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

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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
May 28, 2015	2015_182128_0011	008221-15	Complaint

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

RUTH HILDEBRAND (128)

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): April 30, May 4 - 8, and May 11, 2015

This inspection was completed in conjunction with a Resident Quality Inspection in the home. It was also inspected concurrently with Critical Incident #3047-000016-15 and Info line IL-38445-LO and IL-38384-LO. The inspection was related to numerous concerns with one identified resident including: allegations of abuse and neglect, complaints not being responded to, interventions for prevention of falls, call bell response, nutrition and hydration/food quality, physicians orders, plan of care, skin and wound care, care conference, linens being available, equipment not available and resident charges.

During the course of the inspection, the inspector(s) spoke with the Licensee,Administrator, Acting Administrator, Director of Care, Director of Facility Services, Director of Quality Improvement/Assistant Director of Care, Director of Dietary Services, Registered Dietitian, Office Manager, one Physician,one Registered Practical Nurse, nine Personal Support Workers (PSW), two Residents and three Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Critical Incident Response
Dining Observation
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Safe and Secure Home
Skin and Wound Care

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

7 WN(s)
6 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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home provided a response to the person who made the complaint indicating what the licensee has done to resolve the complaint.

An interview with a family member for an identified Resident revealed that the family had lodged a complaint with the home.

A clinical record review for the identified Resident revealed that the family had complained to a Registered Nursing staff member and the Registered Nursing staff member filled out a complaint form. The progress note indicated that the complaint form

was given to the Administrator.

The complainant indicated that they had not been contacted to indicate what the home had done to resolve the complaint until this inspection was initiated.

The Administrator confirmed that the home had not contacted the family to advise them of the resolution to their concerns. [s. 101. (1) 3. i.]

2. The licensee has failed to ensure that that a documented record was kept in the home that included:
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

The home uses a Client Services Response Form to document complaints.

A review of the Client Services Response Forms revealed that one was filled out after the family of an identified Resident had lodged a complaint with the home.
However, the information on the form did not include the date on which the complaint was received. The issue/concern was identified but the form did not contain the action taken to resolve the complaint or any follow-up action.
There were no responses to the complainant documented on the form or any responses from the complainant.

A clinical record review for an identified Resident revealed a complaint was lodged with the home.

The Administrator acknowledged that there had been no follow-up communication with the family in regard to the complaint and that the complaint record was not completed as per the complaint process in the Long-Term Care Homes Act and Regulations. [s. 101. (2)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 plan of care was based on an assessment of the resident and the resident's preferences.

A review of the "Diet Order Book" in a servery and review of the clinical record for an identified Resident revealed that there were no food preferences documented for the resident.

An interview with the resident revealed several food dislikes.

The Director of Dietary Services confirmed that the resident did not have any food preferences/dislikes documented. She could not confirm whether or not the resident was consulted when the Dietary Profile was completed. She also indicated that it was the home's expectation that preferences be identified in the plan of care. [s. 6. (2)]

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

A. Observation of a lunch meal revealed that an identified Resident was provided food that was not in keeping with the therapeutic diet ordered for the resident. The resident was provided food that was not in keeping with the diet order.

A Personal Support Worker confirmed that the resident was provided food that was not in keeping with the therapeutic diet.

The Director of Dietary Services confirmed the expectation was that the menu plan for residents on therapeutic diets should be adhered to as specified in the plan of care.

B. A review of the clinical record for an identified Resident revealed a physician's order to obtain a specimen from the resident. The clinical record indicated that the specimen was to be obtained related to the resident's change in condition.
There was no documented evidence to support that the order was completed.

The Director of Care indicated that the order had not been followed and the expectation was that the specimen would have been completed no later than 48 hours after the order was written.

C. A review of the clinical record for an identified Resident also revealed a physician's order to obtain blood work for the resident.

There was no documented evidence to support that the blood work was completed.
The Director of Quality Improvement confirmed that the order was not followed.

The Director of Quality Improvement and the Director of Care indicated that their expectation was that care set out in the plan of care was provided to the resident as specified in the plan. [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 plan of care for each resident is based on an assessment of the resident and the resident's preferences. It must also 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Observation of an identified bed revealed that two quarter bed rails, which were attached to the bed, were in the upright position throughout the inspection. The resident also had two half bed rails which were not affixed to the bed. The half rails were purchased by the family and not part of the bed system. The half rail on the left side of the bed was observed in the upright position throughout the inspection. It was noted that both half bed rails could slide around as they were not secured to the bed frame, posing a potential entrapment risk.

The Acting Administrator confirmed the observations of the bed rails and acknowledged the potential entrapment risk. [s. 15. (1) (b)]

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 where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

A clinical record review revealed that an identified Resident did not have a care conference completed within six weeks of admission. The resident did not have a care conference until 11 weeks post admission.

An interview with a family member indicated that they had requested the care conference as the home had not initiated one.

The clinical record for an identified Resident revealed that the care conference was initiated after the family of the resident had expressed numerous concerns.

The Director of Quality Improvement acknowledged that the care conference was not held within six weeks of admission. [s. 27. (1) (a)]

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 interdisciplinary team providing a resident's care is held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, devices and assistive aids for the falls prevention and management program were readily available at the home.

A clinical record review for an identified Resident revealed that two full bed rails were required to prevent the resident from falling out of bed.

An interview with a family member for the identified Resident revealed that the home had a shortage of bed rails so could not provide the required bed rails when they were required by the resident.

The Director of Quality Outcomes acknowledged that the home had had a shortage of bed rails.

The Acting Administrator acknowledged that it was the home's responsibility to provide equipment such as bed rails for residents and indicated that she had ordered bed rails for the resident. [s. 49. (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 equipment, devices and assistive aids, including bed rails for the falls prevention and management program are readily available at the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report included analysis and follow-up action, including:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

Review of Critical Incident # 3047-000016-15 sent to the Ministry revealed that the report did not include:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence

An identified Resident returned to the home post hospitalization, with a significant change in condition.

The Centralized Intake, Assessment and Triage Team requested two updates from the home.

The Director of Quality Outcomes acknowledged that the updates had not been provided.

She also acknowledged that immediate actions and long-term actions to prevent recurrence had not been included in the Critical Incident report. [s. 107. (4) 4.]

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 written report includes analysis and follow-up action, including:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. 131(5) The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

During a lunch meal service, in a dining room, it was noted that medications were left at the table in white paper medicine cups for two identified Residents.

The Registered Staff member who had left them at the table confirmed that this had been done despite awareness that the home's expectation was that medication be administered by registered staff.

The Registered Staff member also acknowledged that neither of these residents had an order for self administration of medication and that he/she should have stayed with the residents until the medications were consumed.

The Director of Care indicated that the expectation was that all registered staff must observe that residents have taken their medication unless they have an order for self administration. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

Issued on this 29th day of May, 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) :	RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2015_182128_0011
Log No. / Registre no:	008221-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 28, 2015
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula Thomson

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee must prepare, submit and implement a plan that identifies how each of the following issues will be addressed:

1. An open communication system to deal with complaints must be developed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home provides a response to the person who made the complaint indicating what the licensee has done to resolve the complaint.

2. A monitoring system must be developed to ensure that that a documented record is kept in the home that includes:
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

The plan must identify who will be responsible for monitoring the documented records.

3.Education must be provided to all residents, staff and families so that there is open communication on how to resolve concerns, as well as complaints.

4.The written plan must outline who will be responsible for developing the education, when and how it will occur for all residents, staff and families.

Please submit the plan being implemented, in writing, to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by June 12, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home provided a response to the person who made the complaint indicating what the licensee has done to resolve the complaint.

An interview with a family member for an identified Resident revealed that the family had lodged a complaint with the home.

A clinical record review for an identified Resident revealed that the family had complained to a Registered Nursing staff member and the Registered Nursing staff member filled out a complaint form. The progress note indicated that the complaint form was given to the Administrator.

The complainant indicated that they had not been contacted to indicate what the home had done to resolve the complaint until this inspection was initiated.

The Administrator confirmed that the home had not contacted the family to advise them of the resolution to their concerns. (128)

2. The licensee has failed to ensure that that a documented record was kept in the home that included:
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

An interview with a family member for an identified Resident revealed that the family had lodged a complaint with the home.
A clinical record review revealed that the family had complained to a Registered Nursing staff member and the Registered Nursing staff member filled out a complaint form which was given to the Administrator.

A review of the Client Services Response Form revealed that the family of an identified Resident lodged a complaint with the home.
However, the information on the form did not include the date on which the complaint was received. The issue/concern was identified but the form did not contain the action taken to resolve the complaint or any follow-up action required.
Additionally, the complainant was not contacted until this inspection was initiated. As such, there were no responses to the complainant documented on

the form or any responses from the complainant.

The Administrator acknowledged that there had been no follow-up communication with the family in regard to the complaint and that the complaint record was not completed as per the complaint process in the Long-Term Care Homes Act.
(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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
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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 28th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND

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