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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2019	2019_668543_0010	009024-19	Complaint

Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Au Chateau
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

TIFFANY BOUCHER (543)

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 23-26, 29-30, and May 1-3, 2019

One intake, related to a complaint that was submitted to the Director regarding care concerns specific to a fall, was inspected.

A Critical Incident Inspection and a Follow-up Inspection were conducted concurrent with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physician, Coordinator of Resident Services, Dietairy Aide, Activity Aides, Physiotherapist (PT), Physiotherapy Assistant (PTA), Executive Vice President of an external service provider, Infection Prevention and Control Coordinator, Housekeeping and Laundry staff, Family Council President, residents and family members.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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	Légende 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint was submitted to the Director on a specific date in 2019, that identified concerns related to the care that resident #008 had received prior to, and after a fall that resulted in an injury.

A Critical Incident (CI) report was submitted to the Director on a specific date in 2019, related to resident #008 sustaining a fall that resulted in an injury.

Inspector #543 interviewed the complainant, who indicated that they were unsure if resident #008 had been appropriately assessed after they fell.

Inspector #543 reviewed resident #008's nursing progress notes, which identified that the resident had stated that they fell and thought they were injured. The progress note indicated that vital signs were taken and the RN on duty was notified.

A subsequent progress note documented by RN #118 was reviewed. That progress note indicated that RN #118 had noted that the resident reported that they were injured. This progress note indicated that the RN had completed an assessment. Upon review of resident #008's health care record, the Inspector was unable to identify that a post fall assessment was completed.

The Inspector reviewed the home's "Falls Prevention and Management Program", revised on February 14, 2017. The program indicated that when a resident had fallen, the resident would be assessed regarding the nature of the fall and the associated consequences, the cause of the fall and the post fall care management. The program described an un-witnessed fall as a fall that occurs when a resident is found on the floor or the resident reports sustaining a fall. The program identified that the RN would follow and complete the "Post Fall Investigation Summary Form" as instructed which also includes scheduled events for follow ups and referral to other disciplines.

Inspector #543 reviewed the "Post Fall Investigation Summary Report", which identified that the checklist was designed to assist in identifying the cause of the fall and guide

documentation. The report included an assessment section which identified contributing factors to the fall. The health and mental status of the resident at the time of the fall, and a section to list any new or changed medications that were administered within 48 hours of the fall.

Also in the report, was a summary of the factors contributing to the fall and any referral that may apply. The interventions in the report included, but were not limited to the following:

-completing a head to toe assessment
-completing vital signs, head injury routine
-any mapping tools initiated
-need to inform the physician at time of fall
-inform the resident's SDM
-entering post fall scheduled events
-reviewing and updating the resident's care plan

This report also included a post fall and follow up section. This section included, but was not limited to; documenting if there was a change in the level of care required, pain management, the outcome of interventions, and follow-ups or referrals. The section further indicated that staff would document any family or resident response to any interventions, if the fall resulted in a transfer to hospital, the probable cause of the fall, the immediate actions taken, as well as the long term actions planned to correct the situation and prevent recurrence.

Inspector #543 interviewed RPN #113, who indicated that it was the responsibility of the RN to complete the post fall assessments.

Inspector #543 interviewed RN #118, who indicated that they arrived to resident #008's room and they did a visual check and there was no obvious injury. RN #118 indicated that the resident had stated that they had fallen. The RN stated that they had checked the resident's limbs and did a skin inspection. RN #118 stated that the RPN on shift with them, had checked for "lumps and bumps" and identified there was nothing apparent. The RN verified that no post fall assessment was completed on their shift.

Inspector #543 interviewed the DOC who indicated that it was the responsibility of the RN to complete the "Post Fall Investigations Summary Form"; and that the assessment should have been completed in the post fall package. [s. 49. (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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A CI report was submitted to the Director on a specific date in 2019. According to the CI report, resident #008 had reported to a staff member that they had fallen and thought they were injured.

Inspector #543 reviewed a progress note dated the day prior to the submitted CI report to the Director, which identified that RPN #126 documented they had noted an injury to resident #008.

The Inspector reviewed a subsequent progress note which indicated that PSW #114 was attempting to provide morning care to resident #008 but was having difficulty and requested help from PSW #117. The progress note indicated that the resident was injured and attributed the injury to the fall.

Inspector #543 reviewed resident #008's care plan related to skin integrity/pressure ulcer, related to skin tears and fragile skin. The goal was to prevent injuries. Interventions identified that the resident was to wear a protective device at all times to protect skin from injuries.

Inspector #543 reviewed resident #008's health care record, specifically the physicians's progress notes, which identified the following:

-a date in 2018: They would be an ideal candidate for a protective device

-a date in 2018 clinically, much improved, alert but new skin injury again, not wearing protective device....cannot find them.

-a date in 2018: was asked to assess the resident's skin. They were not wearing their protective device and indicated they had applied the protective device

Inspector #543 reviewed the resident's health care record, specifically the physician's orders which identified the following:

-an order from a date in 2018 indicated: protective device,
-another order from a date in 2018 indicated: please ensure wearing protective device at all times; and
-a subsequent order from a date in 2018: must wear protective device at all times.

Inspector #543 reviewed the home's "Skin and Wound Care Program" which identified that staff would implement interventions for the prevention of further skin breakdown.

Inspector #543 interviewed PSW #117, who indicated that resident #008 only used the protective device during the day. PSW #117 verified that when they received the resident on their day shifts the protective device was never applied.

Inspector #543 interviewed RPN #139, who verified that resident #008's care plan

identified that the resident was required to wear a protective device at all times to protect skin from injuries. RPN #139 indicated that when a resident's care plan indicated "at all times" that meant that the resident had to have the protective device on day and night.

Inspector #543 interviewed RN #136, who indicated they were not certain if resident #008 wore the protective device all the time, but indicated that the resident did not have the protective device on at the time they saw them the morning they fell.

Inspector #543 interviewed Physician #138, who verified that they had ordered the protective device to be worn at all times. The Physician re-iterated that they had noted several times that the resident required the protective device in their orders. [s. 50. (2) (b) (ii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

With respect to O. Reg., 79/10, section 48 (1), every licensee of a long-term care home shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

A complaint was submitted to the Director on a specific date in 2019, that identified concerns related to the care that resident #008 had received and the documentation related to the care provided.

A) Inspector #543 interviewed the complainant who indicated that they had reviewed resident #008's health care record, and identified that there were no notes documented in the nursing notes identifying that the resident was assessed on the day they fell.

Inspector #543 reviewed resident #008's nursing progress notes, specifically related to the fall. The nursing progress notes indicated the following:

-resident #008 was received by RPN #123 and stated that they had fallen and thought they were injured. This nursing progress note indicated that the RPN had taken the resident's vital signs. These vital signs were not documented anywhere in the resident's health care record.

Inspector #543 reviewed the investigation documents related to the fall that resident #008 sustained and identified seven progress notes entered as "late entry" related to resident #008:

-RN #136 documented a progress note four days after the fall,
-RN #118 documented a progress note six days after the fall,
-RPN #113 documented a progress note 16 days late,
-RN #137 documented a progress note 25 days late,
-RN #118 documented a progress note 26 days late,
-RPN #135 documented a progress note 25 days late, and
-RPN #126 documented a progress note 31 days late.

The investigation documents indicated that "documentation in general [was] not complete- missing some information for this resident", and that "staff would have a hard time remembering what happened after the fact if it's not written".

Inspector #543 reviewed the home's "Falls Prevention and Management Program", which

identified that the nursing staff having the most knowledge of the fall will complete a detailed progress note of the incident including the date and time, witnesses' names, statements, resident's observations and complaints, objective findings, and immediate interventions or actions.

Inspector #543 interviewed the DOC who indicated that upon completing their investigation related to care provided for resident #008 they identified that; documentation was not completed appropriately, there was lacking information, too vague or missing. The DOC also indicated that the post fall package included the "Post Fall Investigation Summary Report", which identified a checklist designed to identify the cause of the fall and guide documentation.

B) Inspector #543 reviewed investigation documents provided by the DOC for resident #008's health condition which identified the following:

-a late entry, written by RPN #135 identified that they were approached by an acquaintance of resident #008; who reported that the resident had appeared unwell. RPN #135 indicated that they would take the resident's temperature. The resident's temperature was not documented anywhere in the resident's health care record.

Inspector #543 interviewed RPN #135 who indicated that they had assessed resident #008 and taken the resident's temperature. The RPN verified that they had not documented the temperature in the resident's health care record in Gold Care.

Inspector #543 interviewed the DOC who verified that RPN #135 had done an assessment and did not report it to the RN. The DOC confirmed that RPN #135 did not document the assessment until 25 days later, which only indicated that the RPN took the resident's temperature and described their health condition. [s. 30. (2)]

WN #4: 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. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM), if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

A complaint was submitted to the Director on a specific date in 2019, that identified concerns related to resident #008 sustaining a fall, and their SDM not being notified of the incident until the next morning.

Inspector #543 reviewed the investigation documents related to the fall that resident #008 sustained on a day in 2019. An investigation was conducted for specific dates by the DOC for resident #008's health condition and identified that on three separate occasions the resident's SDM was not notified of the following:

-the resident was displaying responsive behaviours and required the administration of medications related to those responsive behaviours. RN #118 did not notify the resident's SDM to inform them of responsive behaviours or the administration of medication.

-resident displayed responsive behaviours, and an injury. SDM was not notified.

-resident heard yelling, and reporting that they had fallen and sustained an injury. SDM not notified of query fall.

Inspector #543 reviewed resident #008's nursing progress notes and could not identify that the SDM was notified of the above mentioned incidents.

Inspector #543 reviewed the home's "Post Fall Investigation Summary Report", which identified that part of the interventions post fall were to notify the resident's SDM, at the time of the fall the RN assessment posed concerns or as per the SDM's preferences.

The Inspector reviewed the home's "Falls Prevention and Management Program". The program indicated that the RN will notify the POA/SDM of the resident's fall, the care provided and the status of the resident.

Inspector #543 interviewed the DOC who indicated that resident #008's SDM was not notified at the time of the fall when the resident reported they had fallen because they did not find any injuries at that time and the resident had settled. The DOC further stated that the standard process is to notify the SDM of any out of the ordinary instances that occur with residents. [s. 107. (5)]

Issued on this 14th day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2019_668543_0010
Log No. / No de registre :	009024-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 10, 2019
Licensee / Titulaire de permis :	Board of Management for the District of Nipissing West 100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4
LTC Home / Foyer de SLD :	Au Chateau 100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacques Dupuis

To Board of Management for the District of Nipissing West, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with s. 49 (2) of the O. Reg.

Specifically the licensee must ensure that when any resident has fallen, the resident is assessed and when their condition requires, a post-fall assessment is completed using a clinically appropriate assessment instrument specifically designed for falls.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint was submitted to the Director on a specific date in 2019, that identified concerns related to the care that resident #008 had received prior to, and after a fall that resulted in an injury.

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injured. The progress note indicated that vital signs were taken and the RN on duty was notified.

A subsequent progress note documented by RN #118 was reviewed. That progress note indicated that RN #118 had noted that the resident reported that they were injured. This progress note indicated that the RN had completed an assessment. Upon review of resident #008's health care record, the Inspector was unable to identify that a post fall assessment was completed.

The Inspector reviewed the home's "Falls Prevention and Management Program", revised on February 14, 2017. The program indicated that when a resident had fallen, the resident would be assessed regarding the nature of the fall and the associated consequences, the cause of the fall and the post fall care management. The program described an un-witnessed fall as a fall that occurs when a resident is found on the floor or the resident reports sustaining a fall. The program identified that the RN would follow and complete the "Post Fall Investigation Summary Form" as instructed which also includes scheduled events for follow ups and referral to other disciplines.

Inspector #543 reviewed the "Post Fall Investigation Summary Report", which identified that the checklist was designed to assist in identifying the cause of the fall and guide documentation. The report included an assessment section which identified contributing factors to the fall. The health and mental status of the resident at the time of the fall, and a section to list any new or changed medications that were administered within 48 hours of the fall.

Also in the report, was a summary of the factors contributing to the fall and any referral that may apply. The interventions in the report included, but were not limited to the following:

-completing a head to toe assessment
-completing vital signs, head injury routine
-any mapping tools initiated
-need to inform the physician at time of fall
-inform the resident's SDM
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-reviewing and updating the resident's care plan

This report also included a post fall and follow up section. This section included, but was not limited to; documenting if there was a change in the level of care required, pain management, the outcome of interventions, and follow-ups or referrals. The section further indicated that staff would document any family or resident response to any interventions, if the fall resulted in a transfer to hospital, the probable cause of the fall, the immediate actions taken, as well as the long term actions planned to correct the situation and prevent recurrence.

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Inspector #543 interviewed the DOC who indicated that it was the responsibility of the RN to complete the "Post Fall Investigations Summary Form"; and that the assessment should have been completed in the post fall package.

The severity of this was determined to be a level 3 as there was actual harm or actual risk to the resident. The scope of the issue was a level 1 as it was related to one resident. The home had a level 2 compliance history of one or more non-compliances, none of which were the same section being cited. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

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