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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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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
May 7, 2014	2014_189120_0022	H-000626/000627-13	Follow up

Licensee/Titulaire de permis

1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

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

WEST PARK HEALTH CENTRE
103 Pelham Road, St Catharines, ON, L2S-1S9

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 15, 2014

An inspection (2013-189120-0057) was previously conducted on August 13, 2013 at which time non-compliance was issued related to bed safety (Order #001), flooring condition (Order #002) and guaranteed access to a generator (Order #003). For this follow-up inspection, Order #002 has been complied with, however Orders #001 and 003 have not met all the conditions required as set out in the original Orders.

During the course of the inspection, the inspector(s) spoke with the administrator, housekeeping/laundry supervisor, director of care and registered staff.

During the course of the inspection, the inspector(s) toured the home, including the basement activity area, physiotherapy room and service areas, tested and evaluated all of the doors located in the basement, verified flooring condition in all resident rooms, dining areas, washrooms and corridors, verified elevator access points, reviewed the home's service agreement for the provision of a generator during power loss situations, reviewed the home's cleaning and disinfection procedures and reviewed bed safety audit and assessment documentation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Infection Prevention and Control
Safe and Secure Home

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 élérnents 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. 19. Generators
Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee of the home was not able to provide a guarantee that they will have access to a generator that will be operational within 3 hours of a power outage and that can maintain the required essential services.

On June 28, 2013, the transformer located outside of the home unexpectedly failed and the power supply to the home was interrupted for 6 hours, between 4:30 a.m. and 10:30 a.m. The home was not able to access a generator that could maintain all essential services or had an agreement with a generator supplier to deliver a generator within 3 hours of the power outage which could maintain all essential services as required under clause 1(a), (b) and (c). An Order was therefore issued on September 18, 2013 for inspection #2013-189120-0057.

For this follow-up visit, the licensee did not comply with the Order made on September 18, 2013 because the licensee did not have guaranteed access to a generator that would be operational within three hours of a power outage. The licensee has mitigated some of the risk to residents identified on June 28, 2013 by entering into an agreement with a generator supplier for access to a generator; however, that access is subject to conditions (generator availability, weather, road conditions). Based on the scope of the non-compliance, the risk to residents should a generator not be operational within three hours of a power outage, and the compliance history, an Order is warranted. Because the licensee now has access to a generator the compliance date is set for June 1, 2015. [s. 19(4)]

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not take any steps to prevent resident entrapment where bed rails were used.

A bed system audit was conducted on October 9, 2013 by an external furniture supplier. The results of that audit concluded that over 80% of the bed systems failed one or more zones of entrapment, specifically between the bed rail and the mattress. During a tour of the resident bedrooms, failed beds were observed to be in use by residents with one or more rails in the raised position. No gap fillers or other gap reducing interventions were observed to be in place. Some preventive measures such as the installation of mattress keepers were observed on the majority of beds with several still in the process of being installed. The mattress keepers were located on each corner of the bed to prevent the mattress from sliding back and forth on the deck of the bed and reducing any potential zones of entrapment. Some beds received new quarter length rails which were noted to be tight fitting. Other beds were observed to be equipped with a rotating quarter length assist rail which were very loose on beds in 6 identified rooms thereby increasing the chance of bed entrapment. [s. 15(1)(b)]

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to stairways that residents had access to were kept locked and equipped with a door access control system, an audible door alarm that allowed calls to be canceled at the point of activation and was connected to the resident-staff communication and response system.

The lowest level of the long-term care home or basement was toured and observed to have the kitchen, laundry, physiotherapy room, activity room, staff lunch room, staff lockers, mechanical rooms and a corridor leading to the former retirement home. Four different stairwells and two elevators were identified as points of access to and from the basement. All four stairwells were equipped with door access control systems on the two upper floors, however none were identified on the doors in the basement which led to the stairwells going up to the floors above as required. Residents who are not independent are routinely portered to and from the basement by staff via two separate elevators to attend activities held in the activity room and to attend physiotherapy. Independent residents were also observed using the elevators alone and were able to access the basement. One of the two elevators has two points of egress once it reaches the basement and opened up into a service corridor with an open concept dish wash area and a kitchen.

A door leading to an enclosed outdoor space was equipped with a door access control system and was connected to the resident-staff communication and response system. However the door did not have an audible alarm at the door to alert staff should the door not close and lock properly. The area immediately outside the door leads to a steep ramp that may pose safety issues for residents if not assisted by staff.

Discussion was held with the administrator who was given several options as to which doors would require a door access control system. The administrator also provided information that the permits for the doors had already been submitted to the fire department and approvals were pending. [s. 9(1)]

2. Double doors located in the home's lowest level (basement) which led to a vacant retirement home (non-residential area) were not equipped with locks to restrict resident access when the area is not being supervised by staff.

In discussion with the administrator, these doors would not need to be locked if doors leading to this area are equipped with door access control systems or locks. [s. 9(1)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 all doors leading to stairways that residents have access to are kept locked and equipped with a door access control system, an audible door alarm that allows calls to be canceled at the point of activation and is connected to the resident-staff communication and response system, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. Neither of the home's elevators were equipped to restrict resident access to areas that are not to be accessed by residents.

Both of the home's elevators were easily accessible to residents from both the 1st and 2nd floors. Both elevators exited and opened into the basement, where access to an activity room was provided, an area that residents should have access. However in order to use the activity room, residents also had access to a service corridor, physiotherapy room and multiple unsecured stairwells and a vacant retirement home. Neither of the elevators were equipped with any sort of device or mechanism to prevent the doors from opening. The residents, according to home staff, are typically escorted to and from the basement to use the activity room and a physiotherapy room. However, nothing restricts residents from using and exiting into the basement unsupervised.

Discussion was held with the administrator that only one elevator (located across from the kitchen) requires a device or mechanism to prevent the one set of doors from opening once the service corridor and other doors are secured in the basement. [s. 10(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 to ensure that the elevator that has doors that open and exit onto a service corridor is equipped with a device or mechanism to prevent the doors from opening unless triggered to open by a staff member, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning and disinfection of resident care equipment and devices in accordance with prevailing practices.

The home's cleaning and disinfection policy and procedure (NM-II-C060) dated February 2009 for bed pans and wash basins (articles) was reviewed. The homes procedure identified that the articles "must be cleaned with soap and water before disinfection" and that the articles are to be "sprayed with a disinfectant product and allowed to air dry after each use". This is in accordance with current best practices. However, best practices (Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013) identifies the need to have a separate designated area where de-contamination or cleaning can occur. Staff reported that the articles have been deep cleaned in the tub rooms, inside of the tubs as no sinks were available. Neither of the two soiled utility rooms were equipped with a large sink to be able to submerge the articles for deep cleaning. Toilet or slop hoppers, which are used to collect and flush bodily waste, were available in small closet-sized rooms on the 1st and 2nd floor in the home. No other provisions were made available.

The home's procedures lacked direction for staff as to where to dispose of bodily waste (resident toilet or hopper), how or when to use the hoppers, when to discard personal care articles, where and how these articles are to be properly cleaned prior to disinfection and how they are to be stored. [s. 87(2)(b)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Ontario

Ministry of Health and Long-Term Care

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2013_189120_0057	120
O.Reg 79/10 s. 90. (1)	CO #002	2013_189120_0057	120

Issued on this 7th day of May, 2014

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

B. Susnik

Ontario

Ministry of Health and Long-Term Care

Ministére 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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0022
Log No. / Registre no:	H-000626/000627-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 7, 2014
Licensee / Titulaire de permis :	1508669 ONTARIO LIMITED c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1
LTC Home / Foyer de SLD :	WEST PARK HEALTH CENTRE 103 Pelham Road, St Catharines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARJORIE MOSSMAN

To 1508669 ONTARIO LIMITED, 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_189120_0057, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Order / Ordre :

The licensee shall ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c).

Grounds / Motifs :

1. The licensee of the home was not able to provide a guarantee that they will have access to a generator that will be operational within 3 hours of a power outage and that can maintain the required essential services.

On June 28, 2013, the transformer located outside of the home unexpectedly failed and the power supply to the home was interrupted for 6 hours, between 4:30 a.m. and 10:30 a.m. The home was not able to access a generator that could maintain all essential services or had an agreement with a generator supplier to deliver a generator within 3 hours of the power outage which could maintain all essential services as required under clause 1(a), (b) and (c). An Order was therefore issued on September 18, 2013 for inspection #2013-189120-0057.

For this follow-up visit, the licensee did not comply with the Order made on September 18, 2013 because the licensee did not have guaranteed access to a generator that would be operational within three hours of a power outage. The licensee has mitigated some of the risk to residents identified on June 28, 2013 by entering into an agreement with a generator supplier for access to a generator; however, that access is subject to conditions (generator availability, weather, road conditions). Based on the scope of the non-compliance, the risk to residents should a generator not be operational within three hours of a power outage, and the compliance history, an Order is warranted. Because the licensee now has access to a generator the compliance date is set for June 1, 2015. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1. Complete a maintenance audit of all beds to determine which bed rails require adjustments so that they are tight fitting and stable for resident use. Loose rails shall be adjusted or augmented as necessary. A routine maintenance program shall be established to ensure bed side rails are kept in good working order and tight fitting.
2. Assess all residents who currently sleep in a bed system where bed rails are used and where the bed has not passed all 4 zones of entrapment (1-4). All residents who require use of one or more rails shall have their beds equipped with a bed accessory that will mitigate any risks to the resident as a result of a zone of entrapment.

Grounds / Motifs :

1. The licensee did not take any steps to prevent resident entrapment where bed rails were used.

A bed system audit was conducted on October 9, 2013 by an external furniture supplier. The results of that audit concluded that over 80% of the bed systems failed one or more zones of entrapment, specifically between the bed rail and the mattress. During a tour of the resident bedrooms, failed beds were observed to be in use by residents with one or more rails in the raised position. No gap fillers or other gap reducing interventions were observed to be in place. Some preventive measures such as the installation of mattress keepers were observed on the majority of beds with several still in the process of being installed. The mattress keepers were located on each corner of the bed to prevent the mattress from sliding back and forth on the deck of the bed and reducing any potential zones of entrapment. Some beds received new quarter length rails which were noted to be tight fitting. Other beds were observed to be equipped with a rotating quarter length assist rail which were very loose on beds in 6 identified rooms thereby increasing the chance of bed entrapment. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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

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

and the Director

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.

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

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 7th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : B Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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