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

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347 Preston St Suite 420
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347 rue Preston bureau 420
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2016	2016_285126_0014	020570-16, 020453-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

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): July 14, 15,19 an 20, 2016

Two critical incidents were inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and several residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 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. The licensee had failed to protect resident # 002, # 003 and # 004 from sexual abuse by resident #001.

On July 14, 2016 an inspection began for two critical incidents for an allegation of resident to resident sexual abuse involving resident # 001 in each incident.

On a specified date in July 2016, Personal Support Worker (PSW) #105 observed resident #001 touching resident #002 inappropriately while he/she was sitting in the dinning room. Resident # 002 was very angry and upset with resident #001's advances.

Two days later, resident #001 was observed by PSW #107 to be beside resident #003 and was exhibiting inappropriate sexual behaviours.

O. Reg 2. (1) (b), sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Inspector #126 reviewed resident # 001's health care record. Resident # 001 was admitted to the home a specified date in 2015 with several diagnoses including cognitive impairment . Resident #001's progress notes were reviewed and reflected multiple incidents of inappropriate sexual behaviours such as making sexual comments towards PSWs and exhibiting inappropriate sexual behaviors directed towards three residents. These incidents were documented in resident # 001's progress notes as follows:

On a specific date in June 2016, resident #004 and resident #001 were found lying in the bed of resident #001 engaged in sexual activity. Registered Practical Nurse (RPN) #100 was notified and arrived on the unit after the incident was resolved and both residents were separated. RPN #100 notified the Charge Nurse(CN) #101, who then notified the Assistant Director Of Care (ADOC) who was the Manager on call that evening. On that day, both residents were put on Q.15 minutes check. Resident #004's health care record was reviewed. Resident # 004 was admitted on a specified date in 2015 with several diagnoses including cognitive impairment.

Five days later, there is documentation that the Q.15 minutes checks for resident # 001 was discontinued as per the ADOC.

On a specified date in July 2016, when returning after toileting another resident, Personal Support Worker (PSW) #102 observed resident #001 touching resident # 004 inappropriately.

Three days later, PSW #105 observed resident #001 touching resident #002 inappropriately. Resident # 002 became very angry and upset. PSW #105 notified RPN #103. Behavior mapping was initiated, a medication was administered with effect and the physician was notified. On that day, a new medication was prescribed and a referral to a specialized outside resources was completed. Resident #002's health care record was reviewed. Resident #002 was admitted to the home on a specified day in 2016, with several diagnoses including cognitive impairment.

The following day, resident #001 continued exhibiting inappropriate sexual behaviours. Behavior mapping was on going.

The next day, resident #001 was observed by PSW #107 to be beside resident #003 and was exhibiting inappropriate sexual behaviours. PSW #107 notified RPN #106, who notified CN #101 and the on-call manager. The on-call Manager for that evening was the Administrator who authorized 1:1 and resident #001 was started on Q.15 minutes checks. Resident #003's health care record was reviewed. Resident #003 was admitted to the home on a specified date in 2013 with several diagnoses including cognitive impairment.

On July 14, 2016 discussion was held with the Administrator and the DOC, who indicated that resident #001 was administered the new medication and was transferred to another unit. The Administrator indicated that resident #001 had been on 1:1 and Q.15 minutes checks since the last incident in July 2016 when she was contacted.

On July 15, 2016, discussion was held with the DOC who indicated that when she discussed the incident of June 2016 with the ADOC, the incident was managed internally as per decision tree and was not reported as they felt that it was consensual by residents' response of not reacting negatively to the incident. At the time of inspection the ADOC was no longer available for an interview.

On July 15, 2016, Inspector #126 interviewed RPN #103 who indicated that resident #001's inappropriate sexual behaviours were escalating. The inspector went to the unit and it was observed that resident #001's sitter was not on the unit. Resident #001 was observed to be sleeping soundly in his/her bed. PSW #102 indicated that PSW #108 (sitter) was not there and PSW #102 was covering the unit. Discussion was held with the Administrator who indicated that she was informed by the nurse that the sitter was not at the resident bedside and that she had already spoken to the sitter to reinforce that resident # 001 cannot be without supervision. The Administrator indicated that she would

talk to staff to reinforce the sitter's and nurse's responsibility and that resident # 001 should not be left alone under any circumstances. The Administrator also indicated that 1:1 would be maintained until resident # 001's sexual behavior is no longer present.

On a specified date of the inspection, Inspector #126 interviewed PSW #109 who indicated that resident # 001 exhibited inappropriate sexual behaviours toward him/her. PSW #109 indicated that resident #001 did not exhibit inappropriate sexual behavior toward residents on that shift.

The next day, Inspector #126 reviewed the progress notes of resident #001 to ensure no further incident occurred in the last 24 hours. It was documented in the progress notes written the day before by RPN #110 on the day shift, that resident #001 did not have any inappropriate sexual behaviors when in fact, PSW #109 reported different information to Inspector #126. Discussion was held with the Administrator who indicated that she was going to have a discussion with RPN #110 and that she was going to ensure that all nurses obtain an updated assessment of resident # 001 before completing the documentation at the end of each shift. The Administrator indicated that a progress notes was going to be added in resident # 001's health care record to reflect the behavior of specified date.

The licensee failed to comply with:
1. LTCHA 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: 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. (refer to WN #002)

2. O. Reg 79/10 .r. 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. (refer to WN # 003) [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 has failed to ensure that the person who had reasonable grounds to suspect that sexual abuse occurred, immediately reported the suspicion to the Director.

On a specified date in June 2016, resident #004 and resident # 001 were found lying in bed together. Both residents were engaged in sexual activity. Registered Practical Nurse (RPN) #100 notified Charge Nurse (CN) #101. On July 20, 2016, Inspector #126 held a discussion with CN#101 who indicated that she notified the Manager on call that day. The Assistant Director Of Care (ADOC) was the Manager on call for that day, was informed of incident and did not immediately notify the Director under the Long Term Care Home ACT (LTCHA). Inspector # 126 was not able to interview the ADOC as she was no longer working in the Home

On specified date in July 2016, Personal Support Worker (PSW) #102, observed resident # 001 touching resident #004 inappropriately. PSW #102 reported the incident to RPN #103,who then reported the incident to CN # 104. On July 20, 2016, Inspector #126 held a discussion with CN# 104 who indicated that she notified the Manager on call that day and believed it was the Director of Care (DOC) . On August 9, 2016, discussion was held with the Director of Care who indicated that she was not notified of the incident of July 2016 and became aware of the incident by reviewing the progress notes when Inspector # 126 was in the home for the inspection related to sexual abuse. The Director under the LTCHA was not immediately informed of the incident of abuse.

Both incidents of abuse were not reported to the Director under the LTCHA as per legislative requirements. [s. 24. (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 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: 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., to be implemented voluntarily.

WN #3: 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 has failed to ensure that appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse.

On a specified date in June and July 2016, incidents of alleged sexual abuse occurred between resident # 001 and resident #004. These incidents were not reported to the appropriate police force. [s. 98.]

Issued on this 9th day of August, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2016_285126_0014
Log No. / Registre no:	020570-16, 020453-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 22, 2016
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	GARDEN TERRACE 100 Aird Place, KANATA, ON, K2L-4H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Schyf

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, 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) (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 for achieving compliance with LTCHA, 2007, S.19 (1) to ensure all residents are protected from sexual abuse from resident #001.

The licensee shall ensure the plan includes:
1) Immediately implementing interventions to protect all residents from sexual abuse from resident #001.
2) Developing a monitoring process to ensure that the above are effective and clearly communicated to all members of the health care team.
3) Provision that any person who had reasonable ground to suspect abuse of a resident that resulted in harm or risk of harm immediately reports the suspicion to the Director.
4) Notifying immediately the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.
5) Education to all staff to ensure clear understanding of the meaning of consent in relation to sexual activity between residents, especially if these residents have cognitive impairment.
6) Identifying who is responsible for ensuring completion of each item above.

This plan must be submitted in writing by August 5, 2016

Grounds / Motifs :

1. 1. The licensee had failed to protect resident # 002, # 003 and # 004 from sexual abuse by resident #001.

On July 14, 2016 an inspection began for two critical incidents for an allegation

of resident to resident sexual abuse involving resident # 001 in each incident.

On a specified date in July 2016, Personal Support Worker (PSW) #105 observed resident #001 touching resident #002 inappropriately while he/she was sitting in the dinning room. Resident # 002 was very angry and upset with resident #001's advances.

Two days later, resident #001 was observed by PSW #107 to be beside resident #003 and was exhibiting inappropriate sexual behaviours.

O. Reg 2. (1) (b), sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Inspector #126 reviewed resident # 001's health care record. Resident # 001 was admitted to the home a specified date in 2015 with several diagnoses including cognitive impairment . Resident #001's progress notes were reviewed and reflected multiple incidents of inappropriate sexual behaviours such as making sexual comments towards PSWs and exhibiting inappropriate sexual behaviours directed towards three residents. These incidents were documented in resident # 001's progress notes as follows:

On a specific date in June 2016, resident #004 and resident #001 were found lying in the bed of resident #001 engaged in sexual activity. Registered Practical Nurse (RPN) #100 was notified and arrived on the unit after the incident was resolved and both residents were separated. RPN #100 notified the Charge Nurse(CN) #101, who then notified the Assistant Director Of Care (ADOC) who was the Manager on call that evening. On that day, both residents were put on Q.15 minutes check. Resident #004's health care record was reviewed. Resident # 004 was admitted on a specified date in 2015 with several diagnoses including cognitive impairment.

Five days later, there is documentation that the Q.15 minutes checks for resident # 001 was discontinued as per the ADOC.

On a specified date in July 2016, when returning after toileting another resident, Personal Support Worker (PSW) #102 observed resident #001 touching resident # 004 inappropriately.

Three days later, PSW #105 observed resident #001 touching resident #002 inappropriately. Resident # 002 became very angry and upset. PSW #105 notified RPN #103. Behaviour mapping was initiated, a medication was administered with effect and the physician was notified. On that day, a new medication was prescribed and a referral to a specialized outside resources was completed. Resident #002's health care record was reviewed. Resident #002 was admitted to the home on a specified day in 2016, with several diagnoses including cognitive impairment.

The following day, resident #001 continued exhibiting inappropriate sexual behaviours. Behaviour mapping was on going.

The next day, resident #001 was observed by PSW #107 to be beside resident #003 and was exhibiting inappropriate sexual behaviours. PSW #107 notified RPN #106, who notified CN #101 and the on-call manager. The on-call Manager for that evening was the Administrator who authorized 1:1 and resident #001 was started on Q.15 minutes checks. Resident #003's health care record was reviewed. Resident #003 was admitted to the home on a specified date in 2013 with several diagnoses including cognitive impairment.

On July 14, 2016 discussion was held with the Administrator and the DOC, who indicated that resident #001 was administered the new medication and was transferred to another unit. The Administrator indicated that resident #001 had been on 1:1 and Q.15 minutes checks since the last incident in July 2016 when she was contacted.

On July 15, 2016, discussion was held with the DOC who indicated that when she discussed the incident of June 2016 with the ADOC, the incident was managed internally as per decision tree and was not reported as they felt that it was consensual by residents' response of not reacting negatively to the incident. At the time of inspection the ADOC was no longer available for an interview.

On July 15, 2016, Inspector #126 interviewed RPN #103 who indicated that resident #001's inappropriate sexual behaviours were escalating. The inspector went to the unit and it was observed that resident #001's sitter was not on the unit. Resident #001 was observed to be sleeping soundly in his/her bed. PSW #102 indicated that PSW #108 (sitter) was not there and PSW #102 was covering the unit. Discussion was held with the Administrator who indicated that she was informed by the nurse that the sitter was not at the resident bedside

and that she had already spoken to the sitter to reinforce that resident # 001 cannot be without supervision. The Administrator indicated that she would talk to staff to reinforce the sitter's and nurse's responsibility and that resident # 001 should not be left alone under any circumstances. The Administrator also indicated that 1:1 would be maintained until resident # 001's sexual behaviour is no longer present.

On a specified date of the inspection, Inspector #126 interviewed PSW #109 who indicated that resident # 001 exhibited inappropriate sexual behaviours toward him/her. PSW #109 indicated that resident #001 did not exhibit inappropriate sexual behaviour toward residents on that shift.

The next day, Inspector #126 reviewed the progress notes of resident #001 to ensure no further incident occurred in the last 24 hours. It was documented in the progress notes written the day before by RPN #110 on the day shift, that resident #001 did not have any inappropriate sexual behaviours when in fact, PSW #109 reported different information to Inspector #126. Discussion was held with the Administrator who indicated that she was going to have a discussion with RPN #110 and that she was going to ensure that all nurses obtain an updated assessment of resident # 001 before completing the documentation at the end of each shift. The Administrator indicated that a progress notes was going to be added in resident # 001's health care record to reflect the behaviour of specified date

The licensee failed to comply with:
1. LTCHA 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: 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. (refer to WN #002)

2. O. Reg 79/10 .r. 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. (refer to WN # 003)

The decision to issue an Order is based on the scope of several incidents occurring in a short period and the potential risk of harm of the residents. At the time of the inspection, interventions were in place but resident was continuing

exhibiting inappropriate sexual behaviours. (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 03, 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 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 July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

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