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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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 20, 2015	2014_280541_0040	001362-14	Critical Incident System

Licensee/Titulaire de permis

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

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

KENNEDY LODGE
1400 KENNEDY ROAD SCARBOROUGH ON M1P 4V6

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

AMBER MOASE (541), AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 13-15, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, an Associate Director of Care, a Registered Nurse and Personal Support Workers. The Inspector also reviewed a resident health care record, staff training records and policy #LP-C-20-ON and observed residents on their unit.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect Resident #1 from abuse or neglect by the licensee or staff in the home.

O. Reg 79/10 s. 2(1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gesture, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Resident #1 is known to have responsive behaviours including, wandering. Staff who care for the resident reported that the resident will safely wander the unit while staff provide monitoring and redirection as needed.

On a specified date, Resident #1 was wandering the hallway of the unit. At a specified time, PSW #S102, witnessed RPN #S100 taking Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 left the unit at a specified time, leaving Resident #1 confined in his/her room. Upon the staff member's return to the unit approximately 15 to 30 minutes later the resident had been released (by another wandering resident) from his/her room and was wandering the unit. At a later specified time, PSW #S102 and PSW #S104 witnessed PSW #S101 taking Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 and #S104 did not take action to release Resident #1 from his/her room and were unsure when the resident was released from the room. The room in which Resident #1 resides, is a four bed ward room and at the time of the incident three other residents were in the room resting.

PSWs #S102 and #S104 observed Resident #1 being confined to his/her room on 2 separate occasions and did not release the Resident. Neither PSW knew when Resident #1 was released from his/her room after observing the second incident of confinement.

PSW #S102 and PSW #S104 acknowledged that at the time of the incident both staff members understood the actions taken by RPN #S100 and PSW #S101 to tie the door of Resident #1's room closed, constituted abuse. However, neither staff member took action at the time of the events to ensure the safety of Resident #1 in that both staff members did not untie the door to release the resident nor did either staff member report the incident immediately to their supervisory staff member.

Additionally, PSW #S101 and RPN #S100 worked on the unit together where Resident #1 resides on two specified dates and RPN #S100 also worked on the unit on two specified dates after the incident occurred. It is noted that when home became aware of the incident that occurred on the specified date, both PSW #S101 and RPN #S100 were immediately removed from their duties. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

When asked to provide the policy to promote zero tolerance of abuse and neglect of residents, the home provided policy #LP-C-20-ON.

In accordance with O.Regulation 79/10 s. 2(1) emotional abuse means, any threatening, insulting, intimidating or humiliating gesture, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Policy #LP-C-20-ON states that any staff or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it was based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately.

The policy directs staff to ensure the safety and comfort of the abuse victims(s), first taking all reasonable steps to provide for their immediate safety and well-being.

Resident #1 is known to have responsive behaviors including, wandering. Staff who care for the resident reported that the resident will safely wander the unit while staff provide monitoring and redirection as needed.
On a specified date, Resident #1 was wandering the hallway of the unit. At a specified time, PSW #S102, witnessed RPN #S100 to take Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 left the unit approximately 30 minutes later, leaving Resident #1 confined in his/her room. Upon his/her return approximately 15 to 30 minutes later the resident had been released from his/her room and was wandering the unit. At a later specified time that same date, PSW #S102 and PSW #S104 witnessed PSW #S101 to take Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 and #S104 were unsure when the resident was released from the room. The room in which Resident #1 resides is a four bed ward room and at the time of the incident three other residents were in the room resting.

On the night shift of a specified date, PSW #S104 reported the incident identified above to RN #S107. At the end of the night shift on the specified date RN #S107 reported his/her discussion with PSW #S104 to the ADOC #S108. The home immediately began their investigation of the incident. The home identified, during their investigation that the above described incident was witnessed by PSW #S102 and #S104.

PSW #S102 and #S104 both stated the incident was first reported to the home on the specified date when PSW #S104 reported it to RN #S107. PSW #S102 and PSW #S104 acknowledged that at the time of the incident both staff members understood the actions taken by RPN #S100 and PSW #S101 to tie the door of Resident #1's room closed, constituted abuse. However, neither staff member took action at the time of the events to ensure the safety of Resident #1 in that both staff members did not untie the door to release the resident nor did either staff member report the incident immediately to their supervisory staff member. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff comply with the homes policy that promotes zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 c.8 s. 30(1)3 whereby they did not ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

LTCHA 2007 s.31 states a resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care. LTCHA 2007 s.36 describes the restraining of a person when immediate action is necessary to prevent serious bodily harm to the person or to others.

Resident #1 is known to have responsive behaviours including, wandering. The plan of care as well as the staff who care for the resident both indicate that the resident will safely wander the unit while staff provide monitoring and redirection as needed.

On a specified date, Resident #1 was safely wandering the hallway of the unit. At a specified time, PSW #S102, witnessed RPN #S100 taking Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 left the unit at a specified time, upon his/her return approximately 15 to 30 minutes later, the resident had been released from his/her room and was wandering the unit. At a later specified time, PSW #S102 and PSW #S104 witnessed PSW #S101 to take Resident #1 to his/her room and tie the door closed with a laundry bag. Room 221, in which Resident #1 resides, is a four bed ward room and at the time of the incident three other residents were in the room resting.

On a specified date Resident #1 was retrained by the use of a physical device other than in accordance with section 31 and section 36. [s. 30. (1) 3.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report to the Director, under section 23(2) of the Act, includes a description of the incident, names of all residents and staff members involved, present or discovered the incident.

In accordance with LTCHA 2007, s.23(2), the licensee shall report to the Director the results of every investigation undertaken for every alleged suspected or witnessed incident of abuse of a resident by anyone, and every action taken in response to such an incident. Further to this O.Regulation 79/10 s.104 describes the contents of the written report and the time frame, in which the written report is required by the Director.

In accordance with O.Regulation 79/10, s.2(1), emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

On a specified date, Resident #1 was wandering the hallway of the unit. At a specified time, PSW #S102, witnessed RPN #S100 taking Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 left the unit at a specified time, upon his/her return approximately 15 to 30 minutes later the resident had been released from his/her room and was wandering the unit. At a later specified time, PSW #S102 and PSW #S104 witnessed PSW #S101 to take Resident #1 to his/her room and tie the door closed with a laundry bag. The room in which Resident #1 resides, is a four bed ward room and at the time of the incident three other residents were in the room resting.

On a specified date PSW #S104 reported the incident as described above to RN #S107, a supervisory staff member, who then reported to ADOC #S108. An investigation was immediately initiated by an ADOC, the DOC and Administrator. On the same date, a written Critical Incident Report (CIR) was submitted to the Director (MOHLTC), which was amended 5 days later. The home's Administrator confirmed this to be the only written report submitted to the Director.

The CIR does not accurately report the incident as known to the home's lead investigators. The CIR does not correctly describe the timeline of events, in that the report does not indicate the home's conclusions that the date of the incident was on one specified date only, or describe the events as they were known to have occurred through the home's investigation.

Further, the CIR does not indicate the names of the three other residents residing in Resident #1's room, who were affected by the actions of PSW #S101 and RPN #S100 on the date of the incident, nor does it include the full name of staff members PSW #S102 or the name RN #S107. [s. 104. (1) 1.]

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

Issued on this 3rd day of March, 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) :	AMBER MOASE (541), AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2014_280541_0040
Log No. / Registre no:	001362-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 20, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	KENNEDY LODGE 1400 KENNEDY ROAD, SCARBOROUGH, ON, M1P-4V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HEATHER REUBER

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19(1) to ensure all residents are protected from abuse and or neglect.

The plan shall include:
-a mandatory and comprehensive education session for all direct care staff offered in various formats to meet the learning needs of adult learners on the home's Policy to Promote Zero Tolerance of Abuse and Neglect of residents. Specifically education on mandatory reporting and ensuring all staff understand how to respond to the safety and comfort of abuse victims.

The plan shall also include defined interventions to support staff in the integration of this education into their day to day practice.

Grounds / Motifs :

1. The licensee has failed to protect Resident #1 from abuse or neglect by the licensee or staff in the home.

O. Reg 79/10 s. 2(1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gesture, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.
that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Resident #1 is known to have responsive behaviours including, wandering. Staff who care for the resident reported that the resident will safely wander the unit

while staff provide monitoring and redirection as needed.

On a specified date, Resident #1 was wandering the hallway of the unit. At a specified time, PSW #S102, witnessed RPN #S100 taking Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 left the unit approximately 30 minutes later, leaving Resident #1 confined in his/her room. Upon his/her return at approximately 15-30 minutes afterwards the resident had been released (by another wandering resident) from his/her room and was wandering the unit. At a later specified time, PSW #S102 and PSW #S104 witnessed PSW #S101 taking Resident #1 to his/her room and tie the door closed with a laundry bag. PSW #S102 and #S104 were unsure when the resident was released from the room. The room in which Resident #1 resides, is a four bed ward room and at the time of the incident three other residents were in the room resting.

PSWs #S102 and #S104 observed Resident #1 being confined to his/her room on 2 separate occasions and did not release the Resident. Neither PSW knew when Resident #1 was released from his/her room after observing the second incident of confinement.

On the night shift of October 23, 2014 PSW #S104 reported the incident identified above to RN #S107. At the end of the night shift on October 23, 2014 RN #S107 reported her discussion with PSW #S104 to the ADOC #S108. The home immediately began their investigation of the incident. The home identified, during their investigation that the above described incident was witnessed by PSW #S102 and #S104.

PSW #S102 and #S104 both stated the incident was first reported to the home on October 23, 2014 when PSW #S104 reported it to RN #S107.

PSW #S102 and PSW #S104 acknowledged that at the time of the incident both staff members understood the actions taken by RPN #S100 and PSW #S101 to tie the door of room 221 closed, constituted abuse. However, neither staff member took action at the time of the events to ensure the safety of Resident #1 in that both staff members did not untie the door to release the resident nor did either staff member report the incident immediately to their supervisory staff member.

When asked to provide the policy to promote zero tolerance of abuse and

neglect of residents, the home provided policy # LP-C-20-ON.

Policy #LP-C-20-ON states that any staff or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it was based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately.
The policy directs staff to ensure the safety and comfort of the abuse victims(s), first taking all reasonable steps to provide for their immediate safety and well-being.

The licensee failed to comply with:
- LTCHA 2007 c.8 s. 20(1) whereby they did not ensure there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with
- LTCHA 2007 c.8 s. 30(1)3 whereby they did not ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Additionally, PSW #S101 and RPN #S100 worked on the unit together where Resident #1 resides on two dates after the incident occurred and RPN #S100 also worked on the unit two dates after the incident occurred. It is noted that when home became aware of the incident that occurred on the specified date, both PSW #S101 and RPN #S100 were immediately removed from their duties. (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 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 20th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amber Moase

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