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
Mar 8, 2019	2019_674610_0010	027182-18, 029665-18, 031783-18, 002639-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Southwood Lakes
1255 North Talbot Road WINDSOR ON N9G 3A4

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

NATALIE MORONEY (610), HELENE DESABRAIS (615)

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): February 11 ,12,13, 14, and 15, 2019

This complaint Log #002639-19, IL-63909-LO, was completed related to a discharge.

The following complaint inspections were completed concurrently during this inspection:
Complaint Log #031783-18, IL-62269-LO, related to infection prevention and control.
Complaint Log #029665-18, IL-61501-LO, related to allegation of abuse and neglect.
Complaint Log #027182-18, IL-60739-LO, related to personal support services.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, the LHIN's, Personal Support Workers, families and residents.

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents and reviewed documentation related to the home's responsive behaviours program, zero tolerance of abuse, reporting of complaints, critical incident's, and discharge processes.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dining Observation
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

3 WN(s)
0 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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The license has failed to ensure that a resident that was discharged under subsection 145 (1) that they (a) ensured that alternatives to discharge have been considered and, where appropriate, tried; (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

This inspection was conducted related to a complaint Log #002639-19/IL-63909-LO

received to the Ministry of Health and Long Term Care (MOHLTC) for an identified resident. The complaint showed that the resident had allegedly been discharged without reasons from the home.

Review of documented evidence showed that the Social Worker met with resident's Substitute Decision Makers (SDM)'s. A detailed plan of care for the identified resident's responsive behaviours were documented with intervention that could be implemented for behavioural triggers.

The resident experienced behavioural triggers as identified by the resident's SDM. The home provided BSO staff 1:1 care to the resident.

The Social Worker had record documentation that was not part of the resident health care record (HCR) that showed the following:
Hygiene care was provided successfully to the resident by both the staff and an external party.
The Social Worker and the DOC had told the SDM that long term care was not the ideal place for the identified resident
Record documentation showed a conference call was held with the LHIN's and the home and they had made a joint decision to discharge the identified resident.
-The DOC and Social Worker had a meeting with the resident's family and discharged the identified resident.
There was no record documented evidence that the as needed medication for behaviours was administered to the identified resident per Electronic Medication Administration Records (eMar).

There was also no documented evidence in the resident's health care records regarding of the date the discharge occurred.

During an interview the Social Worker said that they tried to accommodate the resident's needs but were concerned about their safety. The Social Worker agreed that the resident had slept through the night, with 1:1 BSO staff and that they were able to provide care to the resident with no concerns. The Social Worker also expressed that staff had told them they were upset when they learned the resident had been discharged.

a) The Administrator said they ensured that alternatives were exhausted before they discharged the resident.

During an interview with the Administrator they said they had not applied for High Intensity Needs (HIN) from the Ministry of Health and Long Term Care for the identified resident as they hire security guards to assist with 1:1 care. The Administrator further said the home doesn't have the staff, to provide 1:1 care, and felt that the security guards could not assist with the resident's behaviors. The Administrator also said that they did everything they could for the resident, but the home was not able to meet the resident's needs. The Administrator also said that they have one BSO nurse and two BSO PSW staff in the home.

The staff said that there are residents currently in the home that are receiving 1:1 care and the services that are being provided by a staff from an agency.

b) During an interview with the Erie St. Clair Local Health Integration Network (LHIN) the Patient Service Manager said that alternative arrangements for the accommodation and care had been initiated by the LHIN. That they had agreed with the home and that the resident should not have been placed in LTC and that "they drop the ball" with the placement for the resident.

The resident's family said that the services for resident were not started until a week later when they had to contact the LHIN.

c) The resident's family told the inspector that they did not know they had a choice when they were told by the DOC that the resident was being discharged back home to their care. They also said that they were not given an opportunity to participate in the discharge planning and that though they voiced their concerns to the home, there was no consideration toward their wishes for the resident.

d) The Social Worker said that they did not provide a written notice to the resident's substitute decision-maker, with a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident prior to discharging the resident.

The Administrator said that the legislation does not provide a date as to when the written letter needs to provided and that it was not the intent to not follow the legislation.

The scope of this issue was isolated to the identified resident, the severity was determined as level 3, there was no history related to this regulation.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Complaint #IL-60739-LO/Log #027182-18 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to improper care of an identified resident.

Ontario Regulation 79/10 defines "physical abuse" as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

During an interview the complainant stated that the identified resident was allegedly attacked by another resident.

A review of the home's policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" stated in part "Procedures: Ensure the safety of, and provide support to the abuse victim (s), through completion of full assessments, a determination of resident needs and a documented plan to meet those needs" and "anyone who suspects or witnesses abuse, incompetent care or is required to treatment of a resident and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care".

A review of the resident's record documentation stated in part that a resident had physically abused the identified resident and that the Director of Care (DOC) was notified of the physical abuse. No skin or pain assessment was conducted and no Critical Incident report was submitted to the MOHLTC.

During interviews, staff both stated that the incident was abuse and that they would report to their supervisor all incidents of abuse of residents.

During interviews, the Social Worker and DOC both acknowledge that the incident was abuse, that the identified resident should have received a skin and pain assessment and that the home's expectation would be that it should have been reported to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of the identified resident by anyone, by the licensee or staff that resulted in harm or risk of harm had occurred immediately reported the suspicion and the information upon which it was based to the Director.

WN #3: 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).

Findings/Faits saillants :

The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, had a response been 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.

Complaint #IL-62269-LO/Log #031783-18 was submitted to the MOHLTC indicating that an identified resident's family member had submitted to the home a complaint letter regarding concerns about the care of the resident.

A review of the home's documentation included the email of concerns from the complainant to the Administrator and the response of the Administrator to the complainant.

A review of the home's policy last stated in part "Provide written response at conclusion of investigation. The written response will included: what the home has done to resolve the complaint. This will be shared with the complainant/resident/SDM/family/staff or any other individuals involved".

During an interview, the Clinical Coordinator stated that they did not respond to the complainant as they were not the Power of Attorney for the resident.

During an interview, the Administrator stated they had received the complaint email from the complainant and that the complainant was not the POA for the resident and if the email was sent by the POA they would of answered back.

The licensee has failed to ensure that for every written complaint made to the licensee concerning the care of the identified resident had a response been made to the person who made the complaint, indicating; what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

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*

Issued on this 19th day of March, 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) :	NATALIE MORONEY (610), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2019_674610_0010
Log No. / No de registre :	027182-18, 029665-18, 031783-18, 002639-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 8, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Southwood Lakes 1255 North Talbot Road, WINDSOR, ON, N9G-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Ethier

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

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

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. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 148. (2).

Specifically the licensee must:
Refrain from discharging all residents under O.Reg 79/10 s. 145 (1) unless the licensee has first complied with O.Reg 79/10 s.148. Specifically, if the resident is to be discharged the licensee must:
i) Ensure that alternatives to discharge have been considered and, where appropriate, tried;
ii) In collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by all residents.
iii) Ensure all resident's and the substitute decision-maker, if any, and any person they direct, be kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration;
iv) Provide a written letter to all resident's and the resident's substitute decision-maker if any, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident before discharging any resident.

Grounds / Motifs :

1. 1. The license has failed to ensure that a resident that was discharged under subsection 145 (1) that they (a) ensured that alternatives to discharge have been considered and, where appropriate, tried; (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

This inspection was conducted related to a complaint Log #002639-19/IL-63909-

LO received to the Ministry of Health and Long Term Care (MOHLTC) for an identified resident. The complaint showed that the resident had allegedly been discharged without reasons from the home.

Review of documented evidence showed that the Social Worker met with resident's Substitute Decision Makers (SDM)'s. A detailed plan of care for the identified resident's responsive behaviours were documented with intervention that could be implemented for behavioural triggers.

The resident experienced behavioural triggers as identified by the resident's SDM. The home provided BSO staff 1:1 care to the resident.

The Social Worker had record documentation that was not part of the resident health care record (HCR) that showed the following:
Hygiene care was provided successfully to the resident by both the staff and an external party.
The Social Worker and the DOC had told the SDM that long term care was not the ideal place for the identified resident
Record documentation showed a conference call was held with the LHIN's and the home and they had made a joint decision to discharge the identified resident.

-The DOC and Social Worker had a meeting with the resident's family and discharged the identified resident.
There was no record documented evidence that the as needed medication for behaviours was administered to the identified resident per Electronic Medication Administration Records (eMar).

There was also no documented evidence in the resident's health care records regarding of the date the discharge occurred.

During an interview the Social Worker said that they tried to accommodate the resident's needs but were concerned about their safety. The Social Worker agreed that the resident had slept through the night, with 1:1 BSO staff and that they were able to provide care to the resident with no concerns. The Social Worker also expressed that staff had told them they were upset when they learned the resident had been discharged.

a) The Administrator said they ensured that alternatives were exhausted before they discharged the resident.

During an interview with the Administrator they said they had not applied for High Intensity Needs (HIN) from the Ministry of Health and Long Term Care for the identified resident as they hire security guards to assist with 1:1 care. The Administrator further said the home doesn't have the staff, to provide 1:1 care, and felt that the security guards could not assist with the resident's behaviors. The Administrator also said that they did everything they could for the resident, but the home was not able to meet the resident's needs. The Administrator also said that they have one BSO nurse and two BSO PSW staff in the home.

The staff said that there are residents currently in the home that are receiving 1:1 care and the services that are being provided by a staff from an agency.

b) During an interview with the Erie St. Clair Local Health Integration Network (LHIN) the Patient Service Manager said that alternative arrangements for the accommodation and care had been initiated by the LHIN. That they had agreed with the home and that the resident should not have been placed in LTC and that "they drop the ball" with the placement for the resident.

The resident's family said that the services for resident were not started until a week later when they had to contact the LHIN.

c) The resident's family told the inspector that they did not know they had a choice when they were told by the DOC that the resident was being discharged back home to their care. They also said that they were not given an opportunity to participate in the discharge planning and that though they voiced their concerns to the home, there was no consideration toward their wishes for the resident.

d) The Social Worker said that they did not provide a written notice to the resident's substitute decision-maker, with a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident prior to discharging the resident.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

The Administrator said that the legislation does not provide a date as to when the written letter needs to provided and that it was not the intent to not follow the legislation.

The scope of this issue was isolated to the identified resident, the severity was determined as level 3, there was no history related to this regulation.
(610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 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 8th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Moroney

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