Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 2, 5, 6, 7, 9, 13, 14, 2012	2012_204133_0004	Critical Incident

Licensee/Titulaire de permis

THE ROYALE DEVELOPMENT LP
302 Town Centre Blvd, Suite 200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - MADONNA
1541 St. Joseph's Boulevard, Orleans, ON, K1C-7L3

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Resident Care Services, The Environmental Services Manager, the Physiotherapist, the Nursing Rehabilitation Coordinator, registered and non registered nursing staff.

During the course of the inspection, the inspector(s) reviewed documentation and inspection records related to lifting equipment, reviewed lift and transfer in-service attendance records for two personal support workers, reviewed resident's health care records, reviewed Lifts and Transfers policy #V3-850.

The on-site inspection occurred November 2,5,6, 2012

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to comply with s. 36 in that the licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

On a day in September 2012, as reported in a Critical Incident Report (CIR), resident #001 fell to the floor during a transfer from their bed to their wheelchair. It was reported in the CIR that the mechanical lift fell over on one side and the resident fell to the floor as a result.

At the time of the inspection, the Director of Resident Care Services (Director of R.C.S) informed the inspector that due to conflicting statements of the two staff members (#S100, #S101) who were involved in transferring resident #001, it had not been concluded if the lift had tipped over or not. The Director of R.C.S informed the inspector that her inquiry into the incident did reveal that resident #001 had fallen out of their transfer sling after making a sudden forward motion while positioned over the wheelchair and this appears to have occurred before the mechanical lift may or may not have tipped over.

The Director of R.C.S informed that two days following the incident, she interviewed the involved staff members (#S100, #S101) separately and they were asked to demonstrate their role in the transfer of resident #001. The Director of R.C.S informed that both staff members told her that they were the lift operator. As described by the Director of R.C.S, each staff member demonstrated how they applied the transfer sling to the resident, how they affixed the transfer sling to the spreader bar and how they manoeuvred the mechanical lift into place over resident #001s wheelchair. The Director of R.C.S informed that both staff members indicated to her that they had not crossed the sling legs straps prior to affixing the sling to the spreader bar. The Director of R.C.S informed that both staff members indicated to her that they had not opened the lift legs once resident #001 was in position over the wheelchair. The Director of R.C.S informed she was involved in the lift and transfer training that both staff members received in June 2012 and that they and all other staff are taught to cross the sling leg straps prior to affixing the sling to the spreader bar and to open the lift legs when a resident is in position over a wheelchair.

The home has a policy titled "lifts and transfers – resident care"(#V3-850). On page 6 of 10, staff involved in a transfer are directed to ensure that 2 staff persons are present, that one is designated to use the equipment and the other is designated to be the assistant. The assistant is directed to guide the resident in the sling. The Director of R.C.S explained that this means that the assistant should be hands on with the resident while the resident is in the transfer sling except for when they are, for example, positioning the receiver wheelchair into proper position. Neither of the staff persons involved in the incident indicated to the Director of R.C.S that they had physically supported resident #001 during the transfer process.

It was verified by the inspector that the mechanical sling lift and the transfer sling used to transfer resident #001 had not been found to be defective or unsafe following the incident and both were in use at the time of the inspection.

Resident #001 fell on their head when they fell out of the transfer sling and sustained injury as a result. The two staff members involved in the transfer failed to use safe transferring and positioning techniques when assisting resident #001 on a day in September 2012.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to comply with s. 44 in that the licensee has failed to ensure that devices, specifically 6 loop transfer slings, are readily available at the home to meet the nursing and personal care needs of residents.

On a day in September 2012, resident #001 fell out of a 4 loop hammock transfer sling while being transferred from their bed to their wheelchair. Eleven days later, resident #001 was reassessed by the home's physiotherapist who concluded that it would be safer to transfer resident #001 in a 6 loop hammock sling due to their physical condition. Twenty five days following this reassessment a 6 loop hammock sling was received by the home and put into use exclusively for resident #001. At the time of the inspection, this was the only 6 loop transfer sling in the home.

During the Critical Incident inspection, on November 2nd 2012, the inspector arrived onto resident #001s care unit at approximately 11:30am. Nursing staff informed the inspector that resident #001s 6 loop hammock sling was missing and therefore they had used a 4 loop hammock sling to transfer the resident from their bed to their wheelchair that morning.

During the Critical Incident inspection, on November 6th 2012, the inspector arrived onto resident #001s care unit at approximately 11:30am. The inspector noted that resident #001 was still in their bed. Nursing staff had been unable to locate resident #001s 6 loop hammock sling that morning and therefore had not transferred them out of their bed.

The Director of Resident Care Services ordered a second 6 loop hammock sling, for use with resident #001, during the inspection.

2. During the Critical Incident inspection the inspector was made aware that by October 22nd 2012 the home's physiotherapist had completed an undocumented re-assessement of all residents whom require the use of a full transfer sling during a mechanical lift transfer. This re-assessment was completed at the request of the Director of Care. The inspector was provided with a copy of a handwritten list titled "slings sizing for potential buyers". On this list there is the name of 10 current residents (#002-#011), followed by the style and size of sling they require. The physiotherapist assessed that it would be safer to transfer each of these residents in a 6 loop full sling as opposed to 4 loop full sling as is currently being used for them. It was explained to the inspector that following this re-assessment, families of these 10 residents (#002-#011) were contacted and asked if they would like to purchase a 6 loop transfer sling for the dedicated use of the resident and if they did not wish to do so the home would purchase slings for the shared use of residents who required them. While the home is not required to provide a dedicated transfer sling to each resident, transfer slings of a size and style deemed necessary for any/all residents must be made readily available at the home to meet the nursing and personal care needs of the residents, at no cost to the resident or to their family. At the time of the inspection, 6 loop transfer slings were not available for use with these 10 residents.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with s.107(4).1 in that an accurate description of the incident that lead to an injury in respect of which a resident was taken to hospital was not provided to the Director of the Ministry of Health and Long Term Care.

It was reported to the Director, in a Critical Incident Report (CIR), that two Personal Support Workers were transferring resident #001 from their bed to their wheelchair on a day in September 2012 and during that transfer the mechanical lift fell over on one side and the resident fell to the floor.

During the Critical Incident inspection the inspector learned that resident #001 had fallen out of the transfer sling they were in during the transfer. This was not reported to the Director in the CIR. The inspector also learned that the home's investigation had not concluded if the lift fell over or not due to the conflicting accounts of the incident from those involved and those who were on scene immediately following the incident.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with s. 17 (1)(c) in that the licensee has failed to ensure that the home is equipped with a resident staff communication and response system that allows calls to be cancelled only at the point of activation.

During the Critical Incident inspection, on November 2nd 2012, the inspector noted on one of the care units that calls originating from a resident's bedside could be cancelled by lifting up the phone receiver on the system console which is located on the desk at the nurse station. This action did not cancel calls originating from a resident's washroom or common areas. The home's Environmental Services Manager (ESM) informed the inspector this is how the system is set up throughout the home. The ESM removed the phone receiver from every system console within the home and it was verified that calls could not be cancelled by depressing the receiver button on the console.

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 the requirement that the resident staff communication and response system allows calls to be cancelled only at the point of activation., to be implemented voluntarily.

Issued on this 16th day of November, 2012

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

Jessica Lapensée

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

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2012_204133_0004
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Nov 2, 5, 6, 7, 9, 13, 14, 2012
Licensee / Titulaire de permis :	THE ROYALE DEVELOPMENT LP 302 Town Centre Blvd, Suite 200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - MADONNA 1541 St. Joseph's Boulevard, Orleans, ON, K1C-7L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSAN WENDT

To THE ROYALE DEVELOPMENT LP, 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee will ensure that all staff who are involved in transferring residents use safe transferring devices and/or techniques when assisting residents by ensuring that policy V3-850 "Lifts and Transfers – Resident Care" is fully implemented and complied with. This is to include documented re-education of all staff who are involved in transferring residents with a mechanical lift. This re-education will include a component whereby staff will demonstrate their ability to safely transfer a resident, as both the lift operator and the assistant, on any/all different styles of mechanical lifts and transfer slings that they may be required to use in the course of their duties. This re-education will include techniques to be used by staff to attach transfer sling leg straps to the spreader bar, which are dependent on a residents physical condition. The licensee will ensure that there are documented re-assessments of all residents who require the use of a mechanical lift that clearly specifies the most appropriate size and style of transfer sling, and method of sling leg strap attachment to the spreader bar that should be used by staff when transferring the resident. The licensee will ensure that all staff involved in transferring residents are made aware of any changes that may arise as a result of these re-assessments.

Grounds / Motifs :

1. The licensee has failed to comply with s. 36 in that the licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

On a day in September 2012, as reported in a Critical Incident Report (CIR), resident #001 fell to the floor during a transfer from their bed to their wheelchair. It was reported in the CIR that the mechanical lift fell over on one side and the resident fell to the floor as a result.

At the time of the inspection, the Director of Resident Care Services (Director of R.C.S) informed the inspector that due to conflicting statements of the two staff members (#S100, #S101) who were involved in transferring resident #001, it had not been concluded if the lift had tipped over or not. The Director of R.C.S informed the inspector that her inquiry into the incident did reveal that resident #001 had fallen out of their transfer sling after making a sudden forward motion while positioned over the wheelchair and this appears to have occurred before the mechanical lift may or may not have tipped over.

The Director of R.C.S informed that two days following the incident, she interviewed the involved staff members (#S100, #S101) separately and they were asked to demonstrate their role in the transfer of resident #001. The Director of R.C.S informed that both staff members told her that they were the lift operator. As described by the Director of R.C.S, each staff member demonstrated how they applied the transfer sling to the resident, how they affixed the transfer sling to the spreader bar and how they manoeuvred the mechanical lift into place over resident #001s wheelchair. The Director of R.C.S informed that both staff members indicated to her that they had not crossed the sling legs straps prior to affixing the sling to the spreader bar. The Director of R.C.S informed that both staff members indicated to her that they had not opened the lift legs once resident #001 was in position over the wheelchair. The Director of R.C.S informed she was involved in the lift and transfer training that both staff members received in June 2012 and that they and all other staff are taught to cross the sling leg straps prior to affixing the sling to the spreader bar and to open the lift legs when a resident is in position over a wheelchair.

The home has a policy titled "lifts and transfers – resident care"(#V3-850). On page 6 of 10, staff involved in a transfer are directed to ensure that 2 staff persons are present, that one is designated to use the equipment and the other is designated to be the assistant. The assistant is directed to guide the resident in the sling. The Director of R.C.S explained that this means that the assistant should be hands on with the resident while the resident is in the transfer sling except for when they are, for example, positioning the receiver wheelchair into proper position. Neither of the staff persons involved in the incident indicated to the Director of R.C.S that they had physically supported resident #001 during the transfer process.

It was verified by the inspector that the mechanical sling lift and the transfer sling used to transfer resident #001 had not been found to be defective or unsafe following the incident and both were in use at the time of the inspection.

Resident #001 fell on their head when they fell out of the transfer sling and sustained injury as a result. The two staff members involved in the transfer failed to use safe transferring and positioning techniques when assisting resident #001 on a day in September 2012. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2013

Order # /
Ordre no : 002

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Order / Ordre :

The licensee will ensure that 6 loop transfer slings are readily available at the home for use with residents who have been assessed to require one. This equipment will be made readily available at the home without charge to the resident or to their family.

Grounds / Motifs :

1. The licensee has failed to comply with s. 44 in that the licensee has failed to ensure that devices, specifically 6 loop transfer slings, are readily available at the home to meet the nursing and personal care needs of residents.

On a day in September 2012, resident #001 fell out of a 4 loop hammock transfer sling while being transferred from their bed to their wheelchair. Eleven days later, resident #001 was reassessed by the home's physiotherapist who concluded that it would be safer to transfer resident #001 in a 6 loop hammock sling due to their physical condition. Twenty five days following the reassessment, a 6 loop hammock sling was received by the home and put into use exclusively for resident #001. At the time of the inspection, this was the only 6 loop transfer sling in the home.

During the Critical Incident inspection, on November 2nd 2012, the inspector arrived onto resident #001s care unit at approximately 11:30am. Nursing staff informed the inspector that resident #001s 6 loop hammock sling was missing and therefore they had used a 4 loop hammock sling to transfer the resident from their bed to their wheelchair that morning.

During the Critical Incident inspection, on November 6th 2012, the inspector arrived onto resident #001s care unit at approximately 11:30am. The inspector noted that resident #001 was still in their bed. Nursing staff had been unable to locate resident #001s 6 loop hammock sling that morning and therefore had not transferred them out of their bed.

The Director of Resident Care Services ordered a second 6 loop hammock sling, for use with resident #001, during the inspection. (133)

2. During the Critical Incident inspection the inspector was made aware that by October 22nd 2012 the home's physiotherapist had completed an undocumented re-assessement of all residents whom require the use of a full transfer sling during a mechanical lift transfer. This re-assessment was completed at the request of the Director of Care. The inspector was provided with a copy of a handwritten list titled "slings sizing for potential buyers". On this list there is the name of 10 current residents (#002-#011), followed by the style and size of sling they require. The physiotherapist assessed that it would be safer to transfer each of these residents in a 6 loop full sling as opposed to 4 loop full sling as is currently being used for them. It was explained to the inspector that following this re-assessment, families of these 10 residents (#002-#011) were contacted and asked if they would like to purchase a 6 loop transfer sling for the dedicated use of the resident and if they did not wish to do so the home would purchase slings for the shared use of the residents who required them. While the home is not required to provide a dedicated transfer sling to each resident, transfer slings of a size and style deemed necessary for any/all residents must be made readily available at the home to meet the nursing and personal care needs of the residents, at no cost to the resident or to their family. At the time of the inspection, 6 loop transfer slings were not available for use with these 10 residents. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 07, 2012

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

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

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

Director

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.

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

Ministère de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075 rue Bay, 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 14th day of November, 2012

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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