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

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
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159 rue Cedar Bureau 403
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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
Aug 25, 2016	2016_246196_0010	8984-16, 8993-16	Follow up

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

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 11, 12, 13, 14, 15, 2016

This Follow Up Inspection was conducted concurrently with a Complaint Inspection #2016_246196_0009 and a Critical Incident System (CIS) Inspection #2016_246196_0011.
A finding of non-compliance related to s.6(7) in the CIS inspection was issued in this report.

This Follow Up Inspection, log #8984-16 was related to mandatory reporting to the Director and log #8993-16 was related to the Plan of Care.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed various home policies and procedures and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), RAI Coordinator, Quality Care Coordinator and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2016_339617_0004	625

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. 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.

On a day during the inspection, resident #012 was observed by Inspector #196 to urinate on the floor. At the time of the incident, PSW #112 was seen to witness the resident urinate and proceeded to clean up the urine after the resident left the area.

The current care plan was reviewed for information regarding toileting needs. Under the focus of urinary incontinence, the interventions include "(resident #012) is toileted with AM and HS care, following meals and PRN".

An interview was conducted with PSW #112 and they reported that the resident had not been assisted with toileting after supper. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a day during the inspection at 0930hrs, Inspector #196 observed resident #014 actively feeding them-self, chewing food with a plate of regular textured toast and egg in front of them. The table marker identified the resident's name and had a code to signify a specific diet texture. In addition, there were in excess of 20 residents seated at tables in the dining room, some of which were also eating their breakfast meal.

The dining room did not have a staff member present to monitor this resident or any of the other residents that were eating. The Inspector remained in the dining room and noted RN #106 in the DOC's office at 0935hrs.

At 0938hrs, the Food Service Manager (FSM) entered the dining room from the kitchen and the Inspector questioned the supervision of the dining room. They reported that RN #106 was to supervise and confirmed with the Inspector that there were no staff present at the time of observation.

At 0939hrs, RN #106 entered the dining room and reported to the Inspector that they were supervising the dining room. They confirmed to the Inspector that they were in the DOC's office and for a period of time and as a result, there were no staff members in the dining room providing supervision.

The health care records for resident #014 was reviewed by Inspector #196. The current care plan identified the resident as at risk and required monitoring by staff when eating and drinking. [s. 6. (7)]

3. 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.

A Critical Incident System (CIS) report was submitted to the Director for an incident which had occurred in the early part of 2016. The report identified that resident #004 had stated that staff were rough with them. The report identified that the resident was transferred by one staff member, PSW #107, that morning, despite the resident's plan of care identifying that the resident required two staff to transfer.

A review by Inspector #625 of resident #004's care plan in place at the time of the incident, identified that the resident required the assistance of two staff members for transfers with a transfer aid. A review of PSW #107's employee records included a note dated February 2016, from the home to the PSW indicating that the PSW admitted to transferring the resident alone, without the assistance of a second staff member, despite the need for two staff to transfer resident #004.

An interview was conducted by Inspector #625 with the DOC and they reported that resident #004's care plan indicated that they required the assistance of two staff members for transfers and that the resident was transferred by PSW #107, without a second staff member present, and that the PSW had not followed the resident's plan of

care when transferring the resident. [s. 6. (7)]

4. 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.

On a particular day, during the inspection, Inspector #196 observed resident #012 walk down the west side corridor on one of the units and remove a yellow wander strip from a co-resident's door, entered the room and reapplied the wander strip behind them. Inspector #196 also observed the following resident room doors and wander strips:
- one room had the door open and no wander strips
- another room had the door open and one wander strip hanging down and not affixed across the door
- another room had the door open and one wander strip hanging down and not affixed across the door
- another room had the door open and no wander strips
- another room had the door open and no wander strips
- another room had the door open and no wander strips
- another room had the door open and one wander strip affixed across the doorway

At 1835hrs, Inspector #196 observed resident #012 as they wandered into a resident room, which had the door open and a yellow wander strip hanging down and not affixed across the door. As the Inspector stood outside the door, resident #024 and #025 approached this same room and the co-residents began yelling and cursing at resident #012 and told him to get out of their room.

The health care records for resident #012 were reviewed by Inspector #196. The current care plan identified wandering behaviour and identified strategies to minimize the effect to other residents.

On another day during the inspection, resident #012 was observed walking down the west corridor of the unit. Inspector #196 observed the doors on both sides of the nursing desk were open and several yellow wander strips remained hanging and not affixed on resident room doors.

An interview was conducted with PSW #113 and they confirmed to the Inspector that the doors on both sides of the nursing desk were to be kept locked and also confirmed that the wander strips on the west corridor should be attached to the resident doors. [s. 6. (7)]

5. The licensee failed to ensure that the following was documented: The provision of the care set out in the plan of care.

On a particular day during the inspection, one of the units Medication Administration Records (MAR) were reviewed by Inspector #196. The following resident MARs did not include documentation by the registered staff, specifically initials supporting the administration of medications on a specific day shift earlier in the month.

- resident #017- the administration of the 0800hrs medications
- resident #023 - the administration of the 0800 and 1200hrs medications
- resident #015 - the administration of the 0800hrs medications
- resident #018 - the administration of the 0800hrs medications
- resident #019 - the administration of the 0800hrs medications
- resident #020 - the administration of the 0800hrs medications
- resident #021 - the administration of the 0800hrs medications
- resident #022 - the administration of the 0800hrs medications
- resident #011 - the administration of the 0800hrs medications

An interview was conducted with the DOC and they reported that registered staff were to sign immediately after administering medications to a resident as is best practice with the College of Nurses of Ontario. The DOC could not verify that the listed medications on the MAR were administered to the identified residents and they would have to investigate further and interview the registered staff. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 that ensures that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their written policies and protocols for the medication management system was complied with.

On a particular day during the inspection, on a specific unit, the Medication Administration Records (MAR) were reviewed by Inspector #196. Nine resident MARs did not have documentation by the registered staff supporting the administration of medications for the day shift on one day in the month.

The home's policy titled "Missing Signatures" updated June 2016, was reviewed. The policy indicated that a missing signature or a missing administration code on the Medication Administration Record would be considered a medication incident and the procedure for reporting an internal medication incident was to be followed. In addition, the policy identified the nurse would initial on the MAR after dispensing the medication.

An interview was conducted with the DOC and they reported that registered staff were to sign immediately after administering medications to a resident as this is best practice with the College of Nurses of Ontario. The DOC could not verify that the listed medications on the MARs were administered to the the identified residents and they would have to investigate further and interview the registered staff. They further reported that the home's procedure for reporting an internal medication incident regarding the missing signatures on the MARs, was not followed. [s. 8. (1) (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 that ensures their written policies and protocols for the medication management system, specifically medication incident reporting and the documentation by the nurse on the MAR after medication dispensing, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On a particular day at 0945hrs, RPN #109 was observed by Inspector #196 to administer medication to resident #016 on one of the units.

The RPN was questioned as to the time that this resident's medication was administered. They reported that they were unable to go downstairs to the dining room with the resident at breakfast and therefore administered the medication when resident # 016 returned to the unit.

The health care records for resident #016 were reviewed. The Medication Administration Record (MAR) identified the medication and listed the times for administration as 0800, 1200 and 1600hrs. The current care plan included the intervention of "Administer medications as per MD orders (see current MAR)". The physician's order identified the same medication and dosage and specified the medication was to be given with meals.

An interview was conducted with the DOC and they reported that the medication was to be administered as ordered by the physician. They further confirmed to the Inspector that resident #016's medication was not administered as per the physician's order, specifically with the breakfast meal. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 25th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	LAUREN TENHUNEN (196), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2016_246196_0010
Log No. / Registre no:	8984-16, 8993-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 25, 2016
Licensee / Titulaire de permis :	CVH (No.2) LP c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	BIRCHWOOD TERRACE 237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WENDY SARFI

To CVH (No.2) LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2016_339617_0004, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to ensure that the care set out in the plan of care is provided to all residents as specified in their plans of care.

The licensee is specifically ordered to:

a/ Ensure the care plan for resident #012 is current and that care is provided to the resident as specified, related to toileting and wandering.
b/ Ensure the care plan for resident #014 is current and that care is provided to the resident as specified, related to monitoring during eating.

Grounds / Motifs :

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.

A Critical Incident System (CIS) report was submitted to the Director for an incident which had occurred early in 2016. The report identified that resident #004 had stated that staff were rough with them. The report identified that the resident was transferred by one staff member, PSW #107, that morning, despite the resident's plan of care identifying that the resident required two staff to transfer.

A review by Inspector #625 of resident #004's care plan in place at the time of the incident, identified that the resident required the assistance of two staff members for transfers with a transfer aid. A review of PSW #107's employee records included a note dated February 2016, from the home to the PSW

indicating that the PSW admitted to transferring the resident alone, without the assistance of a second staff member, despite the need for two staff to transfer resident #004.

An interview was conducted by Inspector #625 with the DOC and they reported that resident #004's care plan indicated that they required the assistance of two staff members for transfers and that the resident was transferred by PSW #107, without a second staff member present, and that the PSW had not followed the resident's plan of care when transferring the resident. (196)

2. 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.

On a day during the inspection, resident #012 was observed by Inspector #196 to urinate on the floor. At the time of the incident, PSW #112 was seen to witness the resident urinate and proceeded to clean up the urine after the resident left the area.

The current care plan was reviewed for information regarding toileting needs. Under the focus of urinary incontinence, the interventions include "(resident #012) is toileted with AM and HS care, following meals and PRN".

An interview was conducted with PSW #112 and they reported that the resident had not been assisted with toileting after supper. (196)

3. 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.

On a particular day, during the inspection, Inspector #196 observed resident #012 walk down the west side corridor on one of the units and remove a yellow wander strip from a co-resident's door, entered the room and reapplied the wander strip behind them. Inspector #196 also observed the following related resident room doors and wander strips:

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- another room had the door open and no wander strips
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At 1835hrs, Inspector #196 observed resident #012 as they wandered into a resident room which had the door open and a yellow wander strip hanging down and not affixed across the door. As the Inspector stood outside the door, resident #024 and #025 approached this same room and the co-residents began yelling and cursing at resident #012 and told them to get out of their room.

The health care records for resident #012 were reviewed by Inspector #196. The current care plan identified wandering behaviour and identified strategies to minimize the effect to other residents.

On another day during the inspection, resident #012 was observed walking down the west corridor of the unit. Inspector #196 observed the doors on both sides of the nursing desk were open and several yellow wander strips remained hanging and not affixed on resident room doors.

An interview was conducted with PSW #113 and they confirmed to the Inspector that the doors on both sides of the nursing desk were to be kept locked and also confirmed that the wander strips on the west wing should be attached to the resident doors. (196)

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a day during the inspection at 0930hrs, Inspector #196 observed resident #014 actively feeding them-self, chewing food with a plate of regular textured toast and egg in front of them. The table marker identified the resident's name and had a code to signify a specific diet texture. In addition, there were in excess of 20 residents seated at tables in the dining room, some of which were also eating their breakfast meal.

The dining room did not have a staff member present to monitor this resident or any of the other residents that were eating. The Inspector remained in the dining room and noted RN #106 in the DOC's office at 0935hrs.

At 0938hrs, the Food Service Manager (FSM) entered the dining room from the kitchen and the Inspector questioned the supervision of the dining room. They reported that RN #106 was to supervise and confirmed with the Inspector that there were no staff present at the time of observation.

At 0939hrs, RN #106 entered the dining room and reported to the Inspector that they were supervising the dining room. They confirmed to the Inspector that they were in the DOC's office and for a period of time and as a result, there were no staff members in the dining room providing supervision.

The health care records for resident #014 was reviewed by Inspector #196. The current care plan identified the resident as at risk and required monitoring by staff when eating and drinking.

Previous non-compliance related to this legislation, LTCHA 2007,S.O.2007,c.8,s.6, was issued during the following inspections:
May 2016 - Compliance Order – Inspection #2016_339617_0004
July 2015 - Compliance Order – Inspection #2015_246196_0011
August 2014 - Written Notification/Voluntary Plan of Correction – Inspection #2014_211106_0014
July 2014 - Written Notification/Voluntary Plan of Correction – Inspection #2014_211106_0012
April 2014 - Written Notification/Voluntary Plan of Correction – Inspection #2014_333517_0005

The decision to re-issue this Compliance Order was based on the scope which affected several residents which resulted in a pattern, the severity which indicated minimum harm or potential for actual harm and the compliance history. Despite the issuance of two compliance orders and three WN/VPC in the past three years, the licensee continues to be in non compliance with s.6.(7). (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 02, 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 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 25th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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