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 sions de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 26, 2016	2015_342611_0015	032986-15	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 1, and December 2, 2015

During the course of the inspection, the inspector observed the provision of resident care and services, reviewed relevant resident clinical documents, home policies/procedures/practises, relevant investigation notes and relevant employee personnel files

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Manager of Resident Care, Employee Relations Specialist, registered staff, Personal Support Workers (PSW's) and an identified visitor of the home

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.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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 has failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that caused alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Resident #001 had a history of responsive behaviours. This resident's plan of care for an identified date indicated that resident #001 was resistive to treatment/care related to cognitive impairment. The care plan indicated that if resident refused treatment/care staff are to reapproach resident in five (5) to ten (10) minutes.

According to someone who witnessed the actions on an identified date, staff #100 was attempting to administer medication to this resident, as the resident sat in a chair in a common area of the home. This resident refused the medication by verbally indicating "I don't want that". As a result of this refusal, staff #102 physically restrained resident #001's hands in place on their lap, staff #101 physically restrained resident #001's face and jaw in place, and staff #100 administered the medication to the resident. During this time, the resident was exhibiting responsive behaviours and was yelling out loudly in protest. Staff #103 witnessed the incident. During an interview with the witness it was confirmed the resident was "protesting, and was not happy".

During an interview with staff #100, it was confirmed that the staff member "should have stopped and attempt at another time" This staff member further confirmed that excessive force was used and that "if its no, then no, and stop".

During an interview with staff #102, it was confirmed the resident was "restless and agitated" and staff "should have walked away".

Staff #103 observed the incident. This staff member confirmed that the staff were "fighting with the resident to get resident to take pills". The staff member further confirmed the incident "exploded and resident was fighting". This staff member did not intervene, as it was indicated the incident happened rather quickly, and was providing a snack to another resident.

The information provided confirms the staff members lack of acknowledgement towards resident #001's resistance, behaviour and vocal response to the staff's actions when attempting to administer medications. This lack of acknowledgement constitutes emotional abuse.

An interview with the Administrator and Director of Care confirmed the incident towards resident #001 did occur and an internal investigation was conducted. [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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home is restrained, in any way, for the convenience of the licensee or staff.

Resident #001 had a history of responsive behaviours. This residents plan of care on an identified date indicated that resident #001 was resistive to treatment/care related to cognitive impairment. The care plan indicated that if resident refused treatment/care staff are to reapproach resident in five (5) to ten (10) minutes.

According to someone who witnessed the actions on a specified date, staff #100 was attempting to administer medication to this resident in a common area of the home. This resident refused the medication by verbally indicating "I don't want that". As a result of this refusal, staff #102 physically restrained resident #001's hands in place on their lap, staff #101 physically restrained resident #001's face and jaw in place, and staff #100 administered the medication to the resident. During this time, the resident was exhibiting responsive behaviours and was yelling out loudly in protest. Staff #103 witnessed the incident. During an interview with the witness it was confirmed the resident was "protesting, and was not happy".

During an interview with staff #100, it was confirmed that the staff member "should have stopped and attempt at another time" This staff member further confirmed that excessive force was used and that "if its no, then no, and stop".

During an interview with staff #101 it was confirmed that "a little bit of control" was used in an attempt to assist with medication administration. It was further confirmed by this staff member that it "would be easier for us to do evening care if resident took medication".

Staff #103 observed the incident. This staff member confirmed that the staff were "fighting with the resident to get resident to take pills". The staff member further confirmed the incident "exploded and resident was fighting".

An interview with the Administrator and Director of Care confirmed the incident towards resident #001 did occur and an internal investigation was conducted. [s. 30. (1) 1.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 had a history of responsive behaviours. This resident's plan of care on an identified date indicated that resident #001 was resistive to treatment/care related to cognitive impairment. The care plan indicated that if resident refused treatment/care staff are to reapproach resident in five (5) to ten (10) minutes. According to a person who witnessed the action on a specific date, staff #100 was attempting to administer medication to this resident in a common area of the home. This resident refused the medication by verbally saying "I don't want that". As a result of the refusal of medication, staff #100, #101, and #102 did not leave resident and reapproach in five (5) to ten(10) minutes as identified in the care plan. Instead, resident #001 was physically restrained to administer medication by the use of excessive force.

Staff #100 and #101 did not provide care to resident #001 as specified in the care plan. This was confirmed by an interview with the Administrator and the Director of Care. [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 the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home has a policy in place "Prevention, Reporting and Elimination of Abuse and Neglect (number 01-05-03). This policy defines abuse as any action or inaction, misuse of power and/or betrayal of trust by a person against a resident that resulted in harm or risk of hard to the resident. The policy further defines emotional abuse as any threatening, insulting, intimidating or humiliating gesture, action, behaviour, or remark, that cause alarm, or fear to another resident; behaviour or remarks that decreased the resident's sense of identity, dignity, or self-worth including imposed social isolation, lack of acknowledgement and infantilization.

Resident #001 had a history of responsive behaviours. This resident's plan of care on an identified date indicated that resident #001 was resistive to treatment/care related to cognitive impairment. The care plan indicated that if resident refused treatment/care staff are to reapproach resident in five (5) to ten (10) minutes. According to someone who witnessed the action on an identified date staff #100 was attempting to administer medication to this resident in a common area of the home. This resident refused the

medication by verbally indicating "I don't want that". As a result of this refusal, staff #102 physically restrained resident #001's hands in place on their lap, staff #100 physically restrained resident #001's face and jaw in place, and staff #100 administered the medication to the resident. During this time, the resident was exhibiting responsive behaviours and was yelling out loudly in protest.

During an interview with the witness it was confirmed the resident was "protesting, and was not happy".

During an interview with staff #100, it was confirmed that the staff member "should have stopped and attempt at another time" This staff member further confirmed that excessive force was used and that "if its no, then no, and stop"

During an interview with staff #102, it was confirmed the resident was "restless and agitated" and staff "should have walked away"

Staff #103 observed the incident. This staff member confirmed that the staff were "fighting with the resident to get resident to take pills". The staff member further confirmed the incident "exploded and resident was fighting".

The information provided confirms the staff members lack of acknowledgement towards resident #001. This lack of acknowledgement constitutes emotional abuse.

An interview with the Administrator and Director of Care confirmed the incident towards resident #001 did occur and an internal investigation was conducted.

The home's policy on Prevention, Reporting and Elimination of Abuse was not complied with in this instance. [s. 20. (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 the homes policy "Prevention, Reporting and Elimination of Abuse and Neglect" (number 01-05-03) is complied with by all staff at all times, to be implemented voluntarily.

Issued on this 3rd day of May, 2016

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

Original report signed by the inspector.

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2015_342611_0015
Log No. / Registre no:	032986-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 26, 2016
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF HALTON 1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	CREEK WAY VILLAGE 5200 Corporate Drive, BURLINGTON, ON, L7L-7G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marg Patillo

To THE REGIONAL MUNICIPALITY OF HALTON, 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 to ensure that all residents are protected from emotional abuse by anyone. The plan shall include a) strategies to
prevent emotional abuse by staff towards resident #001 and any other resident, b) staff education on abuse and responsive behaviours including dates that the education will be completed and c) quality management activities (including the type of activities and frequency) that will be implemented
to target the specific area of non-compliance. The plan should be submitted via email by May 20, 2016 to Kelly Chuckry at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that caused alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Resident #001 had a history of responsive behaviours. This resident's plan of care for an identified date indicated that resident #001 was resistive to

treatment/care related to cognitive impairment. The care plan indicated that if resident refused treatment/care staff are to reapproach resident in five (5) to ten (10) minutes.

According to someone who witnessed the actions on an identified date, staff #100 was attempting to administer medication to this resident, as the resident sat in a chair in a common area of the home. This resident refused the medication by verbally indicating "I don't want that". As a result of this refusal, staff #102 physically restrained resident #001's hands in place on their lap, staff #101 physically restrained resident #001's face and jaw in place, and staff #100 administered the medication to the resident. During this time, the resident was exhibiting responsive behaviours and was yelling out loudly in protest. Staff #103 witnessed the incident. During an interview with the witness it was confirmed the resident was "protesting, and was not happy".

During an interview with staff #100, it was confirmed that the staff member "should have stopped and attempt at another time" This staff member further confirmed that excessive force was used and that "if its no, then no, and stop".

During an interview with staff #102, it was confirmed the resident was "restless and agitated" and staff "should have walked away".

Staff #103 observed the incident. This staff member confirmed that the staff were "fighting with the resident to get resident to take pills". The staff member further confirmed the incident "exploded and resident was fighting". This staff member did not intervene, as it was indicated the incident happened rather quickly, and was providing a snack to another resident.

The information provided confirms the staff members lack of acknowledgement towards resident #001's resistance, behaviour and vocal response to the staff's actions when attempting to administer medications. This lack of acknowledgement constitutes emotional abuse.

An interview with the Administrator and Director of Care confirmed the incident towards resident #001 did occur and an internal investigation was conducted. [s. 19. (1)] (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no resident of the home is restrained in any way, for the convenience of the licensee or staff. The plan shall include a) strategies to prevent residents from being restrained for the convenience of staff. b) staff education on the use of restraints and what constitues restraining for the convenience of staff, including dates that the education will be completed and c) quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance. The plan should be submitted via email by May 20, 2016 to Kelly Chuckry at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that no resident of the home is restrained, in any way, for the convenience of the licensee or staff.

Resident #001 had a history of responsive behaviours. This residents plan of care on an identified date indicated that resident #001 was resistive to treatment/care related to cognitive impairment. The care plan indicated that if resident refused treatment/care staff are to reapproach resident in five (5) to ten (10) minutes.

According to someone who witnessed the actions on a specified date, staff #100 was attempting to administer medication to this resident in a common area of the home. This resident refused the medication by verbally indicating "I don't want that". As a result of this refusal, staff #102 physically restrained resident #001's hands in place on their lap, staff #101 physically restrained resident #001's face and jaw in place, and staff #100 administered the medication to the resident. During this time, the resident was exhibiting responsive behaviours and was yelling out loudly in protest. Staff #103 witnessed the incident. During an interview with the witness it was confirmed the resident was "protesting, and was not happy".

During an interview with staff #100, it was confirmed that the staff member "should have stopped and attempt at another time" This staff member further confirmed that excessive force was used and that "if its no, then no, and stop".

During an interview with staff #101 it was confirmed that "a little bit of control" was used in an attempt to assist with medication administration. It was further confirmed by this staff member that it "would be easier for us to do evening care if resident took medication".

Staff #103 observed the incident. This staff member confirmed that the staff were "fighting with the resident to get resident to take pills". The staff member further confirmed the incident "exploded and resident was fighting".

An interview with the Administrator and Director of Care confirmed the incident towards resident #001 did occur and an internal investigation was conducted. [s. 30. (1) 1.] (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 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 sions 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 sions 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 26th day of April, 2016

Signature of Inspector / Signature de l'inspecteur :

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

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