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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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
Jan 27, 2015	2015_271532_0001	L-001703-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ELMIRA
120 Barnswallow Drive Elmira ON N3B 2Y9

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

NUZHAT UDDIN (532), CHRISTINE MCCARTHY (588), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 9,12 and 13.

Concurrent CIS were completed:009833-14,008074-14

During the course of the inspection, the inspector(s) spoke with the Executive Director , Director of Care (DOC), Associate Director of Cares (ADOC), Environmental Service Manager, Dietitian, Director of Dietary Service, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance staff, Family and Resident Council Representatives, Residents and Family members. The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures, reviewed educational records, general maintenance of the home, and resident communication system, medication storage areas, and reviewed medication records as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **6 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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 failed to ensure where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) A review of a bed audit revealed that a percentage of the Residents in the home were identified as using one or more bed rails, and another percentage of the Residents were identified as using one or more full bed rails, however, there were no assessments completed and the bed system was not evaluated.

In an interview the Director of Care confirmed that the bed assessment was being developed and that the Residents currently were not being assessed for bed rails or the bed system in accordance with the evidence-based practice and or in accordance with prevailing practices to minimize the risk to the residents. [s. 15. (1) (a)]

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

A) Record review revealed all resident bed systems were tested for entrapment with noted multiple zone fails for multiple Residents with no documented corrective action and no evidence of documentation for reasons for failure.

Record review comparing the two bed audits revealed that there was a time lapse of 18 months where by the home did not follow up with corrective action for either audit where failed zones of entrapment were identified.

Observations of multiple bed systems revealed that there were multiple inconsistencies in mattress type, bed system type and type of rails used for multiple residents as identified on the audit completed by the home.

[redacted]

Staff interview with the DOC and the ESM, confirmed that the home did not have documented evidence that corrective action was taken to correct the failed zones of entrapment dating back to when the entrapment inspection was completed and where bed rails were used, there were no steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (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 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident.

A) Review of care plan records revealed no interventions related to the use of bed rails.

Observation of an identified Resident in bed revealed the use of [redacted] rails.

The RN confirmed that the expectation was that the care plan be accurate in terms of the use of bed rails.

Interview with the Assistant Director of Care confirmed that the Care Plan for this Resident did not include any entries related to the use of bed rails. Care plans did not set out the planned care related to the use of bed rails and did not provide clear directions to staff and others who provide direct care.(588)

B) Record review of the current care plans for the following Residents revealed:

- An identified Resident did not have interventions related to the use of [redacted] bed rail [redacted]
- An identified Resident did not have interventions related to the use of [redacted] bed rails
- An identified Resident did not have interventions related to the use of [redacted] bed rails
- An identified Resident current care plan stated, "Has [redacted] bed rail up [redacted] while in bed." Observation of resident's bed system revealed one full rail and one half bed rails in use while in bed.
- An identified Resident did not have interventions related to the use of [redacted] bed rail [redacted].
- An identified Resident did not have interventions related to the use of [redacted] bed rail.
- An identified Resident current kardex indicated [redacted] bed rails in use. [redacted]

Staff interview with a PSW confirmed the plan of care did not provide clear direction and it was the home's expectation that the accurate number and type of rails used was documented in the plan of care.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that multiple residents' care plans did not set out the planned care related to the use of bed rails and did not provide clear directions to staff and others who provide direct care. [s. 6. (1)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A) A record review and plan of care indicated that an assistive device was applied on an identified Resident.

In an interview the Resident indicated that the assistive device was applied to ensure their safety.

At the time of observation there was no assistive device applied.

Registered Nurse in an interview indicated that the assistive device should be attached to the Resident.

A PSW was observed searching for the assistive device and was unable to locate it. The same PSW reported that the assistive device was removed from the Resident the evening prior.

RN confirmed that when the Resident was reassessed, the plan of care should have been reviewed and revised at the time when the Resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with:

A) Record review of the "Continence Management Program - Bladder and Bowel" policy revealed " Procedure: 1. Assessment: The inter-professional team will conduct a bladder and bowel continence assessment that addresses the resident's goals, desire and ability

to maintain current function or implement restorative bowel and bladder interventions within 7 days of admission; following any change in resident condition that affects continence, and with quarterly RAP."

A record review revealed that an identified Resident was assessed as being occasionally incontinent of bowel.

A record review revealed that the Resident was assessed as being frequently incontinent of bowel.

A Record review indicated that a "Continence/Bowel Assessment V5" assessment in Point Click Care(PCC) was not completed when a change in bowel function was noted. (532)

B) Record review comparison for an identified Resident revealed an improvement in bowel function. The Resident was most recently assessed as usually continent of bowel.

Record review indicated that a "Continence/Bowel Assessment V5" assessment in Point Click Care (PCC) was not completed when an improvement in bowel function was noted. (563)

C) Record review revealed that a change in urinary continence for an identified Resident was noted as frequently incontinent of bladder.

Another record review listed this Resident as occasionally incontinent.

Record review indicated that a "Continence/Bowel Assessment V5" assessment in Point Click Care (PCC) was not completed when a change in bladder function was noted.

Staff interview with the Director of Care (DOC) revealed that the “Continence/Bowel Assessment V5" assessment was currently being completed on admission and section H in the MDS assessment was considered the assessment tool to be completed quarterly, annually and or for a significant change in bladder and/or bowel function. The DOC confirmed that this contradicted the "Continence Management Program - Bladder and Bowel" policy and the policy and procedure put in place was not complied with. [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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) Continence and Fall evaluation record review revealed that the evaluation did not include the names of the persons who participated in the evaluation, and the dates that the changes were implemented.

In an interview the Director of Care confirmed that all of the organized programs were evaluated in the same format and did not include the names of the persons who participated in the evaluation and the dates that the changes were implemented, however, new forms were being developed and updated to include all of the required Legislation. [s. 30. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutrition Care and Hydration Program include a weight monitoring system to measure and record, with respect to each resident, body mass index (BMI) and height upon admission and annually thereafter.

A) Record review revealed that a percentage of Residents were not measured for height in 2014.

Staff interview with the Resident Assessment Instrument Coordinator (RAI-C) revealed most Residents did not get measured for height and many Residents have not had a height measured and recorded since 2012.

Staff interview with Registered Dietitian confirmed the most recent height measurement was what calculated the BMI for each Resident.

The RAI-C confirmed that Residents should be measured for body mass index and height upon admission and annually. [s. 68. (2) (e) (ii)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) Observations revealed the following:
- An identified Resident had an unlabelled denture cup in the shared bathroom in an identified room.
- An identified Resident had an unlabelled toothbrush, razor and soap dish sitting in shared bathroom in an identified room.
- An identified Resident had an unlabelled urine collection hat stored on the hand rail behind the toilet in an identified room.
- An identified Resident had unlabelled items i.e. soap dish, toothbrush razors and deodorant stick in a shared bathroom.

Infection Control Practitioner confirmed that Resident's personal items should be labelled in the shared bathrooms and Sharpie markers were provided to the staff to ensure all items were labelled and stored appropriately. [s. 229. (4)]

Issued on this 27th day of January, 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) :	NUZHAT UDDIN (532), CHRISTINE MCCARTHY (588), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2015_271532_0001
Log No. / Registre no:	L-001703-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 2015
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - ELMIRA 120 Barnswallow Drive, Elmira, ON, N3B-2Y9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHY HOLLAND

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT 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)

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 ensure that each resident in the home 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.

Grounds / Motifs :

1. The licensee failed to ensure where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) A review of a bed audit revealed that a percentage of the Residents in the home were identified as using one or more bed rails, and another percentage of the Residents were identified as using one or more full bed rails, however, there were no assessments completed and the bed system was not evaluated.

In an interview the Director of Care confirmed that the bed assessment was being developed and that the Residents currently were not being assessed for bed rails or the bed system in accordance with the evidence-based practice and or in accordance with prevailing practices to minimize the risk to the residents.

[s. 15. (1) (a)] (532)

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

A) Record review revealed all resident bed systems were tested for entrapment with noted multiple zone fails for multiple Residents with no documented corrective action and no evidence of documentation for reasons for failure.

Record review comparing the two audits revealed that there was a time lapse of 18 months where by the home did not follow up with corrective action for either audit where failed zones of entrapment were identified.

Observations of multiple bed systems revealed that there were multiple inconsistencies in mattress type, bed system type and type of rails used for multiple residents as identified on the audit completed by the home.

[redacted]

[redacted]

Staff interview with the DOC and the ESM, confirmed that the home did not have documented evidence that corrective action was taken to correct the failed zones of entrapment dating back to when the entrapment inspection was completed and where bed rails were used, there were no steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)] (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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 27th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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