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 sions de longue durée

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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
Mar 15, 2016	2015_417178_0011	T-2996-15	Critical Incident System

Licensee/Titulaire de permis

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

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

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive Maple ON L6A 3P8

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 18, 19, 20, 26, 27, 31, September 4, 8, 16, 17, 18, 21, 28, 30, October 2, 26, 2015, February 4, 9, 2016.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Physiotherapist, Primary Physician, Coroner, Chief Coroner, Police Detective, registered staff, Agency employed registered staff, personal support workers, resident's family member.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Review of two identified Critical Incident Reports, as well as interviews with the home's Executive Director (ED) and Director of Care (DOC) confirmed the following facts:

Resident #01 was found on the morning of an identified date, with bruising and swelling in an identified area of the body. The resident was in bed at the time of the discovery. The resident was totally dependent on others for his/her mobility needs, required a mechanical lift for transfers in and out of bed, and had not suffered a recent fall. By 1730 hours on that same day, the resident's symptoms had increased, and the resident was experiencing increased pain. The resident was transferred to hospital for assessment, and was diagnosed with two injuries, one recent, and one the age of which could not be determined. The resident was transferred back to the home two days later. The resident was deemed palliative, and the plan of care was revised to include comfort measures only.

Interviews with the DOC and ED confirmed the following:
-The home began their investigation into the incident on the day the injuries were discovered, and it was confirmed that the resident was last transferred on the evening before, by PSW #116. PSW #116 transferred the resident from the toilet to bed.
-On an identified date a few days after the resident's injuries were discovered, PSW #113 reported to the DOC that he/she had been approached by PSW #116 that afternoon, and told that if asked, PSW #113 should tell management that he/she had assisted PSW #116 to transfer resident #01 into bed on the evening before the resident's injuries were discovered. PSW #113 refused to do so, and reported the conversation to home management.
-When PSW #116 was subsequently interviewed by the DOC, he/she stated that PSW #115 had assisted him/her to transfer resident #01 from toilet to bed on the evening before the resident's injuries were discovered, using a mechanical lift. The home's ED and DOC confirmed that PSW #115 was not working in the same home area as PSW #116 on that evening. At this point, PSW #116 was put on paid leave, the police were contacted, and a criminal investigation into the incident was initiated.

An interview with the investigating Detective on February 9, 2016, confirmed that the criminal investigation remains ongoing.

Review of resident #01's plan of care in place at the time of the injury, confirmed that the resident required the assistance of two staff members, using a mechanical lift to transfer from one position to another.

During an interview with the inspector, PSW #113 confirmed that PSW #116 had asked him/her to lie and state that he/she had assisted PSW #116 to transfer resident #01 on

the evening before the resident's injuries were discovered, when in fact PSW #113 had not provided assistance.

During interviews with the inspector, PSW #116 stated that on the evening before the resident's injuries were discovered, PSW #115 assisted him/her to transfer resident #01 from wheelchair to toilet and from toilet into bed, using the mechanical lift, and the transfer was uneventful. PSW #116 stated that he/she and PSW #115 remained in the resident's room with the washroom door shut during the entire time the resident was on the toilet, and that the resident remained hooked up to the sit to stand lift during this time. PSW #116 also denied ever asking PSW #113 to lie regarding transferring resident #01.

During an interview with the inspector, PSW #115 maintained that on the evening before resident #01's injuries were discovered, he/she had come to PSW #116's unit to obtain some supplies, had stopped to speak with PSW #116, and had assisted him/her to transfer resident #01 from wheelchair to toilet, and then from toilet to bed. PSW #115 also stated that the transfer was uneventful.

During an interview with the resident's subsitute decision maker (SDM), he/she informed the inspector that on one occasion approximately three months prior to resident #01's injury, the SDM had come to the resident's room and found the resident alone in the bathroom. The SDM stated that PSW #116 arrived to the room and when the SDM expressed surprise that the resident had been left alone in the bathroom, PSW #116 assured the SDM that this was allowed and was a safe practice. The resident's SDM further stated that PSW #116 then transferred resident #01 from the toilet to bed, using a mechanical lift, with no assistance from anyone else.

Interview with the DOC confirmed that it is the expectation that two staff must assist when transferring a resident with a mechanical lift. The DOC further confirmed that it is the practice in the home to keep the sling on the resident with the lift attached while being toileted, but it is the expectation that the resident is not left alone during this process.

Review of PSW #116's employee records, confirmed that he/she received written discipline in May 2006 for failing to use the correct lift when assisting a co-worker with a resident transfer, in spite of a logo being posted at the resident's bedside, instructing which lift the resident required.

During an interview with the investigating Coroner, the Coroner stated that resident #01

died from complications of an identified injury in an identified area of the body. The Coroner stated that he/she believed the injury was caused by the resident being lifted by one person using a mechanical lift. The Coroner stated that he/she came to this conclusion based on the resident's bruising, and on information he had obtained from the home, which included the fact that one PSW had been asked by another PSW to lie about assisting to transfer the resident. The final Coroner's report has not been released at the time of this inspection report.

Interviews with the home's ED confirmed that although they cannot be certain, based on their investigation into the incident, it is the belief of the home's administration that resident #01 was injured as a result of a staff member or members failing to transfer the resident safely on the evening before the resident's injuries were discovered.

The home was previously found to be in non-compliance with this requirement on March 18, 2015 (Resident Quality Inspection #2015_413500_0004), regarding a resident who sustained bruising to the head, arm and hand, after hitting the mechanical lift during transfer. The incident was determined to be a result of the lift sling being positioned improperly. A Voluntary Plan of Correction (VPC) was issued at this time. During the present inspection one resident was affected. The resident sustained severe injury which, according to the Coroner, resulted in the resident's eventual death. Based on the severity of the outcome for the resident, and the home's history of staff failing to lift safely, a compliance order is warranted. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #01 was reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary.

Review of the resident's record and interviews with home staff confirmed that resident #01 was not reassessed for lifts and transfers for nearly one year, between an identified date in August 2014 and an identified date in July 2015.

Interviews with the home's DOC, and review of the home's Safety in Ambulating, Lifting and Transferring (SALT) Program policies (#HS16-P-10 and HS16-0-18) confirmed that it is the home's policy to complete a Resident Lift and Transfer Assessment for each resident at a minimum, quarterly. The home's DOC confirmed that it has been the home's process to document this quarterly assessment on a form titled Assessment Form for Lifts and Transfers, either electronically in the home's documentation software program, or on a paper version of the form.

Review of the resident's electronic and paper assessment records for lifts and transfers confirmed that the most recent documented Lift and Transfer Assessment for resident #01 was performed on an identified date in August 2014, and was performed by an identified registered nurse. This assessment included assessments of the resident's behaviours, physical strengths, pain, and ability to weight bear. The assessment stated that the resident required a sit to stand mechanical lift for transfers.

Review of resident #01's paper Assessment Form for Lifts and Transfers, confirmed that an unidentified staff member initialled the form on an identified date in February 2015. It indicated that the resident was reassessed for lifts and transfers on this date, and that the resident's transfer needs had not changed from the previous assessment. During

interview, the DOC was unable to identify what staff member the initials belong to, and the DOC confirmed that no documentation of the details of the reassessment appears anywhere in resident #01's records.

During interviews, PSW #110 and PSW #108 stated that they performed a lifts and transfer assessment on resident #01 in February 2015, but they confirmed that the resident was not actually transferred or lifted as part of their assessment. Instead, PSW #110 and PSW #108 completed the assessment by speaking to the PSWs on the resident's unit to determine whether or not there had been any changes in the resident's condition. PSW #110 and PSW #108 confirmed that a registered staff member was not present or involved in resident #01's lift and transfer assessment in February 2015.

The home's DOC confirmed that no documentation, other than the illegible initials on the paper Assessment Form for Lifts and Transfers, could be found supporting that resident #01 was reassessed for lifts and transfers between August 2014 and July 2015. PSW #110's and PSW #108's description of this lifts and transfer assessment, and the lack of supporting documentation of the assessment, leads the inspector to conclude that the resident was not adequately reassessed for her lifts and transfer needs between an identified date in August 2014 and an identified date in July 2015. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Review of resident #01's progress notes and interview with staff #111 and the home's DOC confirmed that assessment of resident #01's pain on an identified date, was not documented.
Resident #01's progress notes for an identified date contain an entry written by RPN #111, which states that the resident experienced "a lot of pain on" a date three days prior to when the progress note was written. No documentation is present in the resident's record on the date the resident experienced the pain, to indicate that the resident experienced pain or that the resident's pain was assessed. During interview, PSW #109 confirmed that on the identified date on which the resident experienced the pain, the resident appeared to be in pain during care, and that he/she relayed that information to the RPN #111, who was on duty that day.

During interview, RPN #111 confirmed that she was told by PSW #109 that the resident had been experiencing pain during care on the identified date, and that RPN #111 assessed the resident, but failed to document the pain and the assessment, apart from the progress note three days later, which stated that "the resident had a lot of pain on" the identified date three days prior, when the resident had been experiencing pain.

During interviews, RPN #111 and the home's DOC both confirmed that if a resident is experiencing pain the resident should be assessed and the results documented in the resident's record.

Review of resident # 01's progress notes and interview with Agency RN #114 and the home's DOC confirmed that new and unexplained bruising on resident # 01 was not documented by the staff working at the time that the bruising was first discovered.

Interviews with Agency RN #114 and PSW #112 confirm that resident #01 was observed on night shift, at approximately 5:00 AM on an identified date, to have new and unexplained bruising in an identified area of the body. Review of the resident records confirmed that this bruising was not documented until the next shift, at approximately 11:09 AM.

Interview with Agency RN #114 confirmed that PSW #112 informed him/her of the bruising and he/she assessed the resident, but did not document this assessment on the resident's record. The home's DOC confirmed that the resident's new and unexplained bruising was not documented on the shift on which it was found, and that the resident's unexplained bruising should have been documented in the progress notes in the resident's record at the time it was discovered. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 26th day of April, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178)
Inspection No. / No de l'inspection :	2015_417178_0011
Log No. / Registre no:	T-2996-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 15, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	SHERWOOD COURT LONG TERM CARE CENTRE 300 Ravineview Drive, Maple, ON, L6A-3P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Fazackerley

To REVERA LONG TERM CARE INC., 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff uses safe transferring and positioning devices or techniques when assisting residents. This plan should include, but not be limited to, methods for training, monitoring and supervising staff to ensure that they follow residents' plans of care and the home's lifts and transfer policies.

The plan shall be submitted via email to susan.lui@ontario.ca by March 31, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Review of two identified Critical Incident Reports, as well as interviews with the home's Executive Director (ED) and Director of Care (DOC) confirmed the following facts:

Resident #01 was found on the morning of an identified date, with bruising and swelling in an identified area of the body. The resident was in bed at the time of the discovery. The resident was totally dependent on others for his/her mobility needs, required a mechanical lift for transfers in and out of bed, and had not suffered a recent fall. By 1730 hours on that same day, the resident's symptoms had increased, and the resident was experiencing increased pain. The resident was transferred to hospital for assessment, and was diagnosed with two injuries, one recent, and one the age of which could not be determined. The resident was transferred back to the home two days later. The resident was deemed palliative, and the plan of care was revised to include comfort measures only.

Interviews with the DOC and ED confirmed the following:
-The home began their investigation into the incident on the day the injuries were discovered, and it was confirmed that the resident was last transferred on the evening before, by PSW #116. PSW #116 transferred the resident from the toilet to bed.
-On an identified date a few days after the resident's injuries were discovered, PSW #113 reported to the DOC that he/she had been approached by PSW #116 that afternoon, and told that if asked, PSW #113 should tell management that he/she had assisted PSW #116 to transfer resident #01 into bed on the evening before the resident's injuries were discovered. PSW #113 refused to do so, and reported the conversation to home management.
-When PSW #116 was subsequently interviewed by the DOC, he/she stated that PSW #115 had assisted him/her to transfer resident #01 from toilet to bed on the evening before the resident's injuries were discovered, using a mechanical lift.
The home's ED and DOC confirmed that PSW #115 was not working in the same home area as PSW #116 on that evening. At this point, PSW #116 was put on paid leave, the police were contacted, and a criminal investigation into the incident was initiated.

An interview with the investigating Detective on February 9, 2016, confirmed that the criminal investigation remains ongoing.

Review of resident #01's plan of care in place at the time of the injury, confirmed that the resident required the assistance of two staff members, using a mechanical lift to transfer from one position to another.

During an interview with the inspector, PSW #113 confirmed that PSW #116 had asked him/her to lie and state that he/she had assisted PSW #116 to transfer resident #01 on the evening before the resident's injuries were discovered, when in fact PSW #113 had not provided assistance.

During interviews with the inspector, PSW #116 stated that on the evening before the resident's injuries were discovered, PSW #115 assisted him/her to transfer resident #01 from wheelchair to toilet and from toilet into bed, using the mechanical lift, and the transfer was uneventful. PSW #116 stated that he/she and PSW #115 remained in the resident's room with the washroom door shut during the entire time the resident was on the toilet, and that the resident remained hooked up to the sit to stand lift during this time. PSW #116 also

denied ever asking PSW #113 to lie regarding transferring resident #01.

During an interview with the inspector, PSW #115 maintained that on the evening before resident #01's injuries were discovered, he/she had come to PSW #116's unit to obtain some supplies, had stopped to speak with PSW #116, and had assisted him/her to transfer resident #01 from wheelchair to toilet, and then from toilet to bed. PSW #115 also stated that the transfer was uneventful.

During an interview with the resident's subsitute decision maker (SDM), he/she informed the inspector that on one occasion approximately three months prior to resident #01's injury, the SDM had come to the resident's room and found the resident alone in the bathroom. The SDM stated that PSW #116 arrived to the room and when the SDM expressed surprise that the resident had been left alone in the bathroom, PSW #116 assured the SDM that this was allowed and was a safe practice. The resident's SDM further stated that PSW #116 then transferred resident #01 from the toilet to bed, using a mechanical lift, with no assistance from anyone else.

Interview with the DOC confirmed that it is the expectation that two staff must assist when transferring a resident with a mechanical lift. The DOC further confirmed that it is the practice in the home to keep the sling on the resident with the lift attached while being toileted, but it is the expectation that the resident is not left alone during this process.

Review of PSW #116's employee records, confirmed that he/she received written discipline in May 2006 for failing to use the correct lift when assisting a co-worker with a resident transfer, in spite of a logo being posted at the resident's bedside, instructing which lift the resident required.

During an interview with the investigating Coroner, the Coroner stated that resident #01 died from complications of an identified injury in an identified area of the body. The Coroner stated that he/she believed the injury was caused by the resident being lifted by one person using a mechanical lift. The Coroner stated that he/she came to this conclusion based on the resident's bruising, and on information he had obtained from the home, which included the fact that one PSW had been asked by another PSW to lie about assisting to transfer the resident. The final Coroner's report has not been released at the time of this inspection report.

Interviews with the home's ED confirmed that although they cannot be certain, based on their investigation into the incident, it is the belief of the home's administration that resident #01 was injured as a result of a staff member or members failing to transfer the resident safely on the evening before the resident's injuries were discovered.

The home was previously found to be in non-compliance with this requirement on March 18, 2015 (Resident Quality Inspection #2015_413500_0004), regarding a resident who sustained bruising to the head, arm and hand, after hitting the mechanical lift during transfer. The incident was determined to be a result of the lift sling being positioned improperly. A Voluntary Plan of Correction (VPC) was issued at this time. During the present inspection one resident was affected. The resident sustained severe injury which, according to the Coroner, resulted in the resident's eventual death. Based on the severity of the outcome for the resident, and the home's history of staff failing to lift safely, a compliance order is warranted. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

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 sions 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 sions 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 15th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

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