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

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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
May 21, 2013	2013_200148_0018	O-000296-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

CARLINGVIEW MANOR
2330 CARLING AVENUE, OTTAWA, ON, K2B-7H1

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

AMANDA NIXON (148), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 3 and 6, 2013, on site.

This inspection relates to two Critical Incidents reported to the Director by the home.

During the course of the inspection, the inspector(s) spoke with the Interim Director of Care (IDOC), Executive Director Assistant (EDA), a Clinical Manager, a Registered Practical Nurse (RPN), Recreation Staff member and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the resident health care record, the Critical Incident Reports, the home's investigation notes (as provided by the home) related to both incidents and the home's policy related to restraints.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 :

The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s. 19 (1), in that the licensee did not ensure that Resident #001 was protected from abuse by anyone.

Incident #1:
On a specified date, during the evening shift, Staff member #S101 observed Resident #001 to be confined inside the resident's bedroom. Staff member #S101 reported the observation to Staff member #S102 and to Staff member #S105. Later that same evening, Staff member #S102 observed Resident #001 to be confined inside the resident's bedroom. Staff member #S102 released the restraint, allowing the resident to leave the room and began to question staff on the unit. Staff member #S102 discovered that Staff member #S103, confined the resident inside the bedroom, with the assistance of Staff member #S104, because the resident was being disruptive. Sometime after this, Staff member #S102 reported the incident to a supervisory Staff member #S107. The incident was then later reported to the home's IDOC who instructed Staff member #S102 and #S107 to conduct initial interviews of staff members on the unit.

The IDOC and EDA reported to the LTCH Inspectors, that immediately following Incident #1, Clinical Managers and Registered Nursing Supervisors were informed of the incident and instructed to conduct increased monitoring on the specified unit. The IDOC and EDA reported that they did not actively disseminate information related to the incident to all staff, as it was felt it may compromise the investigation.

Staff members #103, #104 and #101 were disciplined by the home for their respective actions in the incident. The IDOC reported to the LTCH Inspectors that there is an intention to take action with Staff member #102.

During the investigation, lead by the IDOC into Incident #1, an interview with Staff member #S105, stated that the occurrence of confining Resident #001 in the bedroom, had been done on a previous date, approximately 1 week earlier. Staff members providing care on one or both dates included, Staff member #103, #104, #105 and Staff member #S106. The IDOC reported to the LTCH Inspectors that the intention was to interview Staff member #106 on a later date.

Incident #2:
On a separate specified date, during the evening shift, the EDA found a restraint tied to Resident #001's bedroom door. The EDA began to question Staff Member #106

who admitted to the EDA that Resident #001 is confined to the resident's bedroom because of behaviours. On the same date, Staff member #106 was removed from the floor, the police force and Power of Attorney for Resident #001 were contacted. In addition, the EDA and Clinical Manager Staff member #108 provided immediate education for all staff on the evening and night shift. The education included a review of the incident, resident abuse and appropriate approaches to resident behaviours.

Staff member #S106 was disciplined by the home for actions related to this incident.

The licensee did not ensure that Resident #001 was protected from emotional abuse as defined by O.Reg 79/10 s.2(1) as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. This is evidenced by the following:

- Incident #1, indicates that Resident #001 was observed to be confined to the resident's bedroom. Staff members who were informed that the resident was locked in the bedroom, did not take appropriate action at this time to release the resident from the room.

- Incident #1, indicates that action was not taken to ensure the safety of other residents after Staff member #S102 discovered that both staff members #103 and #104 were involved in confining Resident #001 inside the resident's bedroom and both staff members continued to provide care on the floor, potentially putting resident's at risk to similar practices.

- Immediately following Incident #1, Clinical Managers and Registered Nursing Supervisors were informed of the incident and instructed to conduct increased monitoring on the specified unit. Between the dates of Incident #1 and Incident #2, the home did not ensure that all staff working on the specified unit were provided with clear directions to ensure that all staff were aware that to confine a resident inside their bedroom is considered abuse and to cease this practice immediately.

- During the investigation into Incident #1, the IDOC identified staff members who were potentially involved with an incident occurring approximately 1 week prior to Incident #1, by which Resident #001 was confined to the resident's bedroom. The IDOC reported to the inspector that staff members involved in Incident #1 were asked

if they had witnessed the resident being confined in the past, but did not pursue the investigation any further.

- Staff member #106 was not immediately available for questioning following Incident #1, after it was discovered that a previous incident had occurred approximately 1 week prior. Staff member #S106 was scheduled and provided care on the specified unit for two shifts prior to the intended interview date. During the second scheduled shift Staff member #106 admitted to confining Resident #001 to the resident's room. On the next day, Staff member #106 was interviewed by the Executive Director related to the incidents. [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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s.23(1)(b), in that the licensee did not ensure that appropriate action was taken in response to an incident of abuse.

Incident #1:
On a specified date, during the evening shift, Staff member #S101 observed Resident #001 to be confined inside the resident's bedroom. Staff member #S101 reported the observation to Staff member #S102 and to Staff member #S105. Later that same evening, Staff member #S102 observed Resident #001 to be confined inside the resident's bedroom. Staff member #S102 released the restraint, allowing the resident to leave the room and began to question staff on the unit. Staff member #S102 discovered that Staff member #S103, confined the resident inside the bedroom, with the assistance of Staff member #S104, because the resident was being disruptive. Sometime after this, Staff member #S102 reported the incident to a supervisory Staff member #S107. The incident was then later reported to the home's IDOC who instructed Staff member #S102 and #S107 to conduct initial interviews of staff members on the unit.

The IDOC and EDA reported to the LTCH Inspectors, that immediately following Incident #1, Clinical Managers and Registered Nursing Supervisors were informed of the incident and instructed to conduct increased monitoring on the specified unit. The IDOC and EDA reported that they did not actively disseminate information related to the incident to all staff, as it was felt it may compromise the investigation.

Staff members #103, #104 and #101 were disciplined by the home for their respective actions in the incident. The IDOC reported to the LTCH Inspectors that there is an intention to take action with Staff member #102.

During the investigation, lead by the IDOC into Incident #1, an interview with Staff member #S105, stated that the occurrence of confining Resident #001 in the bedroom, had been done on a previous date, approximately 1 week earlier. Staff members providing care on one or both dates included, Staff member #103, #104, #105 and Staff member #S106. The IDOC reported to the LTCH Inspectors that the intention was to interview Staff member #106 on a later date.

Incident #2:
On a separate specified date, during the evening shift, the EDA found a restraint tied

to Resident #001's bedroom door. The EDA began to question Staff Member #106 who admitted to the EDA that Resident #001 is confined to the resident's bedroom because of behaviours. On the same date, Staff member #106 was removed from the floor, the police force and Power of Attorney for Resident #001 were contacted. In addition, the EDA and Clinical Manager Staff member #108 provided immediate education for all staff on the evening and night shift. The education included a review of the incident, resident abuse and appropriate approaches to resident behaviours.

Staff member #S106 was disciplined by the home for actions related to this incident.

The licensee did not ensure that appropriate action was taken in response to the incident of abuse involving Resident #001, as evidenced by the following:

- Incident #1, indicates that Resident #001 was observed to be confined to the resident's bedroom. Staff members who were informed that the resident was locked in the bedroom, did not take appropriate action at this time to release the resident from the room.

- On April 4, 2013, Resident #001 was observed to be confined to his room by Staff member #S102. Appropriate action was not taken, in that Staff member #S102 did not report the incident to the supervisor in the building until sometime after the observation. In addition, action was not taken to ensure the safety of other residents after Staff member #S102 discovered that both staff members #103 and #104 were involved in confining Resident #001 inside the resident's bedroom and both staff members continued to provide care on the floor, potentially putting resident's at risk to similar practices.

- Staff member #106 was not immediately available for questioning following Incident #1, after it was discovered that a previous incident had occurred approximately 1 week prior. Staff member #S106 was scheduled and provided care on the specified unit for two shifts prior to the intended interview date. During the second scheduled shift Staff member #106 admitted to confining Resident #001 to the resident's room. On the next day, Staff member #106 was interviewed by the Executive Director related to the incidents.

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 appropriate action is taken in response to every incident of abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.97 (1)(b), in that the licensee did not ensure that Resident #001's substitute decision-maker were notified within 12 hours upon the licensee becoming aware of a witnessed incident of abuse of the resident.

An incident of abuse occurred on a specified date, in which Resident #001 was confined to the resident's bedroom.

According to the Critical Incident Report submitted to the Director and as reported by the IDOC to the LTCH Inspectors, the substitute decision-maker for Resident #001 was notified the following day of the incident of abuse and not within 12 hours upon the licensee becoming aware of the witnessed incident of abuse. [s. 97. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.98, in that licensee did not ensure that the appropriate police force was immediately notified of a witnessed incident of abuse of a Resident #001, that the licensee suspects may constitute a criminal offence.

An incident of abuse occurred on a specified date, in which Resident #001 was confined to the resident's bedroom.

According to the Critical Incident Report submitted to the Director and as reported by the IDOC to the LTCH Inspectors, the police force was notified the following day of the incident of abuse and not immediately at the time of the incident. [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 112 in that the licensee did not ensure that a device that cannot be immediately released by staff was not used in the home.

An incident of abuse occurred on a specified date, in which Resident #001 was confined to the resident's bedroom using an item as a restraint that cannot be immediately released.

Issued on this 22nd day of May, 2013

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

Amanda Wu RO LTCH 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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2013_200148_0018
Log No. / Registre no:	O-000296-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 21, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	CARLINGVIEW MANOR 2330 CARLING AVENUE, OTTAWA, ON, K2B-7H1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHY DROUIN

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 ensure that Resident #001 is protected from abuse in that Resident #001 is not confined to the resident's bedroom with a prohibited device.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s. 19 (1), in that the licensee did not ensure that Resident #001 was protected from abuse by anyone.

Incident #1:
On a specified date, during the evening shift, Staff member #S101 observed Resident #001 to be confined inside the resident's bedroom. Staff member #S101 reported the observation to Staff member #S102 and to Staff member #S105. Later that same evening, Staff member #S102 observed Resident #001 to be confined inside the resident's bedroom. Staff member #S102 released the restraint, allowing the resident to leave the room and began to question staff on the unit. Staff member #S102 discovered that Staff member #S103, confined the resident inside the bedroom, with the assistance of Staff member #S104, because the resident was being disruptive. Sometime after this, Staff member #S102 reported the incident to a supervisory Staff member #S107. The incident was then later reported to the home's IDOC who instructed Staff member #S102 and #S107 to conduct initial interviews of staff members on the unit.

The IDOC and EDA reported to the LTCH Inspectors, that immediately following Incident #1, Clinical Managers and Registered Nursing Supervisors were informed of the incident and instructed to conduct increased monitoring on the

specified unit. The IDOC and EDA reported that they did not actively disseminate information related to the incident to all staff, as it was felt it may compromise the investigation.

Staff members #103, #104 and #101 were disciplined by the home for their respective actions in the incident. The IDOC reported to the LTCH Inspectors that there is an intention to take action with Staff member #102.

During the investigation, lead by the IDOC into Incident #1, an interview with Staff member #S105, stated that the occurrence of confining Resident #001 in the bedroom, had been done on a previous date, approximately 1 week earlier. Staff members providing care on one or both dates included, Staff member #103, #104, #105 and Staff member #S106. The IDOC reported to the LTCH Inspectors that the intention was to interview Staff member #106 on a later date.

Incident #2:
On a separate specified date, during the evening shift, the EDA found a restraint tied to Resident #001's bedroom door. The EDA began to question Staff Member #106 who admitted to the EDA that Resident #001 is confined to the resident's bedroom because of behaviours. On the same date, Staff member #106 was removed from the floor, the police force and Power of Attorney for Resident #001 were contacted. In addition, the EDA and Clinical Manager Staff member #108 provided immediate education for all staff on the evening and night shift. The education included a review of the incident, resident abuse and appropriate approaches to resident behaviours.

Staff member #S106 was disciplined by the home for actions related to this incident.

The licensee did not ensure that Resident #001 was protected from emotional abuse as defined by O.Reg 79/10 s.2(1) as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. This is evidenced by the following:

- Incident #1, indicates that Resident #001 was observed to be confined to the resident's bedroom. Staff members who were informed that the resident was

locked in the bedroom, did not take appropriate action at this time to release the resident from the room.

- Incident #1, indicates that action was not taken to ensure the safety of other residents after Staff member #S102 discovered that both staff members #103 and #104 were involved in confining Resident #001 inside the resident's bedroom and both staff members continued to provide care on the floor, potentially putting resident's at risk to similar practices.

- Immediately following Incident #1, Clinical Managers and Registered Nursing Supervisors were informed of the incident and instructed to conduct increased monitoring on the specified unit. Between the dates of Incident #1 and Incident #2, the home did not ensure that all staff working on the specified unit were provided with clear directions to ensure that all staff were aware that to confine a resident inside their bedroom is considered abuse and to cease this practice immediately.

- During the investigation into Incident #1, the IDOC identified staff members who were potentially involved with an incident occurring approximately 1 week prior to Incident #1, by which Resident #001 was confined to the resident's bedroom. The IDOC reported to the inspector that staff members involved in Incident #1 were asked if they had witnessed the resident being confined in the past, but did not pursue the investigation any further.

- Staff member #106 was not immediately available for questioning following Incident #1, after it was discovered that a previous incident had occurred approximately 1 week prior. Staff member #S106 was scheduled and provided care on the specified unit for two shifts prior to the intended interview date. During the second scheduled shift Staff member #106 admitted to confining Resident #001 to the resident's room. On the next day, Staff member #106 was interviewed by the Executive Director related to the incidents. [s. 19. (1)] (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 21, 2013

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

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

and the 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.

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.

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

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
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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 21st day of May, 2013

Signature of Inspector / Signature de l'inspecteur : Amanda Nix AD LTCH Inspector

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

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