Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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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
Feb 24, 2017	2016_562620_0029	001066-17	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

ALAIN PLANTE (620), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 19-23, 2016, and January 18-20, and 23, 2017

Logs inspected during this complaint inspection included:
a complaint related to an allegation of improper care and abuse,
a complaint related improper care,
two complaints related numerous falls sustained by a resident, and
a complaint related to an allegation of staff to resident abuse.

A Follow-up (report # 2016_562620_0030) and Critical Incident (report # 2016_562620_0031) inspection were also conducted concurrently. As a result, findings from Critical Incident report # 2016_562620_0031 have been included in this report.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures, programs, and surveillance video.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Directors of Care (ADOCs), Support Services Manager (SSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs), residents, and residents' family members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #613 reviewed a complaint received by the Director alleging call bells going unanswered and improper care and abuse of resident #006.

The Inspector met with the complainant and viewed a surveillance video that identified two staff members of the home providing care to resident #006. The two staff members assisted the resident with an activity of daily living (ADL). The Inspector heard the two staff members' conversation during the provision of care; both were using inappropriate language, making insulting and humiliating remarks about the resident, and making degrading ethnic comments. The two staff members were heard talking about other residents of the home and making insulting and humiliating comments about them while they were providing care to resident #006. During the review of the surveillance video, it was observed by the Inspector that the two staff members ignored resident #006 during the provision of care and only spoke to the resident once to inform the resident to perform a specific action. The two staff members did not initiate conversation with resident #006, nor did they provide an explanation of the care that they were providing to the resident during the provision of care.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program," RC-02-01-01, last revised April 2016, stated Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times.

The complainant provided permission for the Administrator and ADOC #104 to view the

video surveillance. On the same date, both confirmed that emotional abuse had occurred to resident #006 during the provision of care, by PSW #118 and PSW #117. The Administrator stated that they had heard everything that the Inspector had stated was said by the PSWs and that both PSWs did not communicate directly to the resident during the provision of care, except to inform resident #006 to perform a specific action. Both PSW #117 and #118 were disciplined as a result of the incident.

2. Inspector #620 reviewed Critical Incident (CI) report that was submitted to the Director; whereby, resident #001 reported to RPN #107 that PSW #105 had yelled at them for having to go to bathroom too frequently. For further details refer to WN #1 of follow-up report #2016_562620_0030.

The home's investigation records revealed that PSW #105 did approach resident #001 alone in an area of the home to confront them about the allegation brought forward. PSW #105 was subsequently sent home pending an investigation of the incident.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" with a review date of April 2016. The policy advised that the home, "…had zero tolerance for abuse. Any form of abuse by any person interacting with residents, whether through deliberate acts or negligence will not be tolerated."

Inspector #620 interviewed PSW #105 who stated that they approached resident #001 alone to confront them. PSW #105 stated that they recognized that the resident appeared intimidated. PSW #105 stated that the same day they were sent home for their actions and stated that the home had provided them with a written notice of discipline.

Inspector #620 interviewed ADOC #104 who confirmed that they became aware of the allegation of verbal abuse hours after it occurred. They said that PSW #105 was disciplined for their actions related the alleged abuse of resident #001 and that PSW #105 should not have confronted resident #001 because it was in intimidating action. [s. 20. (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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

Inspector #613 reviewed a complaint that was received by the Director alleging improper care and abuse and staff not answering call bells. Refer to WN #1, section 1, of this report for further detail.

A review of resident #006's care plan that was accessible to all staff, identified interventions during personal care as follows: provide an explanation of tasks prior to initiating them to ease the resident's anxiety, before moving resident, greet them upon approach to let them know you are there and tell them what you are doing, avoid sudden movements when transferring or providing care, resident responds well to simple direct communication, use simple direct task segmentation to increase the residents participation for all Activities of Daily Living (ADL's).

Inspector #613 interviewed PSW #118, who confirmed they had provided care to resident #006 with the assistance of PSW #117. PSW #118 confirmed that using inappropriate language, making insulting and humiliating remarks about the resident, and making degrading ethnic comments was not appropriate and staff should not discuss things like

that when providing care to any resident of the long-term care home, as this was the residents' home.

Inspector #613 interviewed PSW #117, who confirmed they had assisted PSW #118 to care for resident #006. PSW #117 stated that they may have made insulting remarks about the resident but they denied making the other comments.

The Administrator stated that they had heard everything that the Inspector had stated was said by the PSWs and that both PSWs did not communicate directly to the resident during the provision of care, except to inform resident #006 to perform one specific action.

2. The licensee has failed to ensure that the resident's rights were fully respected and promoted; specifically, failed to ensure that residents had the right to be sheltered, clothed, groomed, and cared for in a manner consistent with his or her needs.

Inspector #620 reviewed a complaint submitted to the Director. The complainant described numerous care concerns for resident #005 including:

- an inappropriate call bell to meet resident #005's needs,
- the home's management of the resident continence,
- allegation that staff had mobilized the resident in an undignified state of dress,
-allegations that no extra fluids were being provided, and that there was no assistance with feeding.

Inspector #620 interviewed the complainant who stated that they were the substitute decision maker (SDM) for resident #005 and that resident #005 had been assisted down a hallway for their shower in an undignified state of dress. They stated that it was very upsetting for them to witness.

The complainant also stated that they had concerns in regards to resident #005's continence management. They stated that the home had decided that the resident's continence was to be done in a way contrary to resident #005's requests. The complainant stated that the resident felt that it was an indignity. The complainant also described that on numerous occasions resident #005 had been found to be dressed in soiled clothing and that the bedding was also stained with urine.

The complainant described that on one occasion resident #005 had been taken on an

outing into the community wearing undignified clothing. The complainant stated that they tried to address this incident with the home and they stated that the staff member did not recognize the clothing to be undignified.

Inspector #620 reviewed photos provided by the complainant. The photos depicted resident #005 sitting in a public place; the resident was wearing undignified clothing. Other photos depicted the resident in dirty clothing, soiled bed linens, and the resident with an overgrown beard and a soiled face.

On December 22, 2016, Inspector #620 interviewed the Administrator who confirmed that the complainant had valid care concerns and that the home had actively tried to address the concerns. The Administrator confirmed the following:
-resident #005 had been sent into the community in undignified clothing,
-the photos provided by the complainant that depicted soiled linens, clothing, unshaven and dirty face did reflect what had occurred, and
-the resident had been taken for a shower in an undignified manner. [s. 3. (1) 4.]

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 ensure that the resident's rights are fully respected and promoted; specifically, treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity, and ensure that residents have the right to be sheltered, clothed, groomed, and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, a goal in the plan was met; the resident’s care needs changed or care set out in the plan was no longer necessary; or care set out in the plan had not been effective.

Inspector #620 reviewed a complaint received by the Director. The complaint wrote a letter which stated that resident #002 had experienced an excessive number of falls since their admission to the home. The complainant stated that they were gravely concerned for resident #002 and that they felt like the resident required constant supervision to prevent the falls.

Inspector #620 reviewed resident #002’s clinical record. Resident #002 was assessed as a high risk for falls, and since their admission they had experienced a specific number of falls in a in a specific time.

A review of the resident’s care plan that was current at the time of inspection indicated the following:

- under the focus of bed mobility, the interventions included ensuring that there was a specific bed rail and bed system configuration.
- under the focus of transfers, the interventions included a specific bed rail configuration.
- under the focus of altered skin integrity, the care plan advised staff to apply a specific treatment to the resident’s area of altered skin integrity to a specific area.
- under the heading of falls, the care plan advised staff that resident #002’s bed alarm was to be applied to alert staff if the resident tried to self-ambulate; bed controls were also required to be attached to bedrail to prevent resident #002 from raising and lowering the bed.

Inspector #620 observed resident #002's room and identified that the resident did not have the bed system or bed rail configuration as identified in the plan of care.

Inspector #620 also observed that resident #002 had a an area of altered skin integrity different than that identified in the resident's care plan. In an interview with resident #002's SDM it was determined that the injury occurred as a result of their most recent fall.

Inspector #620 interviewed ADOC #001 who confirmed that resident #002 did not have the bed system or bed rail configuration as indicated in the resident's plan of care. They also indicated that the care plan should have been updated to include the changes when the alteration of the resident's bed system occurred. ADOC #001 further indicated that resident #002 had sustained injuries during their most recent fall and that as a result of the fall they had an additional area of altered skin integrity. They disclosed that resident #002's plan of care should have included interventions that addressed the additional area of altered skin integrity and concluded that the resident's care plan needed some revision.

2. A review of resident #006's care plan, that was accessible to all staff, identified an intervention under the focus falls. The care plan advised staff to a apply certain device while resident #006's was utilizing their mobility aid. The device was to be transferred to the resident's bed when they were not utilizing their mobility aid. There was also an intervention for a different device which was to be applied to the resident's bed to reduce the risk of a fall.

During each day of the inspection, Inspector #613 observed resident #006's bed to have a device applied to the bed; however, the Inspector did not observe a device applied to the resident's mobility aid.

On January 23, 2017, the Inspector interviewed RPN #116, who checked resident #006's mobility aid and confirmed there was no device applied. The RPN checked the resident's care plan and confirmed the care plan stated the device was to be applied while resident #006 was using their mobility aid. The device was then applied to resident #006's mobility aid.

On the same date, the Inspector interviewed ADOC #104, who stated resident #006 probably did not need device, as they already had an alternate device in place while they

utilized their mobility aid. ADOC #104 verified that the care plan had not been updated when the new device had been implemented. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, a goal in the plan is met; the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620), LISA MOORE (613)
Inspection No. / No de l'inspection :	2016_562620_0029
Log No. / Registre no:	001066-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 24, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Johanne Messier-Mann

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To EXTENDICARE (CANADA) INC., 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. 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).

Order / Ordre :

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #620 reviewed Critical Incident (CI) report that was submitted to the Director; whereby, resident #001 reported to RPN #107 that PSW #105 had yelled at them for having to go to bathroom too frequently. For further details refer to WN #1 of follow-up report #2016_562620_0030.

The home's investigation records revealed that PSW #105 did approach resident #001 alone in an area of the home to confront them about the allegation brought forward. PSW #105 was subsequently sent home pending an investigation of the incident.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" with a review date of April 2016. The policy advised that the home, "…had zero tolerance for abuse. Any form of abuse by any person interacting with residents, whether through deliberate acts or negligence will not be tolerated."

Inspector #620 interviewed PSW #105 who stated that they approached resident #001 alone to confront them. PSW #105 stated that they recognized that the

resident appeared intimidated. PSW #105 stated that the same day they were sent home for their actions and stated that the home had provided them with a written notice of discipline.

Inspector #620 interviewed ADOC #104 who confirmed that they became aware of the allegation of verbal abuse hours after it occurred. They said that PSW #105 was disciplined for their actions related the alleged abuse of resident #001 and that PSW #105 should not have confronted resident #001 because it was in intimidating action. [s. 20. (1)]
(620)

2. Inspector #613 reviewed a complaint received by the Director alleging call bells going unanswered and improper care and abuse of resident #006.

The Inspector met with the complainant and viewed a surveillance video that identified two staff members of the home providing care to resident #006. The two staff members assisted the resident with an activity of daily living (ADL). The Inspector heard the two staff members' conversation during the provision of care; both were using inappropriate language, making insulting and humiliating remarks about the resident, and making degrading ethnic comments. The two staff members were heard talking about other residents of the home and making insulting and humiliating comments about them while they were providing care to resident #006. During the review of the surveillance video, it was observed by the Inspector that the two staff members ignored resident #006 during the provision of care and only spoke to the resident once to inform the resident to perform a specific action. The two staff members did not initiate conversation with resident #006, nor did they provide an explanation of the care that they were providing to the resident during the provision of care.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program," RC-02-01-01, last revised April 2016, stated Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times.

The complainant provided permission for the Administrator and ADOC #104 to view the video surveillance. On the same date, both confirmed that emotional abuse had occurred to resident #006 during the provision of care, by PSW #118 and PSW #117. The Administrator stated that they had heard everything that

the Inspector had stated was said by the PSWs and that both PSWs did not communicate directly to the resident during the provision of care, except to inform resident #006 to perform a specific action. Both PSW #117 and #118 were disciplined as a result of the incident.

The decision to issue this compliance order was based on the scope which had been identified as isolated, the severity which indicated minimal harm or a potential for actual harm, and the compliance history which despite previous non-compliance having been issued with three Voluntary Plans of Correction between March 16, 2015, and August 08, 2016, in report #2016_395613_0014, #2016_395613_0007, and #2015_281542_0005; non-compliance continued with this section of the legislation. (613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of February, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Alain Plante

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