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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Apr 27, 2016	2016_293554_0002 (A1)	013853-15	Follow up

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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE R. R. #5 PETERBOROUGH ON K9J 6X6

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

KELLY BURNS (554) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Section 184 of O. Reg. 79/10 was rescinded following further discussion with the Licensee

Issued on this 27 day of April 2016 (A1)

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

Ontario

Ministry of Health and Long-Term Care

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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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 18-21, 2016

Intake #013853-15 was inspected upon concurrently with Intakes #025411-15, and #01889-16

Summary of Intakes:
1) Intake #013853-15 - this intake was a Follow Up, specific to LTCHA, 2007, s. 19 (1), every licensee shall protect residents from abuse by anyone. This was a compliance order (CO #001) issued during the 2015 Resident Quality Inspection, which had a compliance due date of September 25, 2015.
2) Intake #025411-15 - relates to a Critical Incident Report; incident of resident to resident sexual abuse of Resident #002, by Resident #001.
3) Intake #001889-16 - related to a complaint, regarding a bed refusal and withdrawal of approval for admission of Applicant #005.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Office Manager, Nutritional Care Manager, Environmental Services Manager, Housekeeping Aide, representative of the Central East Community Care Access Centre, Family, and Residents.

During the course of the inspection, the inspector toured the home, reviewed clinical health records, observed resident to resident interactions, observed staff to resident interactions, reviewed CE-CCAC application of a specific applicant, reviewed home specific policies relating to Zero Tolerance of Abuse and Neglect of Residents, Managing Responsive Behaviours, Caring for a Physically Aggressive Abusive Resident, and Behaviour Assessment Tool.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_293554_0008	554

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to the resident as specified in the plan, specifically as it relates to the safe-guarding of Resident #002.

Related to Intake #025411-15, for Resident #002:

Resident #002 has a history that includes, cognitive impairment. Resident #002 is dependent on staff for all activities of daily living.

Resident #001 has a history that includes, cognitive impairment; he/she is able to move about the home freely with the aid of a mobility device. Resident #001 has a history of exhibiting specific responsive behaviours. Personal Support Workers, Registered Nursing Staff, Director of Care and the Physician, all indicated, Resident #001 has some understanding of right and wrong.

A progress note, for a specific date, details an incident in which Resident #002 was inappropriately touched (non-consensual) by Resident #001. Details of this incident are as follows:

- Resident #001 was observed by staff sitting in his/her wheelchair beside Resident #002 in the lounge, near the main dining room. Resident #001 was observed inappropriately touching Resident #002. There was no documented harm to Resident #002 as a result of this incident; the interaction between the two residents was non-consensual.

The clinical health record for both Resident #002 and Resident #001, indicates that the incident which occurred on a specific date, was the fourth incident (in four months) in which Resident #002 had been inappropriately (non-consensual) touched by Resident #001. (Note: the incidents which occurred prior to the identified date, related to resident to resident abuse, were inspected upon and are identified within another inspection and served to the licensee on February 09, 2016)

The plan of care reviewed, for a period of approximately three months, for Resident #002, specifically directs the following:

- Resident #002 is not to be in the vicinity of Resident #001. Resident #002 is to be placed at the opposite end of the dining room, away from Resident #001. Staff to ensure Resident #002 and Resident #001 are not seated close to each other and are not to enter any common areas together.

Registered Practical Nurse #013, Registered Nurse-Charge Nurse #012 indicated that Resident #002 was provided care, on a specific shift, and on a specific date, by Personal

Support Workers, and was placed in a wheelchair out in the hallway. Both registered nursing staff were unclear as to how Resident #002 got from the hallway to the lounge area.

Registered Nursing Staff (#012 and #013) indicated that Resident #002 was not to be placed unattended in the hallways or in any common area, due to past incidents with Resident #001; and that all staff have been directed to take Resident #002 from his/her room to the dining room or common areas providing constant observation to ensure resident is safe from Resident #001.

Director of Care indicated that staff (PSWs) had placed Resident #002 in the hallway unattended, indicating this was not to be the practice, for Resident #002. Director of Care indicted that it is believed, that a co-resident may have taken Resident #002 to the lounge.

2. The plan of care reviewed, for a period of approximately three months, for Resident #001, specifically directs the following:

- Resident #001 is to be seated with his/her back to co-resident (Resident #002) while in the dining room, in order to prevent Resident #001 from observing Resident #002 and possibly creating any potential interactions between the two residents.

During the dates of this inspection, Resident #001 was observed to not be seated in his/her assigned seat in the dining room, and was observed seated at the dining room table on two occasions facing Resident #002.

Personal Support Worker, Registered Practical Nurse and the Nutritional Care indicated (to the inspector) Resident #001 has an assigned seat in the dining room and he/she is to sit with his/her back to Resident #002. Personal Worker and Nutritional Care Manager indicated often Resident #001 does not sit in his/her assigned seat at the table, as seating is dependent on which resident arrives to the table first. Nutritional Care Manager indicated staff do not redirect residents to their assigned seating in the dining room, as it (staff action) may cause a resident to have (exhibit) a responsive behaviour.

The Director of Care indicated (to the inspector) that it is an expectation that all staff followed the individualized plan of care for residents. Director of Care indicated that during incident (described above) staff were not following the planned care, which was in place to ensure the safety of the Resident #002.

Therefore, the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, which intern, placed Resident #002, a vulnerable and cognitively impaired resident, at risk of potential harm by Resident #001. [s. 6. (7)]

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. 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 failed to comply with O. Reg. 79/10, s. 53 (4) (c), by not ensuring 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.

Related to Intake #025411-15, for Resident #001:

According to the clinical health record, Resident #001 has a history that includes cognitive impairment.

Nursing Staff (personal support workers, registered nursing staff) Director of Care, Administrator and the Physician, all indicated that Resident does have some cognitive

impairment, but does for the most part, know the difference between right and wrong. Nursing Staff, Director of Care and the Administrator indicated Resident #001 continues to exhibit challenging responsive behaviours.

The interventions, included in the plan of care, for times when Resident #001 was exhibiting a responsive behaviour included, telling the resident his/her comments were inappropriate; attempting to distract with conversations; retract and re-approach; call resident's spouse; monitor resident's behaviour; place on DOS; determine trigger of the responsive behaviour; and as needed medications for a specific responsive behaviour.

Progress notes reviewed for a four month period, details thirty-two incidents of Resident #001 exhibiting specific responsive behaviours towards residents and staff. The health record reviewed fails to provide consistent documentation, by registered nursing staff, as to the interventions implemented or the actions taken, by staff, when Resident #001 was exhibiting a responsive behaviour; nor does the documentation consistently provide Resident #001's response to interventions.

Personal Support Worker #014, Registered Nursing Staff (RN #11, 12 and RPN #13), as well as the Director of Care, all indicated that interventions planned were rarely effective; registered nursing staff indicated that it was often difficult to divert Resident #001's attention when he/she exhibited a responsive behaviour.

The plan of care (including physician's orders, progress notes and care plan) reviewed, for the period indicated, fail to provide documentation to support that when resident #001 was exhibiting responsive behaviours and when interventions were ineffective, that alternative strategies were developed, implemented or that a reassessment of resident's care needs had occurred. The review, of the plan of care, further failed to provide documentation suggesting that the physician was contacted when non-pharmacological and or pharmacological interventions were ineffective, despite the exhibited responsive behaviours of resident #001.

The Director of Care indicated that it would be an expectation that registered nursing staff not only detail a resident's exhibited responsive behaviours, but also indicate actions taken by staff and the resident's response to interventions. Director of Care indicated that when Resident #001 was not responding to planned interventions (pharmacological and non-pharmacological), registered nursing staff should have contacted the attending physician for direction, especially when there was a potential risk of harm to others. [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 there is a monitoring process in place to ensure actions are taken to respond to the needs of the resident, including assessments, reassessments, interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s 131 (2), by not ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Intake #025411-15, for Resident #001:

According to interviews with Personal Support Workers, Registered Nursing Staff, the Director of Care and the Attending Physician, Resident #001 exhibits challenging responsive behaviours.

The physician for Resident #001 (and a physician from an external support service) prescribed a specific medication be administered one hour prior to baths.

A progress note, for a specific date, documents that there was a clear correlation between Resident #001's baths and his/her exhibited responsive behaviours. The progress note, for a specific date, relates to a discussion between resident's Physician and the external support service.

On an identified date, Registered Practical Nurse #013 indicated, in a progress note, that the medication was not given, as the resident had a bath with no trouble that shift.

The electronic medication administration record was reviewed and confirmed medication was not administered as prescribed. There was no physician's order documented that day to not administer the prescribed medication.

Registered Practical Nurse #013, when interviewed, could not recall why the medication was not given.

Director of Care indicated that the physician had ordered the indicated medication due to resident's challenging responsive behaviours. Director of Care indicated that physician's orders are to be followed. [s. 131. (2)]

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Issued on this 18th day of February, 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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2016_293554_0002 (A1)
Log No. / Registre no:	013853-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 27, 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 :	SPRINGDALE COUNTRY MANOR 2698 CLIFFORD LINE, R. R. #5, PETERBOROUGH, ON, K9J-6X6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MAUREEN KING

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 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will immediately implement measures and a monitoring process to protect Resident #002 from sexual abuse, by Resident #001 and or others.

The licensee shall:

- Review and revise the plan of care for Resident #002, specifically as such relates to safe-guarding resident from abuse by anyone.

- Implement measures and a monitoring process to ensure that the care set out in the plan of care is provided to Resident #002.

- Provide re-instruction to all registered nursing staff specific to care planning, and ensuring that the plan of care meets the needs of each resident.

- Provide re-instruction to all direct care staff as to the importance of providing care as specified in the plan of care, specifically as it relates to the safe-guarding of residents, especially those who are vulnerable and or cognitively impaired; the re-instruction is to include but not limited to, who staff are to contact if the planned care can't be provided or if the planned care is not effective, so that appropriate and timely action can be taken.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to the resident as specified in the plan, specifically as it relates to the safe-guarding of Resident #002.

Related to Intake #025411-15, for Resident #002:

Resident #002 has a history that includes, cognitive impairment. Resident #002 is dependent on staff for all activities of daily living.

Resident #001 has a history that includes, cognitive impairment; he/she is able to move about the home freely with the aid of a mobility device. Resident #001 has a history of exhibiting specific responsive behaviours. Personal Support Workers, Registered Nursing Staff, Director of Care and the Physician, all indicated, Resident #001 has some understanding of right and wrong.

A progress note, for a specific date, details an incident in which Resident #002 was inappropriately touched (non-consensual) by Resident #001. Details of this incident are as follows:

- Resident #001 was observed by staff sitting in his/her wheelchair beside Resident #002 in the lounge, near the main dining room. Resident #001 was observed inappropriately touching Resident #002. There was no documented harm to Resident #002 as a result of this incident; the interaction between the two residents was non-consensual.

The clinical health record for both Resident #002 and Resident #001, indicates that the incident which occurred on a specific date, was the fourth incident (in four months) in which Resident #002 had been inappropriately (non-consensual) touched by Resident #001. (Note: the incidents which occurred prior to the identified date, related to resident to resident abuse, were inspected upon and are identified within another inspection and served to the licensee on February 09, 2016)

The plan of care reviewed, for a period of approximately three months, for Resident #002, specifically directs the following:

- Resident #002 is not to be in the vicinity of Resident #001. Resident #002 is to be placed at the opposite end of the dining room, away from Resident #001. Staff to ensure Resident #002 and Resident #001 are not seated close to each other and are not to enter any common areas together.

Registered Practical Nurse #013, Registered Nurse-Charge Nurse #012 indicated that Resident #002 was provided care, on a specific shift, and on a specific date, by Personal Support Workers, and was placed in a wheelchair out

in the hallway. Both registered nursing staff were unclear as to how Resident #002 got from the hallway to the lounge area.

Registered Nursing Staff (#012 and #013) indicated that Resident #002 was not to be placed unattended in the hallways or in any common area, due to past incidents with Resident #001; and that all staff have been directed to take Resident #002 from his/her room to the dining room or common areas providing constant observation to ensure resident is safe from Resident #001.

Director of Care indicated that staff (PSWs) had placed Resident #002 in the hallway unattended, indicating this was not to be the practice, for Resident #002. Director of Care indicted that it is believed, that a co-resident may have taken Resident #002 to the lounge.

2. The plan of care reviewed, for a period of approximately three months, for Resident #001, specifically directs the following:

- Resident #001 is to be seated with his/her back to co-resident (Resident #002) while in the dining room, in order to prevent Resident #001 from observing Resident #002 and possibly creating any potential interactions between the two residents.

During the dates of this inspection, Resident #001 was observed to not be seated in his/her assigned seat in the dining room, and was observed seated at the dining room table on two occasions facing Resident #002.

Personal Support Worker, Registered Practical Nurse and the Nutritional Care indicated (to the inspector) Resident #001 has an assigned seat in the dining room and he/she is to sit with his/her back to Resident #002. Personal Worker and Nutritional Care Manager indicated often Resident #001 does not sit in his/her assigned seat at the table, as seating is dependent on which resident arrives to the table first. Nutritional Care Manager indicated staff do not redirect residents to their assigned seating in the dining room, as it (staff action) may cause a resident to have (exhibit) a responsive behaviour.

The Director of Care indicated (to the inspector) that it is an expectation that all staff followed the individualized plan of care for residents. Director of Care indicated that during incident (described above) staff were not following the planned care, which was in place to ensure the safety of the Resident #002.

Therefore, the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, which intern, placed Resident #002, a vulnerable and cognitively impaired resident, at risk of potential harm by Resident #001. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 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
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 and the Director

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

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.

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
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

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 18th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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