Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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130 avenue Dufferin 4ème étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2016	2016_326569_0005	003681-16	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE ON MARY BUCKE
4 MARY BUCKE STREET ST. THOMAS ON N5R 5J6

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

DONNA TIERNEY (569), ALI NASSER (523), ALICIA MARLATT (590), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 16, 17, 18, 19, 23, 24, 25, and 26, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Resident Assessment Instrument Minimum Data Set Co-ordinator (RAI MDS), the Activity Director, the Ward Clerk, 3 Registered Nurses (RN), 5 Registered Practical Nurses (RPN), 6 Personal Support/Health Care Aide workers (PSW), family members, and over 40 residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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. 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) A review of the home's policy "Pain Assessment" with a revision date of May 2015 revealed that pain assessments are to be completed for residents who are assessed as having pain. It also indicated that the Caressant Care Pain Assessment tool should be used for those pain assessments.

Review of the clinical record for 2 identified residents revealed assessments in which the residents were noted to be experiencing pain were documented on two occasions. There was no documented evidence found of further pain assessments completed for these residents using the Caressant Care Pain Assessment Tool on Point Click Care(PCC). This was verified by the Director of Nursing(DON) #100 and the RAI Coordinator #102.

Review of the Pain Management Program Annual Assessment, dated October 15, 2015 showed that the pain management flow sheets for monitoring pain were not being used.

Interview with DON #100 on February 23, 2016 confirmed the expectation that Pain Assessments and the Pain Management Flow Sheets were to be completed in Point Click Care as per the home's policy. (537)

B) A clinical record review for an identified resident revealed there was an increase in the resident's pain frequency and intensity from the previous quarterly assessment. There was no documented evidence found of any other pain assessments completed for this resident.

Interview with RAI Coordinator #102 verified that the assessment indicated that the resident had an increase in pain frequency and intensity, the Caressant Care Pain Assessment Tool was not completed, and the Pain Management Flow Sheet was not completed. Staff #102 confirmed that the home's policy was not complied with.

Interview with DON #100 confirmed the expectation that pain assessments and the Pain Management Flow Sheets were to be completed in PCC as per the home's policy. (523) [s. 8. (1) (a),s. 8. (1) (b)] (537)

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

A review of the Medical Pharmacies policy 6-6 "Shift Change Monitored Drug Count" dated January 2014 revealed the following:
"3. This Shift Count is a means to regularly audit the monitored medication for accuracy. Report any discrepancies to the Director of Care (or delegate) immediately."

A clinical record review revealed that on several different occasions, a registered staff member documented missing medication for an identified resident.

An Interview with DON #100 on February 26, 2016 verified that she was not aware of the missing medication for the resident and that the registered staff did not follow the policy of reporting medication count discrepancies as per the policy.

DON #100 confirmed the expectation that the staff would comply with the home's policies. [s. 8. (1) (b)] (523)

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. Clinical record review for an identified resident revealed that the plan of care directed staff to provide a specific care task within a specified time frame.

Observations of the resident revealed that the specific care task was not provided to the resident.

An interview with Personal Support Worker(PSW) #115 revealed that they did not check the Kardex on a regular basis. They confirmed that the specific care task was not provided to the resident as specified in the Kardex.

An interview with DON #100 and registered staff #102 revealed that the identified resident gets very agitated when the specific care task is not provided within the specified time frame. They confirmed that the resident's care was not provided as specified in the plan. [s. 6. (7)] (523)

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

Clinical record review for a specific resident revealed that the treatment for wounds included daily checks and were to be signed off as completed on the Treatment Assessment Record (TAR). Further review revealed that four daily checks were not signed off as completed on the TAR.

Interview with DON #100 and RPN #101 on February 24, 2016 confirmed the four days of missing documentation and were unable to confirm if the resident's wounds were checked on those days. [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 care set out in the plan of care is provided to the resident as specified in the plan, and that the provision of care is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the organized required program of pain management was interdisciplinary, and included an evaluation of the program and a summary of the changes made and the date that those changes were implemented.

A review of the Pain Management program binder revealed a Registered Nurse (RN) and the Director of Nursing (DON) had completed the annual evaluation. There were no action plans documented for concerns identified in the evaluation, and there were no dates for when the changes were implemented.

An interview with DON #100 revealed that the home's pain management program consisted of the DON and an RN. The DON confirmed that there were no other staff or disciplines involved in the pain management program.

A record review of the October 5, 2015 pain program evaluation with DON #100 identified that the pain management flow sheets were not being used, the use of the pain assessment tool needed improvements, no interventions were documented to address these identified concerns in the areas for improvements, and there were no dates for the implementation of changes made to the program.

DON #100 confirmed the home's required pain program was not fully implemented. [s. 30. (1)] (523)

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 required program of pain management is an interdisciplinary program, and that there is a written description of the program, and to keep a written record relating to each evaluation under paragraph 3 that includes the summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

A review of the Pixalere wound management system for an identified resident revealed that the resident had a skin lesion in a specified area. A clinical record review of the resident's progress notes indicated that they had sustained additional skin lesions which required treatment. Further review of the Pixalere wound management system failed to identify the additional skin lesions for the resident.

An Interview with Registered Practical Nurse (RPN) #101 confirmed that the resident's additional skin lesions were not added to the Pixalere wound management system, and those wounds were not being assessed by the registered staff every seven days.

An interview with DON #100 and (RPN) #101 confirmed the expectations that new wounds be added to the wound management system and that wounds be assessed every seven days. [s. 50. (2)(b)(iv)] (523)

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident in the home related to a missing or unaccounted for controlled substance no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A clinical record review of an identified resident's progress notes revealed documentation entered by a registered staff of missing controlled substances on seven different occasions.

A review of the Critical Incident system as of March 1, 2016 revealed no reports submitted by the home regarding the missing controlled substances.

An interview with DON #100 confirmed that no critical incident reports were completed and submitted to the Director for the missing controlled substances. [s. 107. (3) 3.] (523)

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 Director is informed of critical incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) related to a missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs.

An interview with an identified resident revealed that they were upset that their personal health complaints were discussed in an open non private area.

Interview with Registered Nurse (RN) #107 on February 23, 2016 confirmed that this resident's personal health issues were discussed in an open area.

Interview with DON #100 on February 19, 2016 revealed that the home had not fully respected and promoted the resident's right to be afforded privacy in treatment and in caring for their personal needs. [s. 3. (1) 8.] (569)

Issued on this 13th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DONNA TIERNEY (569), ALI NASSER (523), ALICIA MARLATT (590), NANCY SINCLAIR (537)
Inspection No. / No de l'inspection :	2016_326569_0005
Log No. / Registre no:	003681-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 13, 2016
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ON MARY BUCKE 4 MARY BUCKE STREET, ST. THOMAS, ON, N5R-5J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kori Amon

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must take immediate action to achieve compliance with O.Reg 79/10, s.8.(1) (b).

The licensee must ensure that the home's policy "Pain Assessment" is complied with, including but not limited to the following:
1. For any resident who is assessed as having pain
2. When a resident indicates pain is present

The home must also ensure that all direct care staff receive education related to the policy.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) A review of the home's policy "Pain Assessment" with a revision date of May 2015 revealed that pain assessments are to be completed for residents who are assessed as having pain. It also indicated that the Caressant Care Pain Assessment tool should be used for those pain assessments.

Review of the clinical record for 2 identified residents revealed assessments in which the residents were noted to be experiencing pain were documented on two occasions. There was no documented evidence found of further pain

assessments completed for these residents using the Caressant Care Pain Assessment Tool on Point Click Care(PCC). This was verified by the Director of Nursing(DON) #100 and the RAI Coordinator #102.

Review of the Pain Management Program Annual Assessment, dated October 15, 2015 showed that the pain management flow sheets for monitoring pain were not being used.

Interview with DON #100 on February 23, 2016 confirmed the expectation that Pain Assessments and the Pain Management Flow Sheets were to be completed in Point Click Care as per the home's policy. (537)

B) A clinical record review for an identified resident revealed there was an increase in the resident's pain frequency and intensity from the previous quarterly assessment. There was no documented evidence found of any other pain assessments completed for this resident.

Interview with RAI Coordinator #102 verified that the assessment indicated that the resident had an increase in pain frequency and intensity, the Caressant Care Pain Assessment Tool was not completed, and the Pain Management Flow Sheet was not completed. Staff #102 confirmed that the home's policy was not complied with.

Interview with DON #100 confirmed the expectation that pain assessments and the Pain Management Flow Sheets were to be completed in PCC as per the home's policy. (523) [s. 8. (1) (a),s. 8. (1) (b)] (537)

The scope of this issue was determined to be a pattern. The severity of the issue was determined to be a level 2 with minimal harm or potential for actual harm to a resident. The home did have a history of non-compliance with this sub-section of the regulation. It was previously issued as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection (RQI) on June 15, 2015, inspection number 2015_355588_0015, related to the pain policy not being followed. It was also issued as a VPC on August 1, 2012, inspection number 202_090172_0040 related to the pain policy not being followed. (537)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 18, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 13th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Donna Tierney

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