



**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**

**Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255**

**Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ème} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255**

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
Mar 17, 2014	2014_210169_0002	H-000882- 13	Complaint

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

YVONNE WALTON (169), BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
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The purpose of this inspection was to conduct a Complaint inspection.

**This inspection was conducted on the following date(s): January 29, 30, 31 and
February 6, 7 2014**

**The following complaints are included in this report: H-00121-14, H-00127-14
and H-00882-13**

**During the course of the inspection, the inspector(s) spoke with the
Administrator, Acting Director of Care, Assistant Director of Care, Registered
Nursing staff, Food Service Manager, Personal Support Workers, Residents and
Families.**

**During the course of the inspection, the inspector(s) observed care areas
(including early morning and evening), reviewed clinical documentation, policies
and procedures.**

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

- s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
 - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
 - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).



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Findings/Faits saillants :

1. The licensee did not ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care.

Resident #3 was observed wearing specialized equipment while sitting in their wheelchair in their room. The registered nursing staff were interviewed and asked about the directions for use of the machine. The registered nursing staff went to the clinical record for direction and were unable to locate any directions for use. The Assistant Director Of Care confirmed there were no clear directions in the plan of care for staff who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee did not ensure that residents receive care according to their plan of care. Residents were observed with equipment in place, however not turned in an on position.

The nursing staff confirmed this was not in place according to their plans of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 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. 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 :



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1. The licensee did not ensure that the policy named "After hours emergency Services" number 1.4, effective April 2002 and revised October 2010 was complied with. The policy directs staff to contact the pharmacist on call with the after hours emergency number, if the satellite pharmacy is unable to provide the desired medication. Resident #3 received an order from the doctor for a new medication. The nursing staff did not follow the policy by contacting the pharmacist on call to fill the prescription, resulting in Resident #3 not receiving the prescribed medication for over 48 hours. [s. 8. (1)]

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 that ensures 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee did not ensure that each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy. Resident #2 shares a room with a co-resident. Resident #2 did not have a privacy curtain that provided privacy during their care. The curtain was observed to be short and care could be seen from the hallway due to it being short. The curtain was not long enough to close around Resident #2 bed. The curtain only came about half way around Resident #2 bed. The nursing staff confirmed the curtain was too short to provide privacy. [s. 13.]



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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 that ensures that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that food and fluids are served at a temperature that is palatable to residents. Resident #3 was brought to the dining room on January 31, 2014 for breakfast and wheeled up to their table. The food on the table included fried eggs and toast and they were observed to be sitting there for one hour. When the resident was assisted to the table, the food was not warmed and the resident was not offered any hot beverages. Resident #3 left the table without any breakfast. [s. 73. (1) 6.]

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 that ensures food and fluids are served at a temperature that is palatable to residents and, to be implemented voluntarily.



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WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee did not ensure that all hazardous substances are kept inaccessible to residents at all times. On January 31, 2014 the maintenance staff were using a cart that had many tools on it and an open bucket of drywall compound. The cart was observed to be unattended on several occasions and left in the hallway where residents were walking and wandering by. The cart was left unattended for periods of up to five minutes. [s. 91.]

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 that ensures all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
 - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
 - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**
-

Findings/Faits saillants :



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1. The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary. The shower curtain in the 300 wing tub room was observed to have feces on it on three consecutive days. On January 29, 30 and 31, 2014. The residents were being showered on all three days and used the soiled shower curtain. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

- s. 27. (1) Every licensee of a long-term care home shall ensure that,**
- (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**
 - (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**
 - (c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**

Findings/Faits saillants :

1. The licensee did not ensure that a care conference of the interdisciplinary team was held to discuss the plan of care with the substitute decision maker at least annually. The substitute decision makers were not invited to participate in the re-assessments or to a care conference. The documentation and the substitute decision maker confirmed this. [s. 27. (1)]



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Issued on this 17th day of March, 2014

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

Yvonne Walton



**Ministry of Health and
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**Ministère de la Santé et
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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
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**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) : YVONNE WALTON (169), BERNADETTE SUSNIK
(120)

Inspection No. /

No de l'inspection : 2014_210169_0002

Log No. /

Registre no: H-000882-13

Type of Inspection /

Genre

Complaint

d'inspection:

Report Date(s) /

Date(s) du Rapport : Mar 17, 2014

Licensee /

Titulaire de permis : REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA,
ON, L5R-4B2

LTC Home /

Foyer de SLD :

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON,
N3R-7G5

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur :

CATHERINE DONAHUE



**Ministry of Health and
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section 154 of the *Long-Term Care
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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Order # / Ordre no : 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, implement and submit a plan that ensures there is a written plan of care for all residents including Resident #1 related to oxygen and accessory therapy. (C-pap machine)

The plan shall be submitted by March 21, 2014 to Long Term Care Inspector Yvonne Walton at: yvonne.walton@ontario.ca.

Grounds / Motifs :



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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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*

1. Previously issued as a compliance order August 26, 2013.

The licensee did not ensure there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #3 was observed wearing a specialized breathing machine on January 31, 2014 at 1000 hours, while sitting in his wheelchair in his room. The registered nursing staff were interviewed and asked about the directions for use of the machine and they were unable to explain directions for use. The registered nursing staff went to the clinical record for direction and were unable to locate any directions for use. The Assistant Director of Care confirmed there were no clear directions in the plan of care for staff who provide direct care to the resident. (169)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014



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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
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de l'article 154 de la *Loi de 2007 sur les foyers
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Order # / Ordre no : 002	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, implement and submit a plan that ensures all residents receive care set out in their plan of care, including Resident #1, #5, #6, regarding oxygen therapy.

The plan shall be submitted by March 21, 2014 to Long Term Care Inspector Yvonne Walton at: yvonne.walton@ontario.ca.

Grounds / Motifs :



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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
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1. Previously issued as a compliance order on November 12, 2013.

The licensee did not ensure that the care set out in the plan of care was provided to Resident #1, #5, #6 as specified in their plans of care. All three residents were observed on January 31, 2014 during the noon meal with nasal prongs in place and oxygen tanks in place, however the oxygen machines were not turned on.

Resident #1 has a plan of care that directs staff to ensure oxygen is on at all times using the oxygen concentrator. Observation of Resident #1 revealed the oxygen was not in place, nor was the concentrator available in the dining room. Resident #1 did not receive care according to the plan of care.

Resident #5 has a plan of care that directs staff to ensure oxygen is running at 3L per minute via nasal cannula. Observation of Resident #5 revealed the oxygen was in place, however the machine was turned off. Resident #5 did not receive care according to the plan of care.

Resident #6 has a plan of care that directs the continuous use of oxygen. Observation of Resident #6 revealed the oxygen was in place, however the machine was turned off. Resident #6 did not receive care according to the plan of care.

The Registered Practical Nurse and the Assistant Director of Care confirmed all three residents were not receiving their oxygen according to their plan of care.
(169)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014**



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REVIEW/APEAL 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



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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.



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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, 11^e 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.



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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

Ministère 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

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 17th day of March, 2014

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : YVONNE WALTON

Service Area Office /

Bureau régional de services : Hamilton Service Area Office