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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2014	2013_168202_0068	T-536-13	Other

Licensee/Titulaire de permis

MARIANN NURSING HOME AND RESIDENCE
9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1

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

MARIANN HOME
9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1

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

VALERIE JOHNSTON (202), RANIA RUFFA (562), TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 16, 17, 18, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Program/Volunteer Manager, Registered Nursing Staff, Personal Support Workers, Activation Aide, Dietary Aide, Housekeeping Aides, Residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, conducted a tour of the home, observed lunch meal service, reviewed Resident's Council meeting minutes for January 2013-December 2013, reviewed the home's policies related to abuse and neglect, reviewed staff education records on abuse.

The following Inspection Protocols were used during this inspection:
Dining Observation
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 failed to ensure that residents are protected from verbal abuse. [s.19. (1)]

A review of Resident's Council meeting minutes for an identified period of time revealed that on an identified date residents expressed concerns of not being

respected by staff during meal services. Residents reported that the following statements were made by staff while in the dining room.
1. "You are not the only resident here you know".
2. "We have more stuff to do then waste our time with you".
3. "Quit talking and do more eating".
An interview with an identified Activation Aide (AA) in attendance at the identified Resident's Council meeting confirmed that residents reported the above statements and indicated that he/she documented the concerns within the Resident's Council meeting minutes and forwarded the minutes to the Director of Care (DOC). An interview with the DOC confirmed that the concerns raised at the identified Resident's Council meeting were verbal abuse. The DOC revealed that he/she responded to the verbal abuse allegations by educating staff on the Resident's Bill of Rights and the home's Abuse policy. The DOC indicated that the verbal abuse allegations were not further investigated because residents of the home did not provide a staff member's name or date of occurrence. The DOC revealed that staff #1 was terminated for speculation that this staff member had verbally abused residents based on his/her employee record on file at the home. The DOC was unable to provide specific details to support that the home conducted an investigation, including residents and staff that may have been interviewed both prior to and proceeding the termination of staff #1. The DOC indicated that the home reported back to the Resident's Council at the next meeting and indicated that the residents at the meeting expressed no further concerns.
Staff and residents were interviewed throughout the home which revealed ongoing concerns of verbal abuse by staff #2 who is loud, rude and intimidating to cognitively impaired residents especially in the dining room. Residents and staff indicated in interviews that they were fearful to report staff #2 for fear of repercussion from both staff #2 and management of the home.
Resident interviews revealed that after reporting the verbal abuse at the Resident's Council meeting on an identified date, there have been no changes in the home. Staff #2 continues to work at the home and continues to be intimidating to residents. An interview with resident #003 revealed that he/she has confronted staff #2 when he/she is verbally abusive to other residents, however staff #2 will yell and state that he/she is to mind his/her own business. An interview with resident #005 revealed that he/she is concerned about this staff member in the home and wishes to feel safer living at the home. All interviews lead to the identification of staff #2 currently working in the home and not staff #1 who had been terminated for the above allegations. The results of this inspection were shared with the Administrator. [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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated. [s. 23 (1) (a) (i)].

A review of Resident's Council meeting minutes for an identified period of time revealed that on an identified date residents expressed concerns of not being respected by staff during meal services. Residents reported that the following statements were made by staff while in the dining room.
1. "You are not the only resident here you know".
2. "We have more stuff to do then waste our time with you".
3. "Quit talking and do more eating".
An interview with the DOC confirmed that the concerns raised at the identified Resident's Council meeting were verbal abuse. The DOC revealed that he/she responded to the verbal abuse allegations by educating staff on the Resident's Bill of Rights and the home's Abuse policy. The DOC confirmed in an interview that the above statements could not be investigated because the residents of the home did not provide a staff members name. The DOC revealed however that an identified staff member was terminated for speculation that he/she had verbally abused residents based on his/her employee record on file at the home. The DOC was unable to provide specific details to support that the home conducted an investigation, including residents and staff that may have been interviewed both prior to and proceeding the termination of staff #1. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours. [s.53.(4)(b)]

Staff interviews and clinical record review identified resident #001 as having responsive behaviours. A review of resident #001's progress notes for an identified period of time, revealed that on an identified date resident #001 was agitated and upset, received an injury from another resident's wheelchair while residents were transferring out of the dining room. An interview with an identified staff member revealed that resident #001 becomes agitated and will accuse the staff of stealing his/her things. Staff interviews revealed that taking items from resident #001 is an identified trigger for resident #001's aggression. Staff interviews and clinical record review confirmed that there are no other strategies developed or implemented to respond to resident #001's responsive behaviours. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On December 16, 2013 at 1030 hours, the tub room door on the second floor was observed to be unlocked with no locking system on door. There were two prescription creams found on carts in the tub room.
On December 16, 2013 at 1100 hours, the tub room door on the third floor was observed to have no locking system on the door, and the door knob was broken. There was a prescription cream found on the cart in the tub room.
An interview with an identified Personal Support Worker confirmed that prescription creams are kept on the cart in the tub room which is unlocked and accessible by all residents as residents use the central bathroom inside. An interview with an identified Registered Nurse confirmed that residents' prescription creams are applied by Personal Support Workers during care, however the prescription creams are to be placed on locked treatment carts in the medication room after care is provided. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents. [s.5]

During the course of this inspection on December 16, 17, 2013 the second and third floor utility rooms were observed to be unlocked with one spray bottle of Mikro Quat Detergent/Germicide on a shelf inside accessible to residents. The label on the bottle of the Mikro Quat Detergent indicated harmful if swallowed. Interviews held with an identified Personal Support Worker and the Director of Care confirmed that the above soiled utility rooms were unlocked and are kept unlocked at times. [s. 5.]

WN #6: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s.20.(2) (d)]

A review of the Home's abuse and neglect policy titled, Standards of Employee Conduct - Resident Abuse & Neglect Policy - Zero Tolerance dated Sept 2013 states that all staff and volunteers MUST immediately report to the Director of Care all suspected, alleged, witnessed or actual incidents of resident abuse or neglect. The home's abuse and neglect does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director. [s.24 (1)]

A review of Resident's Council meeting minutes for an identified period of time revealed that on an identified date residents expressed concerns of not being respected by staff during meal services. Residents reported that the following statements were made by staff while in the dining room.
1. "You are not the only resident here you know".
2. "We have more stuff to do then waste our time with you".
3. "Quit talking and do more eating".
An interview with the DOC confirmed that the concerns raised at the above Resident's Council meeting were verbal abuse. The DOC confirmed in an interview that the allegations of verbal abuse were not reported to the Director. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.
A review of the Home's abuse and neglect policy titled, Standards of Employee Conduct - Resident Abuse & Neglect Policy - Zero Tolerance dated Sept 2013 and staff interview confirmed that the above policy does not identify the training and retraining requirements for all staff. [s. 96. (e)]

Issued on this 24th day of January, 2014

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

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) :	VALERIE JOHNSTON (202), RANIA RUFFA (562), TILDA HUI (512)
Inspection No. / No de l'inspection :	2013_168202_0068
Log No. / Registre no:	T-536-13
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Jan 20, 2014
Licensee / Titulaire de permis :	MARIANN NURSING HOME AND RESIDENCE 9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1
LTC Home / Foyer de SLD :	MARIANN HOME 9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BERNARD BORELAND

To MARIANN NURSING HOME AND RESIDENCE, 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) (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 to ensure that residents are protected from verbal abuse. Please submit plan to valerie.johnston@ontario.ca by February 14, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that residents are protected from verbal abuse. [s.19. (1)]

A review of Resident's Council meeting minutes for an identified period of time revealed that on an identified date residents expressed concerns of not being respected by staff during meal services. Residents reported that the following statements were made by staff while in the dining room.
1. "You are not the only resident here you know".
2. "We have more stuff to do then waste our time with you".
3. "Quit talking and do more eating".
An interview with an identified Activation Aide (AA) in attendance at the identified Resident's Council meeting confirmed that residents reported the above statements and indicated that he/she documented the concerns within the Resident's Council meeting minutes and forwarded the minutes to the Director of Care (DOC). An interview with the DOC confirmed that the concerns raised at the identified Resident's Council meeting were verbal abuse. The DOC revealed that he/she responded to the verbal abuse allegations by educating staff on the Resident's Bill of Rights and the home's Abuse policy. The DOC indicated that the verbal abuse allegations were not further investigated because residents of the home did not provide a staff member's name or date of occurrence. The DOC revealed that staff #1 was terminated for speculation that this staff member had verbally abused residents based on his/her employee record on file at the

home. The DOC was unable to provide specific details to support that the home conducted an investigation, including residents and staff that may have been interviewed both prior to and proceeding the termination of staff #1. The DOC indicated that the home reported back to the Resident's Council at the next meeting and indicated that the residents at the meeting expressed no further concerns.
Staff and residents were interviewed throughout the home which revealed ongoing concerns of verbal abuse by staff #2 who is loud, rude and intimidating to cognitively impaired residents especially in the dining room. Residents and staff indicated in interviews that they were fearful to report staff #2 for fear of repercussion from both staff #2 and management of the home.
Resident interviews revealed that after reporting the verbal abuse at the Resident's Council meeting on an identified date, there have been no changes in the home. Staff #2 continues to work at the home and continues to be intimidating to residents. An interview with resident #003 revealed that he/she has confronted staff #2 when he/she is verbally abusive to other residents, however staff #2 will yell and state that he/she is to mind his/her own business. An interview with resident #005 revealed that he/she is concerned about this staff member in the home and wishes to feel safer living at the home. All interviews lead to the identification of staff #2 currently working in the home and not staff #1 who had been terminated for the above allegations. The results of this inspection were shared with the Administrator. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2014

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 January, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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