Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2015	2015_281542_0007	S-000707-15, S-000708-15, S-000709-15, S-000710-15	Follow up

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St. NORTH BAY ON P1B 6J4

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

CASSELLHOLME
400 OLIVE STREET NORTH BAY ON P1B 6J4

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

JENNIFER LAURICELLA (542)

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): May 4, 5, 6, 7, 8, 2015

Additional Follow Up Logs Inspected: S-000711-15, S-000712-15, S-000713-15, S-000714-15.

During the course of the inspection, the inspector(s) spoke with the CEO/Administrator, Director of Human Resources, Human Resource Generalist, Maintenance Manager, Manager of Clinical Services, Manager of Infection Control/Documentation, RAI Coordinator, Registered Staff, Personal Support Workers and Residents.

Inspector #542 reviewed the following;
- various resident health care records
- numerous policies and procedures
- training records for staff in relation to mandatory training requirements
- orientation manual for new hires
- various staff personal files

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_376594_0019	542
O.Reg 79/10 s. 221. (1)	CO #005	2014_376594_0019	542
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #008	2014_376594_0019	542
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #006	2014_376594_0019	542
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #002	2014_376594_0019	542
LTCHA, 2007 S.O. 2007, c.8 s. 76. (4)	CO #003	2014_376594_0019	542

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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled, "Restraints and Personal Assistance Service Devices (PASDS) Policy and Procedure" is complied with.

Inspector #542 reviewed the home's policy R6.2.0 titled, "Restraint and Personal Assistance Service Devices (PASDS)." The policy defines a PASD as a device used to assist a person with a routine activity of daily living and that a PASD may limit or inhibit movement. It also indicates that a PASD may restrain a resident but is not considered a restraint if the intent is to provide assistance with activities of daily living, that full or half bed rails are PASD's when used to prevent a resident from rolling off the bed, or to promote independence with repositioning while in bed and bed rails are never to be used as a restraint. Inspector #542 interviewed a Manager who confirmed that all bed rails in the home are considered PASDS. Inspector #542 observed resident #004 in bed with two fully padded bed rails raised. The most recent care plan explained that resident #004 used the two bed rails to promote bed mobility with extensive assistance from staff x 2 (total dependence). Inspector #542 interviewed S#119 who stated that the resident cannot reposition themselves as they are not physically able to and that the bed rails are used for safety. Inspector #542 spoke with S#122, who stated that the bed rails are used to decrease the risk of the resident falling out of bed. The resident is not using the bed rails for an activity of daily living as the home's policy indicates.

The licensee's policy states that PASDs are used to assist a person with a routine activity of daily living however the home is using them in some cases to prevent the resident from falling out of bed. [s. 29. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A previous compliance order (CO) was issued in October 2014 during inspection # 2014_376594_0019.

On May 6, 2015, Inspector #542 spoke with a Manager and asked who was responsible for assessing the resident's bed system when bed rails are used. The Manager informed this inspector that they were responsible for the completion of the "Bed Rail Risk Assessment" and that the registered nurses use it to assess the need for bed rails. They stated that the maintenance department is responsible for ensuring that entrapment zones, height and latch reliability are assessed on resident beds. The home used the "Adult Hospital Beds: Patient Entrapment Hazards, side rail latching reliability, and other hazards" by Health Canada as a guide.

On May 7th, 2015, Inspector #542 spoke with another Manager. Inspector was informed that the home uses a tool that is specifically designed for assessing entrapment zones. They indicated that the home completed an assessment on all of the resident beds with regards to the entrapment zones. Inspector asked them to provide documentation to support this. Inspector asked if any of the beds failed the inspection and they stated that eight beds failed. Inspector then asked if any of the beds that failed were still on the units being used by residents and they stated that three of the eight were still being used by residents. Inspector #542 and #613 proceeded to the rooms that the Manager identified approximately thirty minutes after speaking to them and noted that they were changing

the beds with new replacement beds.

On May 8th, 2015, Inspector noted that resident #006 had 2 full rails raised while in bed. This resident was also noted to have a very petite body frame. Inspector reviewed the bed rail risk assessment that was completed by a registered nurse during March, 2015. The assessment indicated that the resident required a wedge at the right side of the mattress by the bed rail as the resident has small limbs that could get stuck. Inspector #542 reviewed the most recent care plan which indicated that the resident was to have a wedge placed on right side between mattress and bed rail. Inspector spoke with S#116 who stated that the resident uses the two bed rails when in bed at all times.

Inspector #542 proceeded to the resident's room and noted that there was no wedge in place as stated in the care plan and that there was a significant gap between the rail and the mattress. Inspector #542 informed S#117, who also confirmed that there was no wedge on the bed or present in the room. S#118 stated that they have never seen a wedge in the resident's room or on their bed. S#117 immediately applied a wedge to the resident's bed as stated in the care plan. Inspector #542 reviewed the "Entrapment Inspection Sheet" that was provided to this inspector by the Maintenance Manager and noted that resident #006's bed and bed rails failed Zone 2 and 4 during the assessment for entrapment.

Upon further review of the "Entrapment Inspection Sheet" it was noted that a total of 61 beds failed entrapment zones 2 and 4, 14 beds failed entrapment Zone 1 and 6 beds fails entrapment zone 4. There was no documentation to support that the licensee ensured that steps were taken to prevent resident entrapment. [s. 15. (1) (b)]

2. The licensee has failed to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability.

On May 7th, 2015, Inspector # 542 spoke with one of the Managers. Inspector was informed that the home uses a tool that is specifically designed for assessing entrapment zones. They indicated that they completed an assessment on all of the beds with regards to the entrapment zones. Inspector asked the Manager to provide documentation to support this.

On May 8th, 2015, Inspector was provided with the home's documentation, "Facility Entrapment Inspection Sheet" which detailed that an assessment of the entrapment zones was completed but there was no mention of the height and latch reliability of the

bed rails. [s. 15. (1) (c)]

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

On May 6th, 2015, Inspector #542 reviewed resident #004's most recent plan of care with regards to the use of a tilted wheel chair and a seat belt. The care plan indicated that resident #004 uses a tilt wheel chair with a regular buckle seat belt and to unbuckle and reposition every 2 hours. The care plan did not indicate any specifics with regards to the devices. Inspector #542 interviewed S#119 who indicated that the resident cannot reposition themselves, uses the seat belt because they slide and that they tilt the resident back in the chair when the resident starts to become sleepy. Inspector #542 spoke with the Manager of Clinical Services who confirmed that the care plan did not provide enough direction to the staff and that no consent was received for the use of the tilted wheel chair or the seat belt.

On May 7th, 2015, the Manager of Clinical Services informed this inspector that the staff was obtaining a consent from the family with regards to the use of the tilted wheel chair and the seat belt and that the care plan had been updated to reflect the use of the PASDS. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and other who provide direct care to resident #004, to be implemented voluntarily.

Issued on this 2nd day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2015_281542_0007
Log No. / Registre no:	S-000707-15, S-000708-15, S-000709-15, S-000710-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 2, 2015
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST 400 Olive St., NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	CASSELLHOLME 400 OLIVE STREET, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, 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: 2014_376594_0019, CO #007;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The licensee shall ensure that the written policy on Restraints and Personal Assistance Service Devices (PASDS) is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy titled, "Restraints and Personal Assistance Service Devices (PASDS) Policy and Procedure" is complied with.

Two previous Written Notifications of non-compliance under LTCHA, s.29 have been issued. Including one voluntary plan of correction (VPC) issued in March 2013 during inspection # 2013_099188_0011 and one compliance order (CO) issued in October 2014 during inspection # 2014_376594_0019.

Inspector #542 reviewed the home's policy R6.2.0 titled, "Restraint and Personal Assistance Service Devices (PASDS)." The policy defines a PASD as a device used to assist a person with a routine activity of daily living and that a PASD may limit or inhibit movement. It also indicates that a PASD may restrain a resident but is not considered a restraint if the intent is to provide assistance with activities of daily living, that full or half bed rails are PASD's when used to prevent a resident from rolling off the bed, or to promote independence with repositioning while in bed and bed rails are never to be used as a restraint. Inspector #542 interviewed the Manager of Infection Control and Documentation who confirmed that all bed rails in the home are considered PASDS. Inspector #542 observed resident #004 in bed with two fully padded bed rails raised. The most recent care plan explained that resident #004 used the two bed rails to promote bed mobility with extensive assistance from staff x 2 (total dependence). Inspector #542 interviewed S#119 who stated that the resident cannot reposition themselves as they are not physically able to and that the bed rails are used for safety. Inspector #542 spoke with S#122, who stated that the bed rails are used to decrease the risk of the resident falling out of bed. The resident is not using the bed rails for an activity of daily living as the home's policy indicates.

The licensee's policy states that PASDs are used to assist a person with a routine activity of daily living however the home is using them in some cases to prevent the resident from falling out of bed. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_376594_0019, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where bed rails are used;
1. steps are taken to prevent resident entrapment, specifically regarding the bed systems that failed the entrapment zones and pose a risk to the resident.
2. height and latch reliability is assessed when bed rails are being used by a resident
The plan shall include a detailed description of what steps the home will complete to ensure resident safety when a bed system fails some or all of the entrapment zones. The plan shall also include specified time frames for the development and implementation and identify the staff member (s) responsible for the implementation.

This plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5
Email: jennifer.lauricella@ontario.ca
The plan must be submitted by July 13, 2015 and fully implemented by July 17, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A previous compliance order (CO) was issued in October 2014 during inspection # 2014_376594_0019.

On May 6, 2015, Inspector #542 spoke with a Manager and asked who was responsible for assessing the resident's bed system when bed rails are used. The Manager informed this inspector that they were responsible for the completion of the "Bed Rail Risk Assessment" and that the registered nurses use it to assess the need for bed rails. They also stated that the maintenance department is responsible for ensuring that entrapment zones, height and latch reliability are assessed on resident beds. The home used the "Adult Hospital Beds: Patient Entrapment Hazards, side rail latching reliability, and other hazards" by Health Canada as a guide.

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On May 8th, 2015, Inspector noted that resident #006 had 2 full rails raised while in bed. This resident was also noted to have a very petite body frame. Inspector reviewed the bed rail risk assessment that was completed by a registered nurse during March, 2015. The assessment indicated that the resident required a wedge at the right side of the mattress by the bed rail as the resident has small limbs that could get stuck. Inspector #542 reviewed the most recent care plan which indicated that the resident was to have a wedge placed on right side between mattress and bed rail. Inspector spoke with S#116 who

stated that the resident uses the two bed rails when in bed at all times.

Inspector #542 proceeded to the resident's room and noted that there was no wedge in place as stated in the care plan and that there was a significant gap between the rail and the mattress. Inspector #542 informed S#117, who also confirmed that there was no wedge on the bed or present in the room. S#118 stated that they have never seen a wedge in the resident's room or on their bed. S#117 immediately applied a wedge to the resident's bed as stated in the care plan. Inspector #542 reviewed the "Entrapment Inspection Sheet" that was provided to this inspector by the Maintenance Manager and noted that resident #006's bed and bed rails failed Zone 2 and 4 during the assessment for entrapment.

Upon further review of the "Entrapment Inspection Sheet" it was noted that a total of 61 beds failed entrapment zones 2 and 4, 14 beds failed entrapment Zone 1 and 6 beds fails entrapment zone 4. There was no documentation to support that the licensee ensured that steps were taken to prevent resident entrapment. (542)

2. The licensee has failed to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability.

On May 7th, 2015, Inspector # 542 spoke with one of the Managers. Inspector was informed that the home uses a tool that is specifically designed for assessing entrapment zones. They indicated that they completed an assessment on all of the beds with regards to the entrapment zones. Inspector asked them to provide documentation to support this.

On May 8th, 2015, Inspector was provided with the homes documentation, "Facility Entrapment Inspection Sheet" which detailed that an assessment of the entrapment zones was completed but there was no mention of the height and latch reliability of the bed rails. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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