Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Bureau régional de services d'Ottawa
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 30, May 1, 2, 3, 4, 2012	2012_035124_0015	Complaint

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE, SUITE 825, TORONTO, ON, M5J-2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST, TWEED, ON, K0K-3J0

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with residents, family member, Administrator, Director of Care, Associate Director of Care, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident health records, observed staff-resident interactions and reviewed the home's Abuse policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007, s.20. (1) in that the home's Abuse and Neglect-Zero Tolerance policy and procedure was not complied with as evidenced by the following findings:
- The following statement appears on page 2 of the home's Abuse and Neglect-Zero Tolerance policy and procedure, "All employees are expected to be vigilant and promptly report suspected cases of resident abuse or neglect to their immediate supervisor and to the Administrator.
-Supervisor, #S103 reported that the first time she was advised of the April 13, 2012 incident of witnessed verbal abuse regarding resident #3 and staff #S106 was on April 22, 2012 when approached by staff #S102.
-Similarly, Supervisor #S103 reported that the first time she was advised of the April 16, 2012 incident of witnessed verbal abuse involving resident #4 and staff #S106 was on April 20, 2012 when approached by staff #S104.

-Supervisor #S103 advised the inspector that she had not reported the April 13 or 16, 2012 incidents of witnessed abuse to the Administrator.
-Supervisor #S103 also reported that she was made aware of the April 22, 2012 witnessed verbal abuse involving resident #5 and staff #S106 that day. Supervisor #S103 reported to the inspector that she did not advise the Administrator of the April 22, 2012 incident of witnessed verbal abuse.
-Supervisor, #S110 advised the inspector that she was made aware of the April 19, 2012 witnessed verbal and physical abuse involving resident #1 and staff #S106 that morning. Supervisor #S110 told the inspector that she had not reported the April 19, 2012 incident to the Administrator.
-The Administrator confirmed that he had no knowledge of the April 13, 16 and 19, 2012 incidents until contacted by the inspector on April 26, 2012 and no knowledge of the April 22, 2012 incident until receiving the internal written report on April 30, 2012.

-The following statement appears on page 3 of the home's Abuse and Neglect-Zero Tolerance policy and procedure, "If a staff member is alleged to have engaged in resident abuse, remove their access to the resident immediately.
Staff #S101 was aware of the witnessed incidents of verbal abuse involving staff #S106 on April 13, 16, 19 and 22, 2012 and told the inspector that she advised staff #S102, #S104, #S105 to report directly to the Staff Supervisors. Staff #S106 continued to work her regularly scheduled shifts, caring for the residents involved in the witnessed incidents of April 13, 16, 19 and 22, 2012 until April 26, 2012, when staff #S106 was directed to stay home following a discussion the Administrator had with inspector 124.
- The following statement appears on page 3 of the home's Abuse and Neglect-Zero Tolerance policy and procedure, "Document the circumstances on an Incident Report".
- Director of Care reported to the inspector that there were no incident reports completed related to the witnessed incidents of abuse on April 13, 16, 19 and 22, 2012.

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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone as demonstrated by the following findings:

- Staff #S102 and #S105 reported to the inspector that on April 13, 2012, they overheard staff #S106 yelling at resident #3. Resident #3 appeared upset and nervous. Staff #S102 and #S105 stated that on April 13, 2012, they reported the verbal abuse to staff #S101 and supervisor #S110. Supervisor S#110 stated she had no memory of this being reported to her on April 13, 2012. On April 22, 2012, a written report of this incident was left in the Director of Care's office. On April 24, 2012, the Director of Care reviewed the report and made efforts to contact the staff involved. Staff #S106 continued to work her regularly scheduled shifts until April 26, 2012, when staff #S106 was directed to stay home following a discussion the Administrator had with inspector 124.

-Staff #S102 and #S104 reported to the inspector that on April 16, 2012, they overheard staff #S106 yelling and swearing at resident #4. Staff #S102 told the inspector that on April 16, 2012, she reported the verbal abuse to staff #S101 and supervisor #S103. Staff #S104 told the inspector that she reported the verbal abuse to staff #S101 on April 13, 2012 and to supervisor, #S103 on April 20, 2012. At that time, supervisor, #S103 prepared a written report of this incident and left it in the Director of Care's office. On April 24, 2012, the Director of Care reviewed the report and made efforts to contact the staff involved. Staff #S106 continued to work her regularly scheduled shifts until April 26, 2012, when staff #S106 was directed to stay home following a discussion the Administrator had with inspector 124.

-Staff #S105 reported to the inspector that on April 19, 2012, she witnessed staff #S106 swearing repeatedly at resident #1 and that staff #S106 transferred resident #1 with such force that both resident #1 and staff #S105 landed in the bed. Staff #105 stated that she told both staff #S101 and supervisor #S110. Supervisor #S110 reported to the inspector that on April 19, 2012, a written report of this incident was placed in the Director of Care's office. The Director of Care told the inspector that she did not receive the documentation regarding the April 19, 2012 incident until April 30, 2012. Staff #S106 continued to work her regularly scheduled shifts until April 26, 2012, when staff #S106 was directed to stay home following a discussion the Administrator had with inspector 124.

-Staff #S105 reported to the inspector that on April 22, 2012 she witnessed staff #S106 shouting and swearing at resident #5. Staff #S105 stated that this incident was immediately reported to the supervisor #S103. Supervisor #S103 confirmed that the incident of verbal abuse was reported to her and that she failed to report this incident to the Director of Care or the Administrator. Staff #S106 continued to work her regularly scheduled shifts until April 26, 2012, when staff #S106 was directed to stay home following a discussion the Administrator had with inspector 124. On April 30, 2012, an internal written statement describing the April 22, 2012 incident with resident #5 was provided to the Director of Care and the Administrator.

WN #3: 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 subsections:

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).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007, s. 24. (1)(2) in that there was not immediate reporting to the Director of the suspicion that there had been abuse of residents by staff that resulted in harm or risk of harm to the resident.

On April 26, 2012, through a call to the INFO LINE, the Duty Inspector was alerted to three incidents of suspected abuse of residents by staff that resulted in harm or risk of harm to the residents. These incidents involved residents # 1, 3 and 4 and had not been reported to the Director. A call was made to the Administrator who subsequently submitted a Critical Incident Report.

Staff #S102 and #S105 reported to the inspector that on April 13, 2012, they overheard staff #S106 yelling at resident #3. Resident #3 appeared upset and nervous. On April 22, 2012, a written report of this incident was left in the Director of Care's office. On April 24, 2012, the Director of Care reviewed the report and made efforts to contact the staff involved. The Director of Care confirmed that she did not notify the Administrator or the Ministry of Health and Long Term Care (MOHLTC).

Staff #S102 and #S104 reported to the inspector that on April 16, 2012, they overheard staff #S106 yelling and swearing at resident #4. On April 20, 2012, a written report of this incident was left in the Director of Care's office. On April 24, 2012, the Director of Care reviewed the report and made efforts to contact the staff involved. The Director of Care confirmed that she did not notify the Administrator or the MOHLTC.

Staff #S105 reported to the inspector that on April 19, 2012, she witnessed #S106 verbally abusing resident #1 and that staff #S106 transferred resident #1 with such force that both resident #1 and staff #S105 landed in the bed. Staff #S103 told the inspector that on April 19, 2012, a written report of this incident was placed in the Director of Care's office. The Director of Care reported to the inspector that she did not receive the documentation regarding the April 19, 2012 incident until April 30, 2012. This incident of abuse was reported to the MOHLTC on April 30, 2012.

Staff #S105 told the inspector that on April 22, 2012 that she witnessed staff #S106 shouting and swearing at resident #5. Staff #S105 stated that this incident was immediately reported to Supervisor #S103. Supervisor #S103 confirmed that the incident of verbal abuse was reported to her and that she failed to report this incident to the Director of Care or the Administrator. On April 30, 2012, an internal written statement describing the April 22, 2012 incident with resident #5 was provided to the Director of Care and the Administrator. The MOHLTC was notified on April 30, 2012.

Additional Required Actions:

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

Issued on this 31st day of May, 2012

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

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) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2012_035124_0015
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Apr 30, May 1, 2, 3, 4, 2012
Licensee / Titulaire de permis :	AON INC. 33 HARBOUR SQUARE, SUITE 825, TORONTO, ON, M5J-2G2
LTC Home / Foyer de SLD :	MOIRA PLACE LONG-TERM CARE HOME 415 RIVER STREET WEST, TWEED, ON, K0K-3J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL O'KEEFFE

To AON INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all staff comply with the home's Abuse and Neglect-Zero Tolerance policy and procedure, in particular related to the prompt reporting of resident abuse, the removal of the staff member alleged to have engaged in resident abuse and proper reporting to the Ministry of Health and Long Term Care. The plan must include how training will be delivered to all staff.

This plan is to be submitted to Inspector, Lynda Hamilton at 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4 or by fax at 613-569-9670 on or before May 11, 2012.

Grounds / Motifs :

1. 1. The licensee failed to comply with the LTCHA, 2007, s.20. (1) in that the home's Abuse and Neglect-Zero Tolerance policy and procedure was not complied with as evidenced by the following findings:
- The following statement appears on page 2 of the home's Abuse and Neglect-Zero Tolerance policy and procedure, "All employees are expected to be vigilant and promptly report suspected cases of resident abuse or neglect to their immediate supervisor and to the Administrator.
-Supervisor, #S103 reported that the first time she was advised of the April 13, 2012 incident of witnessed verbal abuse regarding resident #3 and staff #S106 was on April 22, 2012 when approached by staff #S102.
-Similarly, Supervisor #S103 reported that the first time she was advised of the April 16, 2012 incident of witnessed verbal abuse involving resident #4 and staff #S106 was on April 20, 2012 when approached by staff #S104.

-Supervisor #S103 advised the inspector that she had not reported the April 13 or 16, 2012 incidents of witnessed abuse to the Administrator.
-Supervisor #S103 also reported that she was made aware of the April 22, 2012 witnessed verbal abuse involving resident #5 and staff #S106 that day. Supervisor #S103 reported to the inspector that she did not advise the Administrator of the April 22, 2012 incident of witnessed verbal abuse.
-Supervisor, #S110 advised the inspector that she was made aware of the April 19, 2012 witnessed verbal and physical abuse involving resident #1 and staff #S106 that morning. Supervisor #S110 told the inspector that she had not reported the April 19, 2012 incident to the Administrator.
-The Administrator confirmed that he had no knowledge of the April 13, 16 and 19, 2012 incidents until contacted by the inspector on April 26, 2012 and no knowledge of the April 22, 2012 incident until receiving the internal written report on April 30, 2012.

-The following statement appears on page 3 of the home's Abuse and Neglect-Zero Tolerance policy and procedure, "If a staff member is alleged to have engaged in resident abuse, remove their access to the resident immediately.
Staff #S101 was aware of the witnessed incidents of verbal abuse involving staff #S106 on April 13, 16, 19 and 22, 2012 and told the inspector that she advised staff #S102, #S104, #S105 to report directly to the Staff Supervisors. Staff #S106 continued to work her regularly scheduled shifts, caring for the residents involved in the witnessed incidents of April 13, 16, 19 and 22, 2012 until April 26, 2012, when staff #S106 was directed to stay home following a discussion the Administrator had with inspector 124.
- The following statement appears on page 3 of the home's Abuse and Neglect-Zero Tolerance policy and procedure, "Document the circumstances on an Incident Report".
- Director of Care reported to the inspector that there were no incident reports completed related to the witnessed incidents of abuse on April 13, 16, 19 and 22, 2012. (124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 25, 2012

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

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 ensure that the Director is immediately notified of any situations where there are reasonable grounds to suspect that there has been abuse of a resident by anyone.

Grounds / Motifs :

1. 1. The licensee failed to comply with the LTCHA, 2007, s. 24. (1)(2) in that there was not immediate reporting to the Director of the suspicion that there had been abuse of residents by staff that resulted in harm or risk of harm to the resident.

On April 26, 2012, through a call to the INFO LINE, the Duty Inspector was alerted to three incidents of suspected abuse of residents by staff that resulted in harm or risk of harm to the residents. These incidents involved residents # 1, 3 and 4 and had not been reported to the Director. A call was made to the Administrator who subsequently submitted a Critical Incident Report.
Staff #S102 and #S105 reported to the inspector that on April 13, 2012, they overheard staff #S106 yelling at resident #3. Resident #3 appeared upset and nervous. On April 22, 2012, a written report of this incident was left in the Director of Care's office. On April 24, 2012, the Director of Care reviewed the report and made efforts to contact the staff involved. The Director of Care confirmed that she did not notify the Administrator or the Ministry of Health and Long Term Care (MOHLTC).
Staff #S102 and #S104 reported to the inspector that on April 16, 2012, they overheard staff #S106 yelling and swearing at resident #4. On April 20, 2012, a written report of this incident was left in the Director of Care's office. On April 24, 2012, the Director of Care reviewed the report and made efforts to contact the staff involved. The Director of Care confirmed that she did not notify the Administrator or the MOHLTC.
Staff #S105 reported to the inspector that on April 19, 2012, she witnessed #S106 verbally abusing resident #1 and that staff #S106 transferred resident #1 with such force that both resident #1 and staff #S105 landed in the bed. Staff #S103 told the inspector that on April 19, 2012, a written report of this incident was placed in the Director of Care's office. The Director of Care reported to the inspector that she did not receive the documentation regarding the April 19, 2012 incident until April 30, 2012. This incident of abuse was reported to the MOHLTC on April 30, 2012.
Staff #S105 told the inspector that on April 22, 2012 that she witnessed staff #S106 shouting and swearing at resident #5. Staff #S105 stated that this incident was immediately reported to Supervisor #S103. Supervisor #S103 confirmed that the incident of verbal abuse was reported to her and that she failed to report this incident to the Director of Care or the Administrator. On April 30, 2012, an internal written statement describing the April 22, 2012 incident with resident #5 was provided to the Director of Care and the Administrator. The MOHLTC was notified on April 30, 2012. (124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 07, 2012

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

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 4th day of May, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA HAMILTON

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