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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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5700 rue Yonge 5e étage
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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
Nov 10, 2014	2014_168202_0024	T-1217-14	Complaint

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue Woodbridge ON L4L 1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court Woodbridge ON L4L 9T3

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 17, 20, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, registered nursing staff, personal support workers.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **4 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 :

The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

Resident #001's plan of care directs staff to provide two staff assistance using a sit to stand mechanical lift for all transfers as the resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.
A review of the clinical records for resident #001 indicated that on an identified date and time, while being transferred from wheelchair to bed using a sit to stand mechanical lift, one of resident's legs slipped off the base of the lift causing the other lower leg to buckle backwards.
An interview with PSW #01 indicated that on an identified dated and time, he/she entered resident #001's room looking for a sit to stand lift to use to transfer another resident. PSW #01 indicated that upon entering the room, he/she found resident #001 being transferred by PSW #02. The resident appeared to be uncomfortable, his/her arms were notably suspended upright strapped to the top of the lift, his/her leg was bent backwards with his/her knee braced on top of the lower metal bar, and his/her other knee was bent resting on the blue plastic platform of the lift. PSW #01 indicated that the straps that are normally used to support the resident's legs during a transfer had not been placed around the resident's legs. PSW #01 indicated that he/she assisted PSW #02 to lower the sit to stand lift and manually transfer the resident back to bed by holding the resident under his/her arms. PSW #01 indicated that the resident screamed out in pain during the transfer and indicated that he/she was in pain. PSW#01 directed PSW #02 to report the incident, however, PSW #02 directed PSW #01 to not report the incident to anyone.
An interview with PSW #02 indicated that on an identified dated and time, he/she requested the assistance of the RPN and PSW #01 to assist in transferring resident #001 to bed, as the resident required two staff assistance for transfers. PSW #02 indicated that his/her shift had ended and because he/she needed to leave, he/she decided to transfer the resident by him/herself using the sit to stand mechanical lift. PSW #02 indicated that he/she placed the resident in the lift and neglected to use the bottom leg straps to support the resident's legs. PSW #02 indicated that during the transfer, one of

the resident's legs slipped off the base of the lift and his/her other leg bent backwards. PSW #02 indicated that PSW #01 came to the room and both staff assisted the resident out of the lift and into bed. PSW #02 indicated that once the resident was in bed, he/she left the building and did not report the incident to anyone.
PSW #01 indicated that he/she asked the RPN if PSW #02 reported that an incident had occurred with resident #001. The RPN indicated that he/she had not received any report of incident or injury to resident #001. The RPN indicated in an interview that upon receipt of the incident, he/she assessed the resident for injury and indicated that no injury was found at this time and the resident appeared to be comfortable. Approximately two hours later, the RPN further assessed the resident with the evening RN as PSW #03 reported notable swelling. During the assessment, the RPN indicated that the resident grimaced in pain, stated "no, no, no" and visibly swelling was noted. The resident was sent to hospital for further assessment as directed by the physician. The resident returned from the hospital with a fracture diagnosis.
The progress notes for resident #001 indicated that on an identified date post injury, the resident complained of increasing pain during care with notable swelling on one side of his/her body. The resident was assessed by the physician, who then ordered an ultrasound and x-ray of the resident's side that had not been previously assessed after the incident . On a later identified date, the resident went to a follow up appointment at the fracture clinic. The resident returned to the home with another fracture diagnosis.
The RPN indicated in an interview that there were no reported incidents to potentially cause the second injury. The RPN indicated that while the resident was at the hospital for assessment of the initial injury, the resident was only assessed for one side of his/her body and not the other. The DOC and the RPN indicated in interviews that the resulting second fracture could be directly related to the unsafe transfer performed by PSW #02.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident right not to be neglected by the licensee or staff is fully respected and promoted.

The plan of care for resident #001 directs staff to provide two staff assistance using a sit to stand mechanical lift for all transfers as the resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.

Resident #001's plan of care directs staff to provide two staff assistance using a sit to stand mechanical lift for all transfers as the resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.
A review of the clinical records for resident #001 indicated that on an identified date and time, while being transferred from wheelchair to bed using a sit to stand mechanical lift, one of the resident's legs slipped and his/her knee landed on the bottom metal bar of the lift causing the other leg to buckle backwards.
An interview with PSW #01 indicated that on the above mentioned date and time, he/she entered resident #001's room looking for a sit to stand lift to use to transfer another resident. PSW #01 indicated that upon entering the room, he/she found resident #001 being transferred by PSW #02. The resident appeared to be uncomfortable, his/her arms were notably suspended upright strapped to the top of the lift, his/her leg was bent backwards with his/her knee braced on top of the lower metal bar, and his/her other knee was bent resting on the blue plastic platform of the lift. PSW #01 indicated that the straps that are normally used to support the resident's legs during a transfer had not been placed around the resident's legs. PSW #01 indicated that he/she assisted PSW #02 to lower the sit to stand lift and manually transfer the resident back to bed by holding the resident under his/her arms. PSW #01 indicated that the resident screamed out in pain during the transfer and indicated that he/she was in pain. PSW #01 directed PSW #02 to report the incident, however, PSW #02 directed PSW #01 to not report the incident to anyone.

PSW #01 indicated that at the end of his/her shift, he/she asked the RPN if PSW#02 reported the incident to him/her. The RPN indicated that he/she had not received any report of incident or injury to resident #001. The RPN indicated in an interview that upon receipt of the incident, he/she assessed the resident for injury and indicated that no injury was found at this time. The resident was later sent to hospital for further assessment, due to swelling and increased pain. The resident returned from the hospital diagnosed with a fracture.

The DOC indicated in an interview that the incident involving resident #001 was reported to the RPN approximately two hours after the incident occurred. The DOC confirmed that the resident's right to not be neglected by staff or the licensee was not fully respected and promoted. [s. 3. (1) 3.]

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 resident right not to be neglected by the licensee or staff is fully respected and promoted, to be implemented voluntarily.

WN #3: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #001's plan of care directs staff to use a sit to stand mechanical lift for all transfers, using two staff assistance as the resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.

Resident #001's plan of care directs staff to provide two staff assistance using a sit to stand mechanical lift for all transfers as the resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.
A review of the clinical records for resident #001 indicated that on an identified date and time, while being transferred from wheelchair to bed using a sit to stand mechanical lift, the resident's leg slipped and his/her knee landed on the bottom metal bar of the lift causing the lower leg to buckle backwards.
An interview with PSW #01 indicated that on the above identified date and time, he/she entered resident #001's room looking for a sit to stand lift to use to transfer another resident. PSW #01 indicated that upon entering the room, he/she found resident #001 being transferred by PSW #02. The resident appeared to be uncomfortable, his/her arms were notably suspended upright strapped to the top of the lift, his/her leg was bent backwards with his/her knee braced on top of the lower metal bar, and his/her other knee was bent resting on the blue plastic platform of the lift. PSW #01 indicated that the straps that are normally used to support the resident's legs during a transfer had not been placed around the resident's legs. PSW #01 indicated that he/she assisted PSW #02 to lower the sit to stand lift and manually transfer the resident back to bed by holding the resident under his/her arms. PSW #01 indicated that the resident screamed out in pain during the transfer and indicated that he/she was hurting.
The resident was later sent to hospital for further assessment and returned with a fracture diagnosis.
PSW #01 and PSW #02 confirmed in an interview that resident #001 had not been transferred using two staff assistance as directed in the resident's plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

The plan of care for resident #001 directs staff to use a sit to stand mechanical lift for all transfers with the assistance of two staff. The resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.
A review of the clinical records for resident #001 indicated that on an identified date and time, while being transferred from wheelchair to bed using a sit to stand mechanical lift,

the resident's leg slipped and his/her knee landed on the bottom metal bar of the lift causing his/her lower leg to buckle backwards.
An interview with PSW #01 indicated that on the above date and time identified, he/she entered resident #001's room looking for a sit to stand lift to use to transfer another resident. PSW #01 indicated that upon entering the room, he/she found resident #001 being transferred by PSW #02. The resident appeared to be uncomfortable, his/her arms were notably suspended upright strapped to the top of the lift, his/her leg was bent backwards with his/her knee braced on top of the lower metal bar, and his/her left knee was bent resting on the blue plastic platform of the lift. PSW #01 indicated that the straps that are normally used to support the resident's legs during a transfer were not in place. PSW #01 indicated that he/she assisted PSW #02 to lower the sit to stand lift and manually transfer the resident back to bed by holding the resident under his/her arms. PSW #01 indicated that the resident screamed out in pain during the transfer and indicated that he/she was hurting. PSW #01 directed PSW #02 to report the incident, however, PSW #02 directed PSW #01 to not report the incident to anyone.
An interview with PSW #02 indicated that on an identified date and time, he/she requested the assistance of the RPN and PSW #01 to assist in transferring resident #001 to bed. PSW #02 indicated that his/her shift had ended and because he/she needed to leave, he/she transferred the resident by him/herself using the sit to stand mechanical lift. PSW #02 indicated that he/she did not use the straps on the bottom of the lift, that are designed to support a resident's legs when transferring. The resident's leg slipped off the base of the lift twisting his/her leg backwards. PSW #02 indicated that PSW #01 assisted him/her in transferring the resident back to bed and then left the building without reporting the incident.
PSW #01 indicated that at the end of his/her shift, he/she asked the RPN if PSW #02 reported the incident. The RPN indicated that he/she had not received any report of incident or injury to resident #001. The RPN indicated in an interview that upon receipt of the incident, he/she assessed the resident for injury and indicated that no injury was found at this time. The resident was later sent to hospital for further assessment due to increased pain and swelling. The resident returned from the hospital diagnosed with a fracture.
The DOC confirmed in an interview that the Director was notified of the incident on an identified date, one day after the incident and not immediately. [s. 24. (1)]

Issued on this 9th day of January, 2015

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

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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2014_168202_0024
Log No. / Registre no:	T-1217-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 10, 2014
Licensee / Titulaire de permis :	FRIULI LONG TERM CARE 7065 Islington Avenue, Woodbridge, ON, L4L-1V9
LTC Home / Foyer de SLD :	VILLA LEONARDO GAMBIN 40 Friuli Court, Woodbridge, ON, L4L-9T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANNETTE ZUCCARO-VANIN

To FRIULI LONG TERM CARE, 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 use safe transferring and positioning techniques when assisting residents. The plan should include, but not be limited to ensuring that the care set out in the plan of care is provided to the residents, specifically related to transferring, that residents are not neglected by staff or the licensee and that any incident that constitutes improper or incompetent treatment or care of a resident that resulted in harm is immediately reported. Please submit the plan to valerie.johnston@ontario.ca by December 05, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

Resident #001's plan of care directs staff to provide two staff assistance using a sit to stand mechanical lift for all transfers as the resident is unable to participate in the transfer and is totally dependent upon staff for the entire process.
A review of the clinical records for resident #001 indicated that on an identified date and time, while being transferred from wheelchair to bed using a sit to stand mechanical lift, one of resident's legs slipped off the base of the lift causing the other lower leg to buckle backwards.
An interview with PSW #01 indicated that on an identified dated and time, he/she entered resident #001's room looking for a sit to stand lift to use to transfer another resident. PSW #01 indicated that upon entering the room, he/she found resident #001 being transferred by PSW #02. The resident appeared to be uncomfortable, his/her arms were notably suspended upright strapped to the top of the lift, his/her leg was bent backwards with his/her knee braced on top of the lower metal bar, and his/her other knee was bent resting on

the blue plastic platform of the lift. PSW #01 indicated that the straps that are normally used to support the resident's legs during a transfer had not been placed around the resident's legs. PSW #01 indicated that he/she assisted PSW #02 to lower the sit to stand lift and manually transfer the resident back to bed by holding the resident under his/her arms. PSW #01 indicated that the resident screamed out in pain during the transfer and indicated that he/she was in pain. PSW#01 directed PSW #02 to report the incident, however, PSW #02 directed PSW #01 to not report the incident to anyone.
An interview with PSW #02 indicated that on an identified dated and time, he/she requested the assistance of the RPN and PSW #01 to assist in transferring resident #001 to bed, as the resident required two staff assistance for transfers. PSW #02 indicated that his/her shift had ended and because he/she needed to leave, he/she decided to transfer the resident by him/herself using the sit to stand mechanical lift. PSW #02 indicated that he/she placed the resident in the lift and neglected to use the bottom leg straps to support the resident's legs. PSW #02 indicated that during the transfer, one of the resident's legs slipped off the base of the lift and his/her other leg bent backwards. PSW #02 indicated that PSW #01 came to the room and both staff assisted the resident out of the lift and into bed. PSW #02 indicated that once the resident was in bed, he/she left the building and did not report the incident to anyone.
PSW #01 indicated that he/she asked the RPN if PSW #02 reported that an incident had occurred with resident #001. The RPN indicated that he/she had not received any report of incident or injury to resident #001. The RPN indicated in an interview that upon receipt of the incident, he/she assessed the resident for injury and indicated that no injury was found at this time and the resident appeared to be comfortable. Approximately two hours later, the RPN further assessed the resident with the evening RN as PSW #03 reported notable swelling. During the assessment, the RPN indicated that the resident grimaced in pain, stated "no, no, no" and visibly swelling was noted. The resident was sent to hospital for further assessment as directed by the physician. The resident returned from the hospital with a fracture diagnosis.
The progress notes for resident #001 indicated that on an identified date post injury, the resident complained of increasing pain during care with notable swelling on one side of his/her body. The resident was assessed by the physician, who then ordered an ultrasound and x-ray of the resident's side that had not been previously assessed after the incident . On a later identified date, the resident went to a follow up appointment at the fracture clinic. The resident returned to the home with another fracture diagnosis.
The RPN indicated in an interview that there were no reported incidents to

potentially cause the second injury. The RPN indicated that while the resident was at the hospital for assessment of the initial injury, the resident was only assessed for one side of his/her body and not the other. The DOC and the RPN indicated in interviews that the resulting second fracture could be directly related to the unsafe transfer performed by PSW #02. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 23, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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