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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 4, 2012	2012_049143_0052	O-002349-12	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street, KINGSTON, ON, K7L-2Z3

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

RIDEAUCREST HOME
175 RIDEAU STREET, KINGSTON, ON, K7K-3H6

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 26th-28th, December 3-4, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Nurse Practitioner, a Coroner, a Kingston City Police Detective, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Office Administrative Staff, a family member and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records inclusive of assessments, plan of care, physician orders, reviewed falls and abuse policies and procedures and Falls/Restraint Committee minutes and continuous quality improvements related to falls management.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Hospitalization and Death

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

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 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. ON/Regulation 79/10 section 48.(1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and risk of injury.

A review of the homes Fall Policy (policy number 09-02-01, July 2010 origin date) was conducted.

Procedure 10 states that when a resident falls, Registered Staff will:
a. Immediately assess the resident including range of motion, pain (verbal/non verbal) signs, skin integrity, vital signs, responsiveness, head injury and ambulation if applicable.

Procedure 11 states that if there are any concerns related to the well being of the resident, examples include:
a. the resident is unable to move a limb without experiencing pain,
c. there is external rotation and shortening of either lower limb, have the resident remain where they are and call 911 for transfer to hospital.

On a specified date and time S114(Personal Support Worker/PSW) and S105 (Registered Practical Nurse/RPN) overheard a resident altercation. S114(PSW) reports observing resident # 1 flying backwards through the air. Both S114 and S105 reported that resident # 1 presented in pain with loud screams and moaning. A lift was used and resident # 1 was transferred to bed. S105 reported that he/she completed a falls assessment and documented care provided to the resident. S103 assessed the resident and ordered the resident to be transferred to hospital. The charge Registered Nurse(RN) (S104) who was working the night shift of the incident was interviewed by telephone. S104 reported that he/she did not complete a falls assessment of resident # 1's injury.
The licensee has failed to comply with ON/Regulation 79/10 section 8.(1)b by not complying with the homes Fall Policy. [. 8. (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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. On a specified date and time resident # 1 was physically abused (pushed by resident # 2) fell and sustained an injury. The EO Post Falls Analysis was initiated by S105 (RPN) but was not completed. On a specified date and time S103 completed a physical assessment of the resident and ordered the resident be transferred to hospital. The Charge RN (S104) working the night shift of the incident was interviewed on November 27th, 2012 at 0545 by telephone. S104 reported that she/he had not completed a fall assessment of resident #1's injury.
The licensee has failed to comply with ON/Regulation 79/10 section 49.(2) [s. 49. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. On a specified date and time resident # 1 was physically abused by resident # 2. Resident # 2 pushed resident # 1 who fell and sustained an injury. Resident # 1 was transferred to hospital and later passed away. On a specified date resident # 2 was interviewed and reported having pushed resident # 1. On a specified date a Personal Support Worker (S114) reported observing resident # 1 falling backwards. On a specified date RPN (S105) reported that resident # 2 informed him/her that they had pushed resident # 1. On specified date and time (S111) RN documented on the progress notes that resident # 1 wandered into resident # 2 room and that resident # 2 told resident # 1 to get out and hit him/her and pushed him/her to the floor. The resident's substitute decision maker(SDM) was informed of the incident of physical abuse nine hours later.
The licensee has failed to comply with ON/Regulation 79/10 by not immediately notifying the resident's SDM of becoming aware of an incident of physical abuse. [. 97. (1) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker is immediately notified of physical abuse that resulted in physical injury or pain to the resident, to be implemented voluntarily.

WN #4: 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. On a specified date and time resident # 1 was physically abused by resident # 2. Resident # 2 pushed resident # 1 who fell and sustained an injury. Resident # 1 was transferred to hospital and passed away at a later date. On a specified date resident # 2 was interviewed and reported having pushed resident # 1. On a specified date a Personal Support Worker (S114) reported observing resident # 1 falling backwards. On a specified date, RPN (S105) reported that resident # 2 informed her/him that they had pushed resident # 1. On a specified date and time a Registered Nurse (S111) documented on the progress notes that resident # 1 wandered into resident # 2's room and that resident # 2 told resident # 1 to get out and then hit him/her and pushed him/her to the floor. On a specified date the substitute decision maker was informed of the incident of physical abuse nine hours following the incident.
On a specified date the Administrator, the Director of Nursing and the Assistant of Director were interviewed and indicated that they had not assessed the incident as being abusive and had not immediately investigated abuse of the resident.
The licensee has failed to comply with the Long Term Care Homes Act 2007 section 23 (1) (a) by not immediately investigating abuse of a resident by anyone. [. 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 is immediately investigated and appropriate action is taken, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. On a specified date and time resident # 1 was physically abused by resident # 2. Resident # 2 pushed resident # 1 who fell and sustained an injury. Resident # 1 was transferred to hospital and passed away at a later date. On a specified date resident # 2 was interviewed and reported having pushed resident # 1. On a specified date, a Personal Support Worker (S114) reported observing resident # 1 flying through the air backwards. On a specified date RPN (S105) reported that resident # 2 informed her/him that they had pushed resident # 1. On a specified date and time a Registered Nurse (S111) documented on the progress notes that resident # 1 wandered into resident # 2's room and that resident # 2 told resident # 1 to get out and then hit him/her and pushed resident # 1 to the floor. On a specified date the resident's Substitute Decision Maker was informed of the incident of physical abuse nine hours after the incident.
On a specified date the Coroner was advised by the inspector of resident # 1 being observed by the S114 (PSW) falling as well as resident # 2 informing staff and the inspector that he/she had pushed resident # 1. On a specified date the Administrator notified the Kingston City Police of the incident of physical abuse which was approximately twenty one days following the incident.
The licensee has failed to comply with ON/Regulation 79/10 by not immediately notifying the appropriate police force. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect that may constitute a criminal offence, to be implemented voluntarily.

Issued on this 19th day of December, 2012

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) :	PAUL MILLER (143)
Inspection No. / No de l'inspection :	2012_049143_0052
Log No. / Registre no:	O-002349-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 4, 2012
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KINGSTON 216 Ontario Street, KINGSTON, ON, K7L-2Z3
LTC Home / Foyer de SLD :	RIDEAUCREST HOME 175 RIDEAU STREET, KINGSTON, ON, K7K-3H6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deb Green ~~JANICE HODGSON (ACTING)~~

To THE CORPORATION OF THE CITY OF KINGSTON, 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 :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that the homes Falls Prevention Program is complied with.
This plan shall include an educational component to ensure that all Registered Nursing Staff are knowledgeable of the requirements of the falls prevention program including post falls assessment and hospital transfers as required.

The plan is to be submitted in writing by December 18, 2012 to Inspector, Paul Miller at 347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 1-613-569-9670.

Grounds / Motifs :

1. ON/Regulation 79/10 section 48.(1) states that every licensee of a long-term care home shall ensure that the following: interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and risk of injury.

A review of the homes Fall Policy (# 09-02-01, July 2010 origin date) was conducted.

Procedure 10 states that when a resident falls, Registered Staff will:
a. Immediately assess the resident including range of motion, pain (verbal/non verbal) signs, skin integrity, vital signs, responsiveness, head injury and ambulation if applicable.

Procedure 11 states that if there are any concerns related to the well being of the resident, examples include:
a. the resident is unable to move a limb without experiencing pain,
c. there is external rotation and shortening of either lower limb, have the resident remain where they are and call 911 for transfer to hospital.

On a specified date and time S114 (Personal Support Worker/PSW) and S105 (Registered Practical Nurse/RPN) overheard a verbal altercation between two residents. S114(PSW) reports observing resident # 1 flying backwards through the air. Both S114 and S105 reported that resident # 1 presented in pain with loud screams and moaning. A lift was used and the resident was transferred to bed. S105 reported to the inspector that he/she completed a falls assessment and documented care provided to the resident. On a specified date and time S103(Nurse Practitioner) assessed the resident and ordered the resident to be transferred to hospital. The charge Registered Nurse (S104) who worked the night shift of the incident was interviewed by telephone by the inspector. S104 reported that they had not completed a post fall assessment of the resident. The licensee has failed to comply with ON/Regulation 79/10 section 8.(1)b by not complying with the homes Fall Policy.
(143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall ensure that Registered Staff complete post fall assessments.

Grounds / Motifs :

1. On a specified date and time resident # 1 was physically abused (pushed by resident # 2) fell and sustained an injury. The EO Post Falls Analysis was initiated by S105 (RPN) on a specified date and time but was not completed. On a specified date and time the Nurse Practitioner (S103) completed a physical assessment of the resident and ordered the resident to be transferred to hospital. The Charge Registered Nurse (S104) who worked the night shift of the incident was interviewed by the inspector. S104 reported that he/she did not complete a post fall assessment of resident # 1's injury.
The licensee has failed to comply with ON/Regulation 79/10 section 49.(2) by not completing the post falls assessment using a clinically appropriated assessment instrument designed for falls. (143)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that resident's substitute decision-maker are immediately notified upon the licensee becoming aware of an incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident. This plan shall include an educational component to ensure that all Registered Nursing Staff are knowledgeable of the requirements of the abuse prevention program including mandatory reporting requirements.
The plan is to be submitted in writing by December 18, 2012 to Inspector, Paul Miller at 347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 1-613-569-9670.

Grounds / Motifs :

1. On a specified date and time resident #1 was physically abused by resident # 2. Resident # 2 pushed resident # 1 who fell and sustained an injury. Resident # 1 was transferred to hospital and passed away at a later date. On a specified date resident # 2 was interviewed by the Inspector and reported having pushed resident # 1. On a specified date a Personal Support worker (S114) reported observing resident # 1 flying through the air backwards. On a specified date a Registered Practical Nurse(RPN) (S105) reported that resident # 2 informed him/her that they had pushed resident # 1. On a specified date and time a Registered Nurse (S111) documented on the progress notes that resident # 1 wandered into resident # 2 room and that resident # 2 told resident # 1 to get out and that resident # 2 had hit and pushed resident # 2 to the floor. On a specified date the resident's Substitute Decision Maker (SDM) was informed of the incident of physical abuse nine hours following the incident.
The licensee has failed to comply with ON/Regulation 79/10 by not immediately notifying the resident's SDM of an incident of physical abuse. (143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2013

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

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 4th day of December, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : PAUL MILLER

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