CAMPS

Service Area Office /
Bureau régional de services : Sudbury