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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159 Cedar Street, Suite 403
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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
Aug 7, 2014	2014_380593_0001	111-14	Follow up

Licensee/Titulaire de permis

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

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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

GILLIAN CHAMBERLIN (593)

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): July 7th - 8th 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Service Manager, Recreation Manager, Registered Nursing Staff, Personal Support Worker's (PSW), Recreational Staff, Food Service and Housekeeping Staff.

During the course of the inspection, the inspector(s) observed between meal beverage and snack passes, observed main meal service, observed storage of fluids, reviewed diet sheets, reviewed resident health care records, reviewed activity schedules and reviewed home policies and memorandum's related to the provision of food and beverages.

The following Inspection Protocols were used during this inspection:
Dining Observation
Snack Observation

Findings of Non-Compliance were found during this inspection.

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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. 1. A Compliance Order related to LTCHA, 2007, S.O.2007,c.8,s.11(1) was previously re-issued in April 2014 during inspection # 2014_139163_0004.

The inspector observed the provision of between-meal beverages and snacks and noted that it was not organized as evidenced by the following:

1) Residents requiring total assistance with eating and drinking as outlined in their plan of care, specifically residents #01 and #02, were not always provided assistance when served their snacks and beverages at bedside. Furthermore, the home's policy LTC-G-130 outlines that beverages and/or nourishment's shall not be left at the bedside unless indicated in the resident's plan of care.
2) Planned menu items for snacks were not always available as per the menu.
3) It was observed during two snack passes that snack carts lacked quantity and/or variety of commercially thickened beverages resulting in staff having to stop and hand mix beverages for individual residents during the nourishment pass.
4) On March 19, 2014 during the afternoon snack pass, it was observed that Activity staff began serving residents ice cream, while at the same time, the snack pass was underway. On the same day during afternoon snack pass, the inspector also noted that the snack pass ended at 16:10 and staff informed the inspector that dinner would begin at 17:00.
5) Inspector observed on several occasions during morning snack pass on March 20, 2014 that a visitor served themselves food and beverages from the cart. This was not addressed by staff.
6) On March 20, 2014 during the morning beverage pass, a resident requested a cup of coffee from the snack cart. Staff #201 poured the resident a cup of coffee and placed the cup on the lid of a metal garbage can rather than on some type of table typically expected in an organized dining/snack program.
7) Three residents from (#03, #04, #05) who were moved to another floor because of renovations did not have their diet information transferred to the diet sheet attached to the snack cart. [s. 11. (1)] [s. 11. (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. 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. Resident #001 is totally dependent for eating tasks and requires full staff assistance. Resident #001 has dysphagia and is required to have a texture modified diet and thickened fluids to ensure a safe eating experience. This information was obtained from the Residents health care record including the care plan document.

During an interview with Inspector #593, PSW staff member #103 confirmed that Resident #001 requires full feeding assistance, staff are required to follow the diet roster attached to the nourishment carts which advise of the Residents requiring feeding assistance.

Inspector #593 observed on July 08th 2014 PSW staff member #102 provide Resident #001 a piece of carrot loaf from the afternoon nourishment pass. Resident #001 was not provided any assistance and proceeded to eat the carrot loaf without assistance. The carrot loaf provided to Resident #001 was regular texture. As such, the long term care home has failed to ensure that the planned care set out in the Resident's plan of care was delivered as required. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to Resident #001, as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. Inspector #593 observed July 7th, 2014; 23 Residents involved in the 14:30 bingo activity held in a dining area. This activity was completed at 15:45 and no nourishment cart was observed to enter this activity during the activity period. Inspector #593 observed a posted memorandum from the home's Administrator staff member #s100 stating that the afternoon nourishment time is 15:00.

During an interview with Inspector #593 on July 7th, 2014; staff member #114 advised that the nourishment cart is not offered to Resident's during activities. Residents do have the option to leave the activity at 15:00 and return to their floor to receive something from the nourishment cart however most of the Resident's wish to stay in the activity which usually runs past 15:00. Staff member #114 advised that activities happen every weekday at 10:30 and 14:30 and the nourishment pass is never offered during these scheduled activities.

During an interview on July 08th, 2014 with Inspector #593; Recreation Manager staff member #108 advised that most of the scheduled activities involve food as part of the activity or Residents have the option of purchasing food or drink from the homes tuck shop cart. A review of the July 2014 activities schedule showed that 12 scheduled activities included food as part of the activity, 9 scheduled activities provided the option to purchase food or drink from the tuck shop cart and 19 scheduled activities did not include food as part of the activity and did not provide the option to purchase food or drink from the tuck shop cart.

During an interview on July 08th, 2014 with Inspector #593; the homes Administrator staff member #100 and Food Service Manager staff member #109 both confirmed that

the home's expectation is that the nourishment pass is offered during activities held during scheduled nourishment pass times.

As such, the home has failed to ensure that each Resident is offered a between meal beverage in the morning and the afternoon and a between meal snack in the afternoon. [s. 71. (3) (b)]

2. On July 7th, 2014 Inspector #593 observed the warmer trolley with tray service meals being taken to Resident levels of the home at 16:45. On one of the floors it was observed that Resident #003 had finished their main meal at 16:50 and was moving onto dessert. RPN staff member #s112 advised that the Resident was allergic to fish and did not eat their meal in the common dining room when fish was on the menu. A review of Resident #003's care plan did not indicate that this Resident required to receive their evening meal before 5:00 p.m.

Inspector #593 observed on July 8th 2014 at 16:40, five tray services on one of the floors ready for the evening meal. Between 16:45 and 16:50, PSW staff member #s101 was observed to provide all five trays to Residents in the common area on another floor. On the same floor at 16:53, Inspector #593 observed two Residents receive their tray service meals.

During an interview with Inspector #593, PSW staff member #s101 advised that all Residents that receive a tray service for dinner are scheduled for the 5:00 p.m. meal service.

Inspector #593 observed the scheduled meal times posted on the ground floor, the evening meal times were listed as 5:00 p.m. for the first meal service and 6:00 p.m. for the second meal service.

As such, the home failed to ensure that the evening meal is not served before 5:00 p.m. [s. 71. (6)]

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 each Resident is offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening; and ensure that the evening meal is not served before 5.00pm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector #593 observed the posted daily menu on each floor of the home as well as the week at a glance menu posted in the lobby on the ground floor of the home. Meals and meal options were observed on the menu for breakfast, lunch and dinner however the posted daily and weekly menu's did not include between meal snacks and / or beverages.

During an interview with Inspector #593, Food Service Manager staff member #109 advised on July 8th 2014 that the weekly snack menu is posted behind the week at a glance main meal menu on the ground floor.

Inspector #593 observed the weekly snack menu behind the week at a glance menu on the ground floor in the glass display sleeve. This weekly snack menu was not visible to residents at the time of the inspection and as such the home has failed to communicate the weekly snack menu to Residents within the home. [s. 73. (1) 1.]

2. Inspector #593 observed on July 08th, 2014 two milk products on the nourishment cart that were not kept on ice. The ice tray was on the bottom level of the cart and that the two milk products were sitting on the top level of the cart. These milk products were observed to be served to Residents during the snack service. Inspector #593 observed a posted memorandum dated August 30th, 2013 from the homes Administrator staff member #s100. The memorandum stated that during each of the three AM, PM and HS nourishment passes, all milk products are to be kept on ice.

On July 8th, 2014 at 15:25 Inspector #593 observed PSW staff member #102 serve ready to drink (RTD) thickened fluids that were at ambient temperature to Residents within the home. During an interview with Inspector #593, PSW staff member #102 advised that the thickened fluids should be chilled however they were unsure whether they had been chilled or not. Inspector #593 found both cartons of RTD thickened fluid to be at ambient temperature. During an interview with Inspector #593 July 7th, 2014 RPN staff member #104 advised that they do use RTD thickened fluids and they keep them in a drawer in the nurses station. Inspector #593 observed a drawer full of RTD thickened beverages that were not refrigerated on one of the floors of the home.

Inspector #593 observed July 8th, 2014 at 16:57 the milk products from the evening meal nourishment cart on one of the floors were on the counter of the nurses station, these milk products were not kept on ice. Inspector #593 observed these milk products being subsequently served to Residents during the dinner meal service.

As such, the licensee has failed to provide fluids at a safe and palatable temperature for Residents in the home. [s. 73. (1) 6.]

3. A review of Resident #001's care plans indicate that they require full feeding assistance and are at high nutritional risk due to dysphagia. Resident #001 is to

receive thickened fluids and texture modified food and that a plan of care goal is to maintain a safe chewing and swallowing experience through to next review. This is consistent with the printed plan of care and the diet roster attached to the mid-meals nourishment cart.

A review of Resident #002’s care plan indicates that they require full feeding assistance and are at high nutritional risk due to chewing and swallowing difficulties. Resident #002 is to receive thickened fluids and a texture modified diet and that a plan of care goal is to maintain a safe chewing and swallowing experience through to next review. This is consistent with the printed plan of care located in the nurse’s station and diet roster attached to the mid-meals nourishment cart.

Inspector #593 observed July 7th, 2014 at 15:01 PSW staff member #103 feeding Resident #002 a beverage and snack from the afternoon nourishment cart. PSW staff member #103 was observed to be standing over the Resident whilst the Resident was seated in their wheelchair with a 45 degree tilt back.

Inspector #593 observed July 7th, 2014 at 15:21 PSW staff member #103 feeding Resident #001 a snack from the afternoon nourishment cart. PSW staff member #103 was observed to be standing over the Resident whilst the Resident was seated in their wheelchair with a 45 degree tilt back.

During an interview with Inspector #593, PSW staff member #103 advised that they follow the diet roster attached to the nourishment cart which advises the Residents requiring feeding assistance and that the home's requirement for safe feeding assistance is that a registered staff member must be on the floor as these Residents are at risk of choking. PSW staff member #103 could not list any other requirements for safe feeding techniques required by the home at this time.

On July 08th, 2014 during an interview with Inspector #593, the home’s Administrator staff member #100 and Director of Care staff member #107 advised that staff have previously had training on safe feeding techniques and that PSW staff member #103 should have been following the safe feeding techniques. Later that afternoon during an interview with Inspector #593, the home’s Administrator staff member #100 further advised that the current education does not include staff seating requirements for safe feeding techniques.

As such, the licensee has failed to provide proper techniques to assist Residents with

eating. [s. 73. (1) 10.]

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 communication of the seven-day and daily snack menus to Residents; foods and fluids being served at a temperature that is both safe and palatable to the Resident's and proper techniques to assist Residents with eating, including safe positioning of Residents who require assistance, to be implemented voluntarily.

Issued on this 5th day of September, 2014

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

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) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2014_380593_0001
Log No. / Registre no:	111-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 7, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

To REVERA LONG TERM CARE INC., 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)

Linked to Existing Order / Lien vers ordre existant: 2014_139163_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007. c.8, s.11 (1) to ensure that there is (a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition care needs of the residents, and (b) an organized program of hydration for the home to meet the hydration needs of residents.

The plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by September 8, 2014.

Grounds / Motifs :

1. 1. A Compliance Order related to LTCHA, 2007, S.O.2007,c.8,s.11(1) was previously re-issued in April 2014 during inspection # 2014_139163_0004.

The inspector observed the provision of between-meal beverages and snacks and noted that it was not organized as evidenced by the following:

1) Residents requiring total assistance with eating and drinking as outlined in their plan of care, specifically residents #01 and #02, were not always provided assistance when served their snacks and beverages at bedside. Furthermore, the home's policy LTC-G-130 outlines that beverages and/or nourishments shall not be left at the bedside unless indicated in the resident's plan of care.
2) Planned menu items for snacks were not always available as per the menu.
3) It was observed during two snack passes that snack carts lacked quantity and/or variety of commercially thickened beverages resulting in staff having to stop and hand mix beverages for individual residents during the nourishment pass.
4) On March 19, 2014 during the afternoon snack pass, it was observed that Activity staff began serving residents ice cream, while at the same time, the snack pass was underway. On the same day during afternoon snack pass, the inspector also noted that the snack pass ended at 16:10 and staff informed the inspector that dinner would begin at 17:00.
5) Inspector observed on several occasions during morning snack pass on March 20, 2014 that a visitor served themselves food and beverages from the cart. This was not addressed by staff.
6) On March 20, 2014 during the morning beverage pass, a resident requested a cup of coffee from the snack cart. Staff #201 poured the resident a cup of coffee and placed the cup on the lid of a metal garbage can rather than on some type of table typically expected in an organized dining/snack program.
7) Three residents (#03, #04, #05) who were moved to another floor because of renovations did not have their diet information transferred to the diet sheet attached to the snack cart. [s. 11. (1)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board 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 7th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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