Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 18, 2017	2016_444602_0040	013510-16	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED COUNTIES OF LEEDS AND GRENVILLE
746 County Road 42 P.O Box 100 ATHENS ON K0E 1B0

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

MAPLE VIEW LODGE
746 COUNTY ROAD, 42 EAST P.O. BOX 100 ATHENS ON K0E 1B0

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

WENDY BROWN (602), DARLENE MURPHY (103)

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): December 5th, 6th & 7th and December 13th & 14th, 2016

The following logs were included in the inspection:
Log# 034123-16 concerning alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Registered Dietician (RD), Resident & Support Services Supervisors (RSSS), Dietary Staff, residents and resident family members. Additionally, the inspector(s) conducted a full walking tour of the home, completed resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies & procedures, as well as the home's staffing plan.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 that where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

During the inspection, the inspectors observed fourteen out of twenty residents utilized one or more bed rails including full rails, quarter rails, and rails that the home termed "buddy" rails.

Resident #018 was observed to have two full bed rails up when in bed. The resident health care record was reviewed and indicated upon admission to the home in an identified year, a restraint assessment titled, "Restraint initial assessment" had been completed. The assessment indicated the resident required two full rails to prevent falls and risk of injury and that physiotherapy and a low bed had been considered as alternatives at that time. The next documented assessment related to bed rails was completed in November 2016 titled, "Restraint Monthly Review" and indicated the resident continued to require two full bed rails to prevent falls. Under "Time of use", the assessment indicated day time and evening time, and under "resident response" the resident's behaviour was noted. Under "Interventions attempted to decrease or discontinue the restraint" there was nothing listed. The assessment concluded the two full bed rails should be continued and there was no additional documented information related to the use of bed rails with resident #018. PSW staff were interviewed and indicated resident #018 required full bed rails at all times, not just day and evening, when in bed and this same information was included on the resident logo at the bedside.

Resident #009 and #016 were observed to have rails that the home termed as "buddy"

rails. These rails had an inside opening of forty-five centimetres by twenty-eight centimetres and the rails had extensions that were slipped under the mattress and then secured to the bed by means of zip ties to the bed frame. The upper portion of the rails were covered in a protective black foam. Staff were interviewed and indicated the rails were used as a means to assist the resident with bed mobility. The resident health care records were reviewed and there was no documented evidence of assessment related to the use of these bed rails for either resident.

Resident #042 had been admitted to the home in an identified year. This resident was observed to have a bed rail similar to that of resident’s #009 and #016 and resident #042 indicated he/she brought the bed rail with him/her when admitted into the home. There was no documented bed rail assessment found for this resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources". One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they are asleep).

The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered. Where bed rails are considered for transferring and bed mobility, it recommended that discussions needed to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the residents medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed) and environmental factors, all of which could more

accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The Director of Care (DOC) was interviewed and indicated she was aware of the Health Canada documents related to bed system assessments and bed rail safety. She indicated she had assessed all resident bed systems in the home for resident entrapment risk and all beds in the home had passed. The inspector requested a copy of the documented bed rail assessments for residents #018, #009, #016 and #042. The DOC indicated the home only completes a bed rail assessment when two full rails are used as these are considered restraints. The DOC indicated a bed rail assessment would only have been completed for resident #018 as two full bed rails are used.

In discussion with the DOC, the inspector raised concerns that the use of any and all bed rails require assessment, as outlined in the Clinical Guidance document, even if they are not considered restraints due to the potential risk for resident entrapment. Additionally, the inspector raised concerns related to the large opening in the “buddy” rails being used on resident #009’s and #016’s bed as visually this appeared to be an area where entrapment could occur. During discussion with the DOC in regards to the “buddy” rail being used on #042’s bed, the DOC indicated she had not been made aware of the resident's use of this rail until that day and the bed system assessment had not been completed since the addition of this bed rail.

The bed rail assessment utilized in the home for the use of full bed rails was reviewed and failed to consider the areas recommended in the Clinical Guidance document as outlined above. Additionally, the DOC indicated the decision to utilize bed rails was decided primarily by the resident/family members and that a multidisciplinary approach was not currently being utilized.

The decision to issue this non-compliance as an order was based on the following:

The scope was assessed as widespread due to the number of residents utilizing some form of a bed rail.
The severity was assessed as potential for harm given the home’s failure to assess the

use of bed rails other that two full rails and the use of rails that had large openings. The home's compliance history was reviewed and the home did not have any similar findings of non-compliance. [s. 15. (1) (a)]

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 comply with LTCHA 2007, c.8, s. 20 (1) in that every licensee must ensure compliance with their policy to promote zero tolerance of abuse and neglect.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" is defined as: "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident", and/or,
"any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

According to the critical incident report initiated by Maple View Lodge on a specified date, PSWs #115 and #116 were completing resident #050's care; as PSW #116 began to assist resident #050 with a care need, PSW #115 asked why the resident was being assisted. PSW #116 explained that this care was part of the resident's routine. PSW #115 is reported to have indicated resident #050 shouldn't receive this care again as the resident had already received this care earlier and then made several inappropriate, cruel comments regarding the resident. PSW #116 shared that later that shift, when responding to resident #050's call bell, the staff asked the resident if he/she was okay and if he/she had a problem with his/her earlier care; the resident replied "it wasn't you, it was [PSW#115]."

The ADOC was interviewed by Inspector #602 and indicated that PSW#116 alerted her to the incident on a specified date. Upon hearing the information the ADOC interviewed the resident who noted that one of the PSWs was not happy that he/she needed help but explained he/she was given the assistance by others for his/her needs. The resident denied hearing any comments made by PSW #115.

The ADOC provided the Home's Resident Abuse Policy # MVL-RESPOL1. The policy directs that staff are to "report incidents of abuse /neglect immediately". The ADOC indicated that PSW#116 acknowledged, upon review of staff responsibilities specific to abuse reporting, her awareness of the policy and knew she should have reported the incident when it occurred. [s. 20. (1)]

Issued on this 18th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602), DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2016_444602_0040
Log No. / Registre no:	013510-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 18, 2017
Licensee / Titulaire de permis :	UNITED COUNTIES OF LEEDS AND GRENVILLE 746 County Road 42, P.O Box 100, ATHENS, ON, K0E-1B0
LTC Home / Foyer de SLD :	MAPLE VIEW LODGE 746 COUNTY ROAD, 42 EAST, P.O. BOX 100, ATHENS, ON, K0E-1B0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Chaplin

To UNITED COUNTIES OF LEEDS AND GRENVILLE, 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

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 is hereby ordered to complete the following:

1. Amend the home's existing Bed Rail Assessment to include all relevant questions and guidance related to bed safety hazards found in the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Home and Home Care Settings (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008. The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and

b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternatives were effective or not during an observation period.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment and document the assessed results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories that may be required to mitigate any identified bed safety hazards.

4. An on-going monitoring process shall be established to ensure that all staff apply the bed rails as specified in the plan of care (i.e. when and how many).

5. Develop an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

During the inspection, the inspectors observed fourteen out of twenty residents utilized one or more bed rails including full rails, quarter rails, and rails that the home termed “buddy” rails.

Resident #018 was observed to have two full bed rails up when in bed. The resident health care record was reviewed and indicated upon admission to the home in an identified year, a restraint assessment titled, "Restraint initial assessment" had been completed. The assessment indicated the resident required two full rails to prevent falls and risk of injury and that physiotherapy and a low bed had been considered as alternatives at that time. The next documented assessment related to bed rails was completed in November 2016 titled, "Restraint Monthly Review" and indicated the resident continued to require two full bed rails to prevent falls. Under "Time of use", the assessment indicated day time and evening time, and under "resident response" the resident’s behaviour was noted. Under “Interventions attempted to decrease or discontinue the restraint” there was nothing listed. The assessment concluded the two full bed rails should be continued and there was no additional documented information related to the use of bed rails with resident #018. PSW staff were interviewed and indicated resident #018 required full bed rails at all times, not just day and evening, when in bed and this same information was included on the resident logo at the bedside.

Resident #009 and #016 were observed to have rails that the home termed as “buddy” rails. These rails had an inside opening of forty-five centimeters by twenty-eight centimeters and the rails had extensions that were slipped under the mattress and then secured to the bed by means of zip ties to the bed frame. The upper portion of the rails were covered in a protective black foam. Staff were interviewed and indicated the rails were used as a means to assist the resident with bed mobility and that one of the rails had been provided by family and the other rail had been provided by the home. The resident health care records were reviewed and there was no documented evidence of assessment related to the use of these bed rails for either resident.

Resident #042 had been admitted to the home in an identified year. This resident was observed to have a bed rail similar to that of resident's #009 and #016 and resident #042 indicated he/she brought the bed rail with him/her when admitted into the home. There was no documented bed rail assessment found for this resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources". One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they are asleep).

The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered. Where bed rails are considered for transferring and bed mobility, it recommended that discussions needed to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the residents medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed) and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what

sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The Director of Care (DOC) was interviewed and indicated she was aware of the Health Canada documents related to bed system assessments and bed rail safety. She indicated she had assessed all resident bed systems in the home for resident entrapment risk and all beds in the home had passed. The inspector requested a copy of the documented bed rail assessments for residents #018, #009, #016 and #042. The DOC indicated the home only completes a bed rail assessment when two full rails are used as these are considered restraints. The DOC indicated a bed rail assessment would only have been completed for resident #018 as two full bed rails are used.

In discussion with the DOC, the inspector raised concerns that the use of any and all bed rails require assessment, as outlined in the Clinical Guidance document, even if they are not considered restraints due to the potential risk for resident entrapment. Additionally, the inspector raised concerns related to the large opening in the “buddy” rails being used on resident #009’s and #016’s bed as visually this appeared to be an area where entrapment could occur. During discussion with the DOC in regards to the “buddy” rail being used on #042’s bed, the DOC indicated she had not been made aware of the resident's use of this rail until that day and the bed system assessment had not been completed since the addition of this bed rail.

The bed rail assessment utilized in the home for the use of full bed rails was reviewed and failed to consider the areas recommended in the Clinical Guidance document as outlined above. Additionally, the DOC indicated the decision to utilize bed rails was decided primarily by the resident/family members and that a multidisciplinary approach was not currently being utilized.

The decision to issue this non-compliance as an order was based on the following:

The scope was assessed as widespread due to the number of residents utilizing some form of a bed rail.
The severity was assessed as potential for harm given the home’s failure to assess the use of bed rails other that two full rails and the use of rails that had large openings.

The home's compliance history was reviewed and the home did not have any similar findings of non-compliance. (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

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