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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
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Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
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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
Feb 5, 2019	2019_755728_0002	023551-18, 023564-18, 023574-18, 027752-18, 029067-18, 030846-18, 031061-18	Follow up

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

MARIA MCGILL (728), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 14-18, 21, 22, 24, 2018

The following intakes were completed in this follow-up inspection:

Log # 023551-18, follow-up to compliance order (CO) #001 from inspection 2018_508137_0008 related to the prevention of abuse and neglect.
Log # 023564-18, follow-up to CO #002 from inspection 2018_508137_0008 related to immediately investigating abuse, neglect, and any requirements provided in the regulations and responding with appropriate action based on the investigations outcome.
Log # 023574-18, follow-up to CO #003 from inspection 2018_508137_0008 related to reporting.
Log # 027752-18, complaint related to potential improper care of a resident.
Log # 029067-18, complaint related to alleged improper care of a resident.
Log # 030846-18, follow-up related to CO #001 from inspection 2018_773155_0012 related to the home's skin and wound program.
Log # 031061-18, follow-up related to CO #001 from inspection 2018_508137_0026 related to coaching and mentoring of the Executive Director and Director of Care, staff education related to required programs, and auditing required programs.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Administrative Assistant (AA), the Resident Assessment Instrument Coordinator (RAI), the Resident Care Coordinator (RCC), the Regional Director, External Management Company Director of Operations (RHM), External Management Company Nurse Consultant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector(s) also observed resident care provision, staff to resident interactions, relevant resident plans of care, relevant program policies, procedures, education/training records, audits, and the home's documented complaints, responses, and investigations.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Hospitalization and Change in Condition
Pain
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 101. (3)	CO #001	2018_508137_0026	155
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_508137_0008	728
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2018_508137_0008	728

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was received by the Ministry of Health and Long-term Care (MOHLTC) regarding potential improper care of resident #002.

The home's document titled "Complaint – Form" indicated that on an identified date, a staff member approached the home's management regarding a concern related to the care provided to resident #002 on a specified date.

A review of the home's critical incidents submitted to the MOHLTC did not locate a CI related to this specific allegation of improper/incompetent care.

The Administrator #100, DOC #101, and Nurse Consultant #111 said that a critical incident or notification to the Director was not submitted when the allegation of improper or incompetent treatment or care was brought to their attention.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care or incompetent treatment of resident #002 by anyone that resulted in harm or risk of harm to the resident was immediately reported to the Director with suspicion and the information upon which it is based. [s. 24. (1) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #004 was noted to have an area of altered skin integrity. Review of resident #004's clinical record showed that skin and wound assessments were completed for two of the three required weeks. These assessments included a picture taken of the area of altered skin integrity using the Point Click Care (PCC) wound assessment tool as well as a full description of the area of altered skin integrity. One identified week did not have an assessment documented.

Review of resident #004's clinical record showed that there was no picture of the area of altered skin integrity or assessment using the PCC skin and wound assessment tool for one of the identified weeks. Review of resident #004's progress notes documented a late entry skin/wound note for the week that originally had no assessment completed. The progress note stated that the picture of the area of altered skin integrity was not displayed on PCC.

During interviews, staff presented conflicting information related to how the skin and wound assessment was completed that was also not consistent with the documentation.

Director of Care #101 shared that they were made aware that an assessment for an identified date was not completed, that a late entry progress note for the assessment was completed, and confirmed that how the assessment was completed was not consistent with the documentation in the resident's plan of care.

The licensee failed to ensure that resident #004 had an area of altered skin integrity reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care, outcomes, and effectiveness of the plan of care were documented.

A complaint was received by the MOHLTC regarding potential improper care of resident #002.

Resident #002's plan of care documented a late entry progress note that indicated resident #002 was having identified symptoms and was assessed. A second late entry progress note indicated that the resident was sent to hospital as a result of their symptoms. The progress note did not clearly outline the timeline of the resident's symptoms.

A home's document indicated that a staff member approached Nurse Consultant #111 regarding a concern that the registered staff did not act promptly in assessing resident #002. The home completed an investigation of the incident.

The home's documentation included a discipline letter that stated that there was a concern regarding improper documentation on an identified date.

PSW #108, #116, and #117, and Housekeeper #114, all said that the RN was notified at least twice of the resident's symptoms. PSW #108, Housekeeper #114, and PSW #117 all said that the resident was not assessed by the registered staff timely or appropriately. Administrator #100, DOC #101, Nurse Consultant #111, and RN #112, all said that resident #002 was assessed timely and appropriately.

The documentation completed was insufficient to identify the time the sequence of events occurred.

Administrator #100, DOC #101, and Nurse Consultant #111, said that RN #112 did not complete appropriate or timely documentation of the care, outcomes, or effectiveness of the care on an identified date.

The licensee had failed to ensure that resident #002's care, outcomes, and the effectiveness were documented on an identified date. [s. 6. (9)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's pain assessment/pain management policy directed staff to complete the a pain management flow sheet when a scheduled pain medication did not relieve the pain or when pain remained regardless of interventions.

During an interview with Resident Care Coordinator #120, they shared that the pain management flow sheet would be initiated when a resident had a change in dosage of their pain medication. This flow sheet would be completed at a minimum of once a day for three days.

On a specified date, resident #005's pain medication dosage was changed. The pain management flow sheet for resident #005 was completed on two of the three required dates.

During an interview with Director of Care #101 they shared that the pain management flow sheet was not completed for one of the required dates.

The licensee failed to ensure that the Pain Assessment/Management Program policy and procedure was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 27th day of February, 2019

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

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) :	MARIA MCGILL (728), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2019_755728_0002
Log No. / No de registre :	023551-18, 023564-18, 023574-18, 027752-18, 029067-18, 030846-18, 031061-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 5, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Penny Silva

To Caressant-Care Nursing and Retirement Homes 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_508137_0008, CO #003;

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, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s.24(1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that a person who has reasonable grounds to suspect that improper care or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, immediately reports the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #003 from inspection 2018_508137_0008 issued on August 24, 2018 with a compliance date of September 7, 2018.

The licensee was ordered to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director.

Specifically, the licensee must:
a) Ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

The licensee completed part a of the order. However, the licensee failed to be compliant with s. 24(1) of the LTCHA, 2007.

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

A complaint was received by the Ministry of Health and Long-term Care (MOHLTC) regarding potential improper care of resident #002.

The home's document titled "Complaint – Form" indicated that on an identified date, a staff member approached the home's management regarding a concern related to the care provided to resident #002 on a specified date.

A review of the home's critical incidents submitted to the MOHLTC did not locate a CI related to this specific allegation of improper/incompetent care.

The Administrator #100, DOC #101, and Nurse Consultant #111 said that a critical incident or notification to the Director was not submitted when the allegation of improper or incompetent treatment or care was brought to their attention.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care or incompetent treatment of resident #002 by anyone that resulted in harm or risk of harm to the resident was immediately reported to the Director with suspicion and the information upon which it is based. [s. 24. (1) 1.]

The severity of this issue was determined to be a level 1 as there was minimal risk. The scope of the issue was a level 1 as it related to one of the incidents reviewed. The home had a level 5 history as they had previous related non-compliance that included:

- compliance order #003 issued August 24, 2018, with a compliance due date of September 7, 2018 (2018_508137_0008)
- voluntary plan of correction (VPC) issued March 1, 2018 (2018_448155_0001)
- VPC issued August 4, 2016 (2016_325568_0015).
(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2019

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_773155_0012, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s.50 (2)(b)(iv) of O.Reg 79/10.

Specifically, the licensee must:
a) Ensure that resident #004 and all other resident's exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection 2018_773155_0012 issued on November 20, 2018 with a compliance date of December 14, 2018.

The licensee was ordered to:

The licensee must be compliant with O.Reg. 79/10, s.50.(2)(b)(iv).

Specifically the licensee shall ensure that resident #006, #007, and any other residents with altered skin integrity receive weekly skin assessments by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

The licensee failed to complete weekly skin assessments for resident #007 identified in the order who is identified as resident #004 in this report.

The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #004 was noted to have an area of altered skin integrity. Review of resident #004's clinical record showed that skin and wound assessments were completed for two of the three required weeks. These assessments included a picture taken of the area of altered skin integrity using the Point Click Care (PCC) wound assessment tool as well as a full description of the area of altered skin integrity. One identified week did not have an assessment documented.

Review of resident #004's clinical record showed that there was no picture of the

area of altered skin integrity or assessment using the PCC skin and wound assessment tool for one of the identified weeks. Review of resident #004's progress notes documented a late entry skin/wound note for the week that originally had no assessment completed. The progress note stated that the picture of the area of altered skin integrity was not displayed on PCC.

During interviews, staff presented conflicting information related to how the skin and wound assessment was completed that was also not consistent with the documentation.

Director of Care #101 shared that they were made aware that an assessment for an identified date was not completed, that a late entry progress note for the assessment was completed, and confirmed that how the assessment was completed was not consistent with the documentation in the resident's plan of care.

The licensee failed to ensure that resident #004 had an area of altered skin integrity reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)].

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 1 as it related to 1 out of 3 residents. The home had a level 5 history as they had previous related non-compliance that included:
- compliance order (CO) #001 issued November 20, 2018, with a compliance due date of December 14, 2018 (2018_773155_0012)
- voluntary plan of correction (VPC) issued August 4, 2016 (2016_325568_0015). (155)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 04, 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 5th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria McGill

Service Area Office /
Bureau régional de services : Central West Service Area Office