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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2014	2014_163109_0025	T-881-14	Complaint

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1

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

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1

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

SUSAN SQUIRES (109)

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): July 15, 16, 17, 23, 2014.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), unit director, business partner human resources, personal support workers (PSW), family members, private care staff.

During the course of the inspection, the inspector(s) conducted a walk through of the identified care unit, observed the staff to resident interactions, reviewed the health records for the identified residents, reviewed the education records, reviewed the home's abuse policy.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Staff interview revealed that on more than one occasion, they have witnessed staff member A physically abusing resident #5 by pulling his/her arms behind his/her back in a restraining manner and forcing the resident to walk to his/her bedroom without the resident's consent.

Interview with the staff members who witnessed the abuse indicated that it was reported to the charge nurse. They described the actions of staff member A as abusive.

Record review and staff interview reveal the charge nurse did not report the abuse to the management which is the expectation in the home. The charge nurse had been previously reprimanded by the licensee for failing to report abuse of a resident. [s. 19. (1)]

2. The licensee failed to protect resident #4 from physical abuse by the staff in the home.

Record review and staff interview reveals resident #4 exhibits responsive behaviours and resists care daily. Staff interview reveal that staff must wait until the resident falls to sleep to quietly provide a specified care activity otherwise the resident becomes upset and aggressive with staff.

Staff interview revealed that on more than one occasion, resident #4 was physically abused by staff member A when the staff member pressed heavily on the cheeks of resident #4 to loosen his/her dentures posing a risk of injury to the resident.

Interview with other staff that witnessed this technique of removing this resident's dentures stated that it was abusive and that they felt uncomfortable with the manner in which the staff member was treating the resident. [s. 19. (1)]

3. The licensee failed to protect resident #2 from physical abuse by the staff in the home.

Record review and staff interview reveal resident #2 exhibits responsive behaviours during care. Staff interview revealed that on more than one occasion staff member A was witnessed to physically abuse this resident. Staff member A was observed to get on the bed with the resident and place his/her knee on the resident's hand to prevent the resident from punching him/her.

Staff interview revealed that on another occasion staff member A was observed to put his/her knee on the resident's leg in a forceful manner to prevent him/her from kicking him/her.
Staff members B, D and E that observed this abuse stated to inspector that they had observed this on more than one occasion. The staff members further informed the inspector that they believed the actions of staff member A constituted abuse and that the actions toward this resident by the accused staff member made them feel uncomfortable.

Staff member D told the inspector that he/she believed that resident #2 was afraid of staff member A and stated that he/she witnessed staff member A to be handling this resident roughly in the past. When the resident became tense and resisted care, staff member A aggressively shoved the resident to sit forward in the wheelchair when the resident was leaning back into the chair.

The staff members who witnessed the abusive episodes told the inspector that they believed the actions of staff member A to be abusive.

Two of the staff members told the inspector that it made them feel uncomfortable to watch staff member A handle the residents in this manner and staff member B told staff member A that they would not be doing those things to the resident when staff member A told them that the resident is tricky and had to be dealt with using his/her technique. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

Interview and record review revealed resident #5 was observed by more than one staff member to be physically abused by staff member D on more than one occasion. The PSW's that observed the abuse, reported the abuse to the charge nurse as per the home's policy. The home's staff failed to report the abuse to the Director. The charge nurse had been previously reprimanded by the licensee for failing to report abuse of a resident. [s. 24. (1)]

2. Resident #2 was physically abused by a staff member. The witnesses to the abuse reported their concerns to the charge nurse. The home's staff did not report it to the Director.

Staff member B told the inspector that he/she had reported their concerns to the charge nurse about the way staff member A had been handling the resident. The staff member indicated that nothing had been done about his/her concerns. Staff member B stated that he/she was new on the floor and the abusive employee was a full-time employee and believes that the full-time employees have more power. The employee added that he/she was extremely stressed about having come forward to discuss the abuse with the manager and the MOH inspector.

The Director had not been immediately informed of the allegation of abuse toward resident #2 and #5 until after the management received a letter on an identified date. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff receive retraining annually related to the duty to make mandatory reports under section 24 and the whistle-blowing protections.

Interview with staff members and review of education records indicate staff were not provided with training related to mandatory reporting and the whistle-blowing protections.

Review of core curriculum courses provided to the staff does not include training related to mandatory reporting and the whistle-blowing protections.

Two of the staff interviewed were not aware of what whistle-blowers protections meant when asked.
Two other staff members interviewed were not aware of what constituted mandatory reporting under section 24. [s. 76. (4)]

2. Interview with one staff member revealed that she/he did not receive re-training on the home's policy to promote zero tolerance of abuse and neglect of residents. The staff member stated that she/he had been given reading materials for this topic but had not reviewed them. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive retraining annually related to the duty to make mandatory reports under section 24 and the whistle-blowing protections, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff receive annual training, as a condition of continuing to have contact with residents, training in the areas of mental health issues, including caring for persons with dementia and behaviour management.

Interview with the DOC confirmed that the home is currently not compliant with the training requirements for dealing with residents with responsive behaviours.

The DOC stated that the home has not implemented the new training and that the staff had not been re-trained in the required areas. [s. 221. (2),s. 221. (2) 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 all direct care staff receive annual training, as a condition of continuing to have contact with residents, training in the areas of mental health issues, including caring for persons with dementia and behaviour management, to be implemented voluntarily.

Issued on this 3rd day of September, 2014

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

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) :	SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2014_163109_0025
Log No. / Registre no:	T-881-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 25, 2014
Licensee / Titulaire de permis :	THE JEWISH HOME FOR THE AGED 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
LTC Home / Foyer de SLD :	THE JEWISH HOME FOR THE AGED (2824) 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dr. William Reichman

To THE JEWISH HOME FOR THE AGED, 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

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that resident's #2 , #4 and #5 are protected from abuse by anyone.
The plan shall include, but not limited to;

Developing a process to monitor and evaluate the care being provided to the residents to ensure it is consistent with the plan of care, including ensuring at least two staff are present at all time to provide care to those residents who require 2 staff.

Ensuring that all staff are provided with re-training in the home's policy to promote zero tolerance of abuse and neglect of residents, mental health issues, including care for persons with dementia and behaviour management.

Please submit compliance plan to susan.squires@ontario.ca by September 3, 2014

Grounds / Motifs :

1. The licensee failed to protect resident #2 from physical abuse by the staff in the home.

Record review and staff interview reveal resident #2 exhibits responsive behaviours during care. Staff interview revealed that on more than one occasion staff member A was witnessed to physically abuse this resident. Staff member A was observed to get on the bed with the resident and place his/her knee on the resident's hand to prevent the resident from punching him/her.

Staff interview revealed that on another occasion staff member A was observed

to put his/her knee on the resident's leg in a forceful manner to prevent him/her from kicking staff member A.
Staff members B, D and E that observed this abuse stated to inspector that they had observed this on more than one occasion. The staff members further informed the inspector that they believed the actions of staff member A constituted abuse and that the actions toward this resident by the accused staff member made them feel uncomfortable.

Staff member D told the inspector that he/she believed that resident #2 was afraid of staff member A and stated that he/she witnessed staff member A to be handling this resident roughly in the past. When the resident became tense and resisted care, staff member A aggressively shoved the resident to sit forward in the wheelchair when the resident was leaning back into the chair.

The staff members who witnessed the abusive episodes told the inspector that they believed the actions of staff member A to be abusive.

Two of the staff members told the inspector that it made them feel uncomfortable to watch staff member A handle the residents in this manner and staff member B told staff member A that they would not be doing those things to the resident when staff member A told them that the resident is tricky and had to be dealt with using his/her technique.
(109)

2. The licensee failed to protect resident #4 from physical abuse by the staff in the home.

Record review and staff interview reveal resident #4 exhibits responsive behaviours and resists care daily. Staff interview reveal that staff must wait until the resident falls to sleep to quietly provide the specified care activity otherwise the resident becomes upset and aggressive with staff.

Staff interview revealed that on more than one occasion, resident #4 was physically abused by staff member A when the staff member pressed heavily on the cheeks of resident #4 to loosen his/her dentures posing a risk of injury to the resident.

Interview with other staff that witnessed this technique of removing this resident's dentures stated that it was abusive and that they felt uncomfortable

with the manner in which the staff member was treating the resident.
(109)

3. The licensee failed to protect resident #5 from physical abuse by a staff member.
On more than one occasion, staff members have witnessed a staff member physically abuse resident #5 by pulling the residents arms behind his/her back and forcing the resident to walk to their bedroom without the resident's consent. The staff members who witnessed the abuse reported it to the charge nurse. The charge nurse did not report the abuse to the management which is the expectation in the home.
(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan describing how the home will ensure that the person who has reasonable grounds to suspect that abuse of a resident by a staff that resulted in harm or risk of harm shall immediately reported the suspicion and the information upon which is was based to the Director.

Please submit plan to susan.squires@ontario.ca by September 3, 2014

Grounds / Motifs :

1. This non-compliance [s. 24.(1)] has been identified previously in the following inspections:
2014_102116_0018 conducted on May 1, 2014 - VPC
2011_084162_0018 conducted on November 22, 2011 - WN

Resident #2 was physically abused by a staff member. The witnesses to the abuse reported their concerns to the charge nurse. The home's staff did not report it to the Director.

Staff member B told the inspector that he/she had reported their concerns to the charge nurse about the way staff member A had been handling the resident. The staff member indicated that nothing had been done about his/her concerns. Staff member B stated that he/she was new on the floor and the abusive employee was a full-time employee and believes that the full-time employees have more power. The employee added that he/she was extremely stressed about having come forward to discuss the abuse with the manager and the MOH inspector.

The Director had not been immediately informed of the allegation of abuse toward resident #2 and #5 until after the management received a letter on an identified date.
(109)

2. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by a staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which is was based to the Director.

Interview and record review revealed resident #5 was observed by more than one staff member to be physically abused by staff member A on more than one occasion. The PSW's that observed the abuse, reported the abuse to the charge nurse as per the home's policy. The home's staff failed to report the abuse to the Director. The charge nurse had been previously reprimanded by the licensee for failing to report abuse of a resident.
(109)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

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
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN SQUIRES

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