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
Telephone: (613) 569-5602
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347, rue Preston, 4iém étage
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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
Jun 19, 2013	2013_031194_0015	O-000322-13	Follow up

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 3 ,7,and 10, 2013

During the course of this inspection the inspector reviewed outstanding orders under Log #O-000389-13, Log#O-000390-13, Log #O-000391-13

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Unit Manager, 1 Registered Practical Nurse (RPN), 4 Personal Support Worker (PSW), one resident

During the course of the inspection, the inspector(s) reviewed the Responsive Behaviour Program, the implementation of responsive behaviour program, two resident plans of care, reviewed four Critical Incident Reports.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 24 when internal incident report documentation and Critical Incident Reports indicate that two separate incidents of resident to resident physical abuse were identified and were not immediately reported to the Director.

On an identified date a witnessed incident of physical abuse occurred between residents #002 and #019. Resident #019 sustained an injury.

On an identified date a witnessed incident of physical abuse occurred between resident #002 and #003. Resident #003 sustained an injury.

The Unit Manager has confirmed that the Director was not immediately notified. [s. 24. (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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. This order was issued on May 10, 2013 under report # 2013_196157_0013 with a compliance date of May 31, 2013. This order will remain non compliant related to the following evidence.

A review of two residents identified as having repeated altercations causing injury to other residents was completed. Steps taken to minimize further altercations and potentially harmful interactions have been ineffective as evidenced by the following;

The following was identified for resident #002;

The progress notes for resident #002 were reviewed for a period of five months and indicated the following altercations;
-on an identified date a staff was walking past resident #002 when the resident grabbed the staff's wrists and started to shake and push the staff.
-on an identified date staff witnessed resident #002 grabbing co-resident's left arm. The nursing staff states +++ force was needed to separate the two residents, no injury was reported.
-on an identified date resident #002 grabbed RPN's wrist and squeezed, writer had to twist hand to get out of resident's grasp. Writer stated to resident to let go and that it was hurting.
-on an identified date resident #002 reached out and grabbed co-resident's hand, staff had to intervene to separate their hands, no injury was documented.

A review of the Critical Incident Reports for the period of one month for resident #002 was completed and indicated the following;
-A Critical Incident report was submitted to report an altercation between resident #002 and a co-resident, when resident #002 attempted to grab the co-resident. No injury was reported.
-A Critical Incident report was submitted to report an altercation between resident # 002 and a co-resident, when resident #002 grabbed the co-resident, causing injury.
-A Critical Incident report was submitted to report an altercation between resident #002 and a co-resident, when resident #002 grabbed the co-resident, causing a fall and injury.
-A Critical Incident report was submitted to report an altercation between resident #002 and a family member, when resident #002 grabbed the family member and a staff member had to assist in releasing resident's #002 grip. No injury was reported.

The following was identified for resident #001 who is visually impaired:

Progress notes for resident #001 identify the following:
-An altercation occurred with another resident in the shared bathroom where resident #001 struck out at a co-resident with a white cane. The co-resident was frightened but did not sustain any physical injury.
-Resident #001's white cane was removed by the unit manager.
-Resident #001 verbalized being very upset about the cane being removed and is asking where it is. Documentation indicates the RPN told the resident the cane was broken.
-Another physical altercation occurred in the shared bathroom with the same co-resident, no injuries were reported.

The Unit Manager stated that resident #001 did not need the white cane to ambulate and that the resident was using it to hit others and it was therefore removed.
Resident #001's current written plan of care, directs the use of the white cane as an assistive device for walking, and directs that the resident should be encouraged to use the cane properly.

A review of Critical Incident Reports for an identified month were reviewed and indicated that:
- A Critical Incident Report was submitted reporting an altercation between resident #001 and co-resident in the residents' shared bathroom. Resident #001 struck co-resident with the cane. No injury
- A Critical Incident Report was submitted reporting an altercation between resident #001 and the same co-resident in the residents' shared bathroom. Co-resident stated that resident #001 entered the bathroom and "came right at the resident and it took all the resident's strength to get the other resident off."

A meeting was held with DOC and Unit Manager to discuss the management of altercations between residents in the home and specifically on the Woodland Unit. They stated that:
- a "white board" was in place in each of the home unit conference rooms to ensure that residents with responsive behaviours are identified with specific interventions for staff to implement.
- that a full time Behavioural Support Ontario (BSO) position has been implemented to provide leadership for the management of responsive behaviours and the "Dementia

Observation System"(DOS) has been implemented for residents demonstrating behaviours.

On June 7, 2013 inspectors observed the "white board" in Hilltop unit conference room:
- PSW staff interviewed were not familiar with the use of the "white board" and did not know where it was located.
- When the "white board" was located on the floor leaning against the wall, it was not visible to staff.
- Staff interviewed stated that they had not received education on the purpose or use of the "white board".
- The "White Board" listed resident by initials and staff interviewed were unable to identify who the residents were.

On June 7, 2013 inspectors observed the "white board" in Woodland Unit conference room: - the RPN in charge of the unit advised that she was not aware of a "white board" or it's purpose.
- The "white board" was located in the conference room behind the closed doors of a cabinet on the wall.
- PSW interviewed stated that the information on the "white board" was not reviewed during report at the beginning of her 12 hour shift.
- The BSO staff on duty stated her shift started at noon and she was not provided report related to significant behaviours on the unit. She confirmed that she did not review the "white board".
- When BSO staff was questioned about the behaviour for resident #002 she stated that "that's just how the resident is" and she stated that she had no problem releasing from the resident's hold when she was grabbed.
- During the inspectors' observation of the conference room it was noted that a DOS assessment for resident #002 was initiated for 72 hours. When the DOS assessment was reviewed there was a period of 8 1/2 hours were no assessments had been documented by staff for this resident.
- During the inspectors' observation of the conference room it was noted that a communication memo outlining interventions for resident #002 was on the table for staff to review and sign. The memo was dated June 7, 2013 and on June 12, 2013 there were no signatures provided to indicate that staff have reviewed the directive.

The processes implemented to minimize the risk of further altercations and potentially

harmful interactions between residents have been ineffective as evidenced by staff interviews, a review of the interventions and related documentation, reviewed by the inspectors on June 11, 2013 [s. 54. (b)]

Additional Required Actions:

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

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:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #004	2013_196157_0013	194
O.Reg 79/10 s. 53. (1)	CO #001	2013_196157_0013	194
O.Reg 79/10 s. 98.	CO #006	2013_196157_0013	194

Issued on this 24th day of June, 2013

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

Chantal Lafrenière / Pat Powers

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

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) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2013_031194_0015
Log No. / Registre no:	O-000322-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 19, 2013
Licensee / Titulaire de permis :	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GARY SIMS

To MARYCREST HOME FOR THE AGED, 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_196157_0013, CO #007;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
1. Ensure that a person who has reasonable grounds to suspect the abuse of a resident by anyone that resulted in harm or risk of harm to a resident, immediately reports the suspicion and the information upon which it is based to the Director..
2. Ensure that the licensee's quality assurance process includes a mechanism to evaluate the effectiveness of the reporting process.

Grounds / Motifs :

1. This order was issued on May 10, 2013 under report #2013_196157_0013 with a compliance date of May 15, 2013. This order will remain non-compliant related to the following evidence:

The licensee failed to comply with LTCHA, 2007 s. 24 when internal incident report documentation and Critical Incident Reports indicate that two separate incidents of resident to resident physical abuse were identified and were not immediately reported to the Director.

On an identified date a witnessed incident of physical abuse occurred between residents #002 and #019. Resident #019 sustained an injury.

On an identified date a witnessed incident of physical abuse occurred between resident #002 and #003. Resident #003 sustained an injury.

The Unit Manager has confirmed that the Director was not immediately notified. [s. 24. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_196157_0013, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that the risk of altercations and potentially harmful interactions between residents is minimized by:
1. Providing education related to the newly developed "Response Behaviour Program" to all staff.
2. Monitoring and evaluating of implementation and effectiveness of the newly developed "Responsive Behaviour Program", at a minimum monthly for a period six months.
3. Monitoring and evaluating of interventions implemented for residents at risk for altercation and potentially harmful interactions.
4. Monitoring and evaluating the communications system that has been established for staff to identify residents at risk for altercations and planned interventions.
5. Ensure that the licensee's quality assurance process includes a mechanism to evaluate the effectiveness of the processes noted above.

Grounds / Motifs :

1. This order was issued on May 10, 2013 under report # 2013_196157_0013 with a compliance date of May 31, 2013. This order will remain non compliant related to the following evidence:

A review of two residents identified as having repeated altercations causing

injury to other residents was completed. Steps taken to minimize further altercations and potentially harmful interactions have been ineffective as evidenced by the following;

The following was identified for resident #002;

The progress notes for resident #002 were reviewed for the period of five months indicating the following altercations;
-on an identified date a staff was walking past resident #002 when the resident grabbed the staff's wrists and started to shake and pushed the staff against the wall.
-on an identified date a staff reports finding resident #002 grabbing a co-resident's left arm. Nursing staff stated +++force was needed to separate the two residents, no injury was reported.
-on an identified date resident #002 grabbed an RPN's wrist and squeezed. The RPN had to twist to get out of resident's grasp. RPN stated to resident to let go and that it was hurting.
-on an identified date resident #002 reached out and grabbed co-resident's hand, staff had to intervene to separate their hands, no injury was documented.

A review of the Critical Incident Reports for an identified month for resident #002 was completed and indicated the following;
-A Critical Incident report was submitted to report an altercation between resident #002 and a co-resident, when resident #002 attempted to grab the co-resident. No injury was reported.
-A Critical Incident report was submitted to report an altercation between resident # 002 and a co-resident, when resident #002 grabbed the co-resident's right hand, causing an injury.
-A Critical Incident report was submitted to report an altercation between resident #002 and a co-resident, when resident #002 grabbed the co-resident's right forearm, causing a fall and an injury.
- A Critical Incident report was submitted to report an altercation between resident #002 and a family member, when resident #002 grabbed the family member and a staff member had to assist in releasing resident's #002 grip.

The following was identified for resident #001 who is visually impaired:

Progress notes for resident #001 identify the following:

-An altercation occurred with co-resident in the shared bathroom, where resident #001 struck out at a co-resident with a white cane. The co-resident was frightened but did not sustain any physical injury.
- Resident #001's white cane was removed by the unit manager.
- Resident #001 verbalized being very upset about her cane being removed and is asking where it is. Documentation indicates the RPN told the resident the cane was broken.
- Another physical altercation occurred in the shared bathroom with the same co -resident, no injuries were reported.

The Unit Manager stated that resident #001 did not need the white cane to ambulate and that it was being used to hit others and it was therefore removed. Resident #001's current written plan of care, continues to direct the use of the white cane as an assistive device for walking, and directs that the resident should be encouraged to use the cane properly.

A review of Critical Incident Reports for an identified month for resident #001 were reviewed and indicated that:
- A Critical Incident Report was submitted reporting an altercation between resident #001 and co-resident in the residents' shared bathroom. Resident #001 struck co-resident arms with the cane. No injury was reported
-A Critical Incident Report was submitted reporting an altercation between resident #001 and the same co-resident in the residents' shared bathroom. Co-resident stated that resident #001 entered the bathroom and came right at the resident taking all the resident's strength to get the resident off. ."

A meeting was held with DOC and Unit Manager to discuss the management of altercations between residents in the home and specifically on the Woodland Unit.
They stated that:
- a "white board" was in place in each of the home unit conference rooms to ensure that residents with responsive behaviours are identified with specific interventions for staff to implement.
- that a full time Behavioural Support Ontario (BSO) position has been implemented to provide leadership for the management of responsive behaviours and the "Dementia Observation System"(DOS) has been implemented for residents demonstrating behaviours.

On June 7, 2013 inspectors observed the "white board" in Hilltop unit conference room:
- PSW staff interviewed were not familiar with the use of the "white board" and did not know where it was located.
- When the "white board" was located on the floor leaning against the wall, it was not visible to staff.
- Staff interviewed stated that they had not received education on the purpose or use of the "white board".
- The "White Board" listed resident by initials and staff interviewed were unable to identify who the residents were.

On June 7, 2013 inspectors observed the "white board" in Woodland Unit conference room: - the RPN in charge of the unit advised that she was not aware of a "white board" or it's purpose.
- The "white board" was located in the conference room behind the closed doors of a cabinet on the wall.
- PSW interviewed stated that the information on the "white board" was not reviewed during report at the beginning of her 12 hour shift.
- The BSO staff on duty stated her shift started at noon and she was not provided report related to significant behaviours on the unit. She confirmed that she did not review the "white board".
- When BSO staff was questioned about the behaviour for resident #002 she stated that "that's just how he is" and she stated that she had no problem releasing his hold when he grabbed her.
- During the inspectors' observation of the conference room it was noted that a DOS assessment for resident #002 was initiated for 72 hours. When the DOS assessment was reviewed there was a period of 8 1/2 hours were no assessments had been documented by staff for this resident.
- During the inspectors' observation of the conference room it was noted that a communication memo outlining interventions for resident #002 was on the table for staff to review and sign. The memo was dated June 7, 2013 and on June 12, 2013 there were no signatures provided to indicate that staff have reviewed the directive.

The processes implemented to minimize the risk of further altercations and potentially harmful interactions between residents have been ineffective as evidenced by staff interviews, a review of the interventions and related documentation, reviewed by the inspectors on June 11, 2013 (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

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.

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

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 19th day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

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