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 soins de longue durée

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

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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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
Feb 22, 2017	2016_572627_0028	006109-16, 007696-16, 009739-16, 018891-16, 019239-16, 025614-16, 028392-16, 029974-16, 032033-16, 032034-16	Critical Incident System

Licensee/Titulaire de permis

FINLANDIA NURSING HOME LIMITED
c/o Sudbury Finnish Rest Home 233 Fourth Avenue SUDBURY ON P3B 4C3

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

FINLANDIA HOIVAKOTI NURSING HOME LIMITED
233 FOURTH AVENUE SUDBURY ON P3B 4C3

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

SYLVIE BYRNES (627), SYLVIE LAVICTOIRE (603)

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): December 5-9, 2016.

This Critical Incident System inspection was related to:
Six Critical Incident reports submitted to the Director related to resident to resident sexual abuse;
One Critical Incident report submitted to the Director related to resident to resident physical abuse;
Four Critical Incident reports submitted to the Director related to staff to resident abuse and neglect.

A Follow-Up inspection, #2016_572627_0030, and a Complaint inspection, #2016_572627_0029, were conducted concurrently. Please refer to Follow-Up inspection, #2016_572627_0030 for additional findings of non compliance.

The Inspector(s) conducted a daily walk through resident areas, observed the provision of care towards residents, observed staff to resident interactions, resident to resident interactions, reviewed residents' health care records, staff training records, policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #603 reviewed a Critical Incident (CI) report which was submitted to the Director. A review of the CI report, by the Inspector, indicated that two residents had a physical altercation. The CI was reported 12 hours and 49 minutes after the occurrence.

A review, by the Inspector, of the home's policy titled "Resident Abuse and Neglect - Zero Tolerance" ID-20, indicated that "A person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it was based to the Director (MOHLTC): 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".

The Inspector interviewed the Director of Care (DOC) who revealed that the home had not reported the incident immediately. The DOC explained that the staff had been trained to report any suspected abuse immediately and knew that if an incident had occurred after hours, the staff was to call the Ministry of Health and Long Term Care

(MOHLTC)'s pager. [s. 24. (1)]

2. Inspector #603 reviewed a CI report submitted to the Director, which alleged staff to resident abuse/neglect. The CI was reported 16 hours and 44 minutes after the occurrence.

A review of the home's policy titled, "Resident Abuse and Neglect - Zero Tolerance" ID-20, indicated that, "A person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (MOHLTC): 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".

During an interview with the Inspector, the DOC explained that all staff had been trained to report any suspected abuse immediately and knew that if an incident had occurred after hours, the staff were to call the MOHLTC's pager.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Two CI reports were submitted to the Director alleging resident to resident sexual abuse between resident #003 and #002.

Inspector #627 reviewed the home's current policy titled, "Prevention and Treatment of Responsive Behaviour", #68 NM-S-9. The policy indicated that PSWs/staff members were to report responsive/inappropriate behaviours. When a resident was observed displaying a responsive behaviour, the staff were to complete antecedent behaviour chart (ABC) and dememtia observational system (DOS) forms and analyze each incident to prevent further incidents in the future. If all available interventions had been utilized and failed and the residents behaviour escalated to the point that staff and residents were in imminent risk of harm, the policy directed the staff to ensure safety of all involved, and to notify the medical Doctor (MD) immediately to discuss potential transfer to Behavioural Support Ontario/Emergency Room (BSO/ER) psychiatric evaluation.

The Inspector reviewed resident #003's care plan in effect at the time of the inspection and noted a focus for responsive behaviours.

A review by the Inspector of resident #003's health care records failed to reveal any completed DOS or ABC forms.

A review, by the Inspector, of the progress notes for resident#003 revealed numerous occasions of responsive behaviours toward staff and residents.

During an Interview with the Inspector, the ADOC stated that DOS and ABC forms had not been completed. They further agreed that a particular type of behaviour was inappropriate. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy titled "Prevention and Treatment of Responsive Behaviour" #68 NM-S-9, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included: assessments, reassessments, interventions, and that the resident's responses to interventions were documented.

Inspector #603 reviewed a CI report which was submitted to the Director. A review of the CI report indicated that RPN #104 heard a resident yelling. The RPN entered resident #005's room and observed a physical altercation between resident #006 and #005.

The Inspector reviewed resident #006's health care record which identified that the resident had a specific amount of documented incidents of physical aggression prior to the CI. On a specific date, resident #006 exhibited responsive behaviours towards another resident. At a later date, resident #006 was seen exhibiting responsive behaviours towards another resident. With each incident, resident #006 was separated and redirected.

According to the health record, the last BSO assessment was completed on a certain date, one year prior to the incidents. Their recommendations were included in the care plan, under the focus of a specific type of responsive behaviours. No further updates were completed for this focus.

The Inspector reviewed the home's policy titled, "Prevention and Treatment of Responsive Behaviour" #68 NM-S-9. The policy indicated that when a resident displaying responsive behaviour was observed, the staff were to complete ABC and DOS forms and analyze each incident to prevent further incidents in the future. If all available interventions had been utilized and failed and the residents behaviour escalated to the point that staff and residents were in imminent risk of harm, the policy directed the staff to ensure safety of all involved, and to notify the Medical Doctor (MD) immediately to discuss potential transfer to BSO/Emergency Room (ER)/psychiatric evaluation.

A review of the plan of care for resident #006 revealed that there were no further assessment or Antecedent-Behavior-Consequence (ABC) and Dementia Observational System (DOS) forms completed, nor were there any new interventions put in place.

During an interview with the Inspector, the ADOC stated that there was no further assessment or DOS forms completed after each of the three incidents. They further stated that the staff continued to follow the previous BSO recommendations from one year prior to the incident. [s. 53. (4) (c)]

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 when resident #006 exhibits responsive behaviours, assessments, reassessments, interventions are completed and the resident's response to the interventions are documented, to be implemented voluntarily.

WN #4: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home had received training as required.

The Long-Term Care Homes Act, 2007, defined staff, in relationship to a long term care home, to mean persons who worked at the home (b) pursuant to a contract or agreement with the licensee. Ontario Regulations 79/10 (O.Reg.79/10), section (s.) 222 (1) (b) (c) listed the training exemptions for staff who only provided occasional maintenance or repair services to the home and had not provided direct care to residents. O.Reg. 79/10 s. 222 (2) directed the licensee to ensure that the persons described in clauses (1) (a) to (c) were provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services.

A CI report was submitted to the Director alleging that a contract worker was involved in an incident which involved a resident. The resident suffered no injury.

A review, by Inspector #627, of the policy titled "Orientation Program" revealed the following:
Contract workers:
The training requirements for those who are not direct employees and will not provide direct care to residents must receive the following information before providing their services:
• Resident Bill of Rights
• Resident Abuse Policy
• Mandatory Reports Section 24
• Whistle Blowing Policy
• Fire Prevention and Safety
• Emergency and Evacuation
• Infection prevention and control: hand hygiene, modes of infection transmission, cleaning and disinfecting practices and use of personal protective equipment.

During an interview with the Inspector, the DOC confirmed that the contract worker had not been provided with the required information prior to providing services to Finlandia Village. [s. 76. (2)]

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 contract workers who only provide occasional services and do not provide direct patient care be provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services, to be implemented voluntarily.

Issued on this 24th day of February, 2017

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_572627_0028
Log No. / Registre no:	006109-16, 007696-16, 009739-16, 018891-16, 019239-16, 025614-16, 028392-16, 029974-16, 032033-16, 032034-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 22, 2017
Licensee / Titulaire de permis :	FINLANDIA NURSING HOME LIMITED c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, SUDBURY, ON, P3B-4C3
LTC Home / Foyer de SLD :	FINLANDIA HOIVAKOTI NURSING HOME LIMITED 233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Harvey

To FINLANDIA NURSING HOME 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

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. 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 ensure that a person who has reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #603 reviewed a CI report which was submitted to the Director. A review of the CI report indicated that two residents had a physical altercation. The CI was reported 12 hours and 49 minutes after the occurrence.

A review, by the Inspector, of the home's policy titled "Resident Abuse and Neglect - Zero Tolerance" ID-20, indicated that "A person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it was

based to the Director (MOHLTC): 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".

The Inspector interviewed the Director of Care (DOC) who revealed that the home had not reported the incident immediately. The DOC explained that the staff had been trained to report any suspected abuse immediately and knew that if an incident had occurred after hours, the staff was to call the Ministry of Health and Long Term Care (MOHLTC)'s pager.
(603)

2. Inspector #603 reviewed a Critical Incident (CI) report, submitted to the Director, which alleged staff to resident abuse/neglect. The CI was reported 16 hours and 44 minutes after the occurrence.

A review of the home's policy titled, "Resident Abuse and Neglect - Zero Tolerance" ID-20, indicated that, "A person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (MOHLTC): 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".

During an interview with the Inspector, the DOC explained that all staff had been trained to report any suspected abuse immediately and knew that if an incident had occurred after hours, the staff were to call the MOHLTC's pager.

The decision to issue this compliance order was based on the scope which was identified as isolated, the severity which indicated the potential for harm, and the compliance history which despite previous non-compliance issued, a Voluntary Plan of Correction (VPC) during inspection 2015_391603_0009 and inspection 2014_283544_0034, non-compliance continued with this section of the legislation.
(603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2017

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
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 soins 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 soins 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 22nd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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