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
Sep 10, 2013	2013_031194_0031	000302-13,000664-13	Critical Incident System

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0

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

HYLAND CREST
6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): August 26 & 27, 2013

During the course of this inspection 2 critical incident inspections were completed, Log #000302-13 and Log #000664-13.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care(ADOC), Registered Nursing staff, Personal Support Staff, House keeping staff and Resident

During the course of the inspection, the inspector(s) Reviewed the clinical health records of three residents, licensee's policy on "Falls Prevention Management","Abuse and Neglect" and "Head Injury", two Critical Incident reports, Internal incident reports and observed the staff/resident provision of care

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. Log #000664-13

The written plan of care for resident #2 does not:
-set out planned care for the sexual behaviour witnessed on an identified date
-provide goals to ensure the safety of other residents in the home
-set out clear direction to staff and others who provide care, related to the management of the sexual behaviour exhibited by resident #2

Resident #2 is a cognitively well resident. Resident #3 is a cognitively impaired resident.

-On an identified date, resident #2 demonstrated inappropriate sexual behaviour towards resident #3 this was witnessed by staff #108. Staff #108 stated that for the remainder of the day and the next day, resident #2's behaviour continued towards resident #3. This was reported to RN #3 who stated that the staff would watch the resident more closely.
-The next day resident #2 was witnessed by RN #2 inappropriately touching resident #3 while in an unsupervised area. The direct care staff were given verbal direction to monitor resident #2.
-A note was left for the DOC by RN #2 that evening advising her of the incident that had occurred between resident #2 and resident #3. The RN's note stated that resident #2 sexual behaviour towards resident #3 had been a constant for the past 2 evenings. The RN#2 said nothing to resident #2 after the incident with resident #3.
-The DOC placed restrictions on resident #2 within the home. Staff were to be aware of resident's whereabouts and document on hourly check record.
-Hourly check record for resident #2 was incomplete for several time frames.
-RPN #2 was unclear about restrictions for resident #2 when interviewed.
-The RAI MDS for resident #2 dated after the incident does not identify the sexual behaviour witnessed.
-The current written plan of care for resident #2 did not set out planned care or clear direction to staff and others on how to manage the resident's sexual behaviour. [s. 6. (1)]

2. Log #000604-13

The Licensee failed to comply with LTCHA, 2007 s.6(9)2 when resident #2's hourly monitoring was not documented.

The DOC left directions for the staff to monitor and document the whereabouts of resident #2 following the incident.

Safety Check Record for resident #2 had numerous incomplete entries. [s. 6. (9) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 ensuring provision of the care set out in the plan of care for resident #2 related to hourly monitoring is documented, to be implemented voluntarily.

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. Log #000302-13

The licensee failed to comply with LTCHA 2007, s.8(1) (b) when the licensee's policy for falls management was not complied with

As per legislative requirements O.Reg s.48(1)1 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury

Review of the licensee's Fall Prevention & Management policy # VII-G-60.00 dated May 2012 directs staff to;
-conduct the falls risk assessment in Point Click Care (PCC) at the following times;
-within 24 hours of admission
-ensure that preventative interventions are included in the resident's care plan
-monitor the preventative interventions and evaluate effectiveness on an ongoing basis and with the quarterly review
-initiate a head injury routine if a head injury is suspected, or if the resident's fall is un-witnessed and he/she is on anticoagulants
-Monitor Head Injury Routine (HIR) for 48 hours post fall for signs of neurological changes.(see HIR policy VII-G-10.22)
-complete falls incident report.

Licensee's Policy for "Head Injury" VII-G-1-.22 dated May 2013 directs;
All un-witnessed resident falls will be assessed for a potential head injury.
Note: Following an un-witnessed fall and subsequent assessments, if the resident has sustained no injuries and the resident's level of consciousness and vital signs are within the resident's normal limits, repeat assessment of the resident's level of consciousness, blood pressure, pulse, respiration and pupillary reaction within 30 minutes and again at 60 minutes. If normal for the resident, the HIR does not have to completed.

Review of the clinical health record for resident #7 indicates that the resident fell 6 times in 12 days.

-there was no evidence of an admission falls assessment completed on Point Click Care(PCC)

-there was no preventative interventions included in the resident's written plan of care
-there was no monitoring of the preventative interventions and evaluation of effectiveness on an ongoing basis.
-there were 4 falls incident reports completed for 6 documented falls.
-there was no HIR initiated for the 5 un-witnessed falls. [s. 8. (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 ensuring that the licensee's policy "Falls Prevention and Management" is complied with, to be implemented voluntarily.

WN #3: 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. Log #000664-13

The licensee failed to comply with LTCHA s.24 (1) when the RN #2 witnessed an incident of abuse and did not report immediately to the Director

DOC has confirmed that the RN #2 did not immediately contact MOHLTC to report abuse.
DOC submitted the Critical Incident Report the next day. [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 ensuring that the Director is immediately notified when abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Log #000302-13

The licensee failed to comply with O.Reg s.49(2) when resident #7 was not assessed post fall with an appropriate assessment instrument that is specifically designed for falls.

The resident experienced 6 falls in 12 days. No post fall assessment was completed for two identified falls.[s. 49. (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 ensuring that when a resident has fallen a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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. Log #000664-13

The licensee failed to comply with LTCHA, 2007 s.19(1)when resident #3 was not protected from abuse.

Resident #2 is a cognitively well resident. Resident #3 is a cognitively impaired resident.

-On an identified date, resident #2 demonstrated inappropriate sexual behaviour towards resident #3 this was witnessed by staff #108. Staff #108 stated that for the remainder of the day and the next day, resident #2 sexual behaviour towards resident #3 continued. This was reported to RN #3 who stated that the staff would watch the resident#2 more closely.
-The next day resident #2 was witnessed by RN #2 inappropriate touching resident #3 while in an unsupervised area. The direct care staff were given verbal direction to monitor resident #2.
-A note was left for the DOC by RN #2 that evening advising her of the incident that had occurred between resident #2 and resident #3. The RN's note stated that resident #2 sexual behaviour towards resident #3 had been a constant for the past 2 evenings. The RN said nothing to resident #2 after the incident with resident #3.
-The DOC placed restrictions on resident #2 within the home. Staff were to be aware of resident's whereabouts and document on hourly check record.
-Hourly check record for resident #2 was incomplete for several time frames.
-RPN #2 was unclear about restrictions for resident #2 when interviewed.

The Director was not immediate notified of the abuse. An immediate investigation into the abuse was not initiated.
The DOC notified police and MOHLTC and initiated investigation the following day.

The licensee failed to protect resident #3 from abuse when interventions to monitor resident #2 were not initiated earlier. The staff were aware and did not address resident #2's inappropriate sexual behaviour. [s. 19. (1)]

WN #6: 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Log #000664-13

The licensee failed to comply with LTCHA s.23 (1)(a) when the RN #2 did not immediately commence an investigation after a witnessed incident of abuse.

-DOC has confirmed that the RN #2 did not immediately commence an investigation into the abuse.
-DOC has confirmed that RN #2 has received education in mandatory reporting requirements and abuse training.
-DOC stated that she started investigation the following day when she became aware and notified police. [s. 23. (1) (a)]

2. The licensee failed to comply with LTCHA s.23 (2) when the results of the abuse investigation were not reported to the Director

The DOC confirmed that the results of the investigation for the incident between resident #2 and resident #3 for abuse has not been reported to the Director. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. Log #000302-13

The licensee failed to comply with O. Reg s.24(3)(b) when the plan of care for resident #7 did not set out clear directions to staff for the prevention of falls.

Resident #7 was admitted to the home for a respite stay. Resident #7 sustained 6 falls over a 12 day period. The 24 hour admission care plan, identifies that the resident was at risk for falls, related to unsteady gait, but no clear direction for staff was provided to care for the resident's risk of falls. [s. 24. (3)]

2. Log #000302-13

The licensee failed to comply with O. Reg s.24(9)(c)when the plan of care for resident # 7 was not revised when the care set out in the plan was not effective.

The written plan of care for resident # 7 reviewed (24 hour admission plan of care) identified that resident was at risk for falls and had an unsteady gait. There were no identified interventions on the admission written plan of care.

The resident had 6 falls in 12 days. The plan of care for resident #7 was not revised after the first and second fall. After another two falls, interventions were put into place, but the resident had another two falls. [s. 24. (9)]

Issued on this 17th day of September, 2013

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

Chantal Lafreniere (194)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2013_031194_0031
Log No. / Registre no:	000302-13,000664-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 10, 2013
Licensee / Titulaire de permis :	HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	HYLAND CREST 6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Varouj Eskedjian

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

To HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION, 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. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the written plan of care for resident #2
-sets out planned care for the sexual behaviour witnessed .
-provides goals to ensure the safety of other residents in the home
-sets out clear direction to staff and other who provide care related, to the management of the sexual behaviour exhibited by resident #2

Grounds / Motifs :

1. Resident #2 is a cognitively well resident. Resident #3 is a cognitively impaired resident.

-On an identified date, resident #2 demonstrated inappropriate sexual behaviour towards resident #3 this was witnessed by staff #108. Staff #108 stated that for the remainder of the day and the next day, resident #2's behaviour continued towards resident #3. This was reported to RN #3 who stated that the staff would watch the resident more closely.
-The next day resident #2 was witnessed by RN #2 inappropriately touching resident #3 while in an unsupervised area. The direct care staff were given verbal direction to monitor resident #2.
-A note was left for the DOC by RN #2 that evening advising her of the incident that had occurred between resident #2 and resident #3. The RN's note stated that resident #2 sexual behaviour towards resident #3 had been a constant for the past 2 evenings. The RN#2 said nothing to resident #2 after the incident with resident #3.
-The DOC placed restrictions on resident #2 within the home. Staff were to be aware of resident's whereabouts and document on hourly check record.
-Hourly check record for resident #2 was incomplete for several time frames.
-RPN #2 was unclear about restrictions for resident #2 when interviewed. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Sep 18, 2013~~ September 30/2013.
Chantal Lafreniere

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
Toronto (Ontario) M5S 2T5

Directeur
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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 10th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Chantal Lafreniere (194)

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

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