Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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
Jan 16, 2019	2018_723606_0024	024466-18	Complaint

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Gateway Haven Long Term Care Home
671 Frank Street P.O. Box 10 WIARTON ON N0H 2T0

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

JANET GROUX (606)

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): December 3, 4, 5, and 6, 2018.

The following complaint intake was inspected:
Log # 024466-18 regarding the home's falls management program, personal support services, hygiene care, missing personal care items, and transferring and positioning concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Clinical Care Coordinator (CCC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSWs), Laundry Aide, Hair dresser, Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Pain
Personal Support Services
Sufficient Staffing

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

- **8 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported an allegation of improper care related to the falls management of resident #001.

During resident #001's falls inspection, the inspector was informed that when the resident fell the home did not have a registered nurse (RN) on duty.

Review of the home's RN schedule during a time period revealed the home did not consistently have an RN during identified day, evening and night shifts.

Registered Staff #105 stated that they did not have an RN in the building when resident #001 fell.

The Director of Care (DOC) confirmed that they did not have an RN in the building when resident #003 fell, and stated the home had operated the home as mentioned above having an RN absence for part of or the entire shift. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

A complaint submitted to the MOHLTC reported an allegation of improper care related to the falls management of resident #001 resulting in a serious injury.

The progress notes stated resident #001 has had several falls prior to the falls that resulted in a serious injury.

Resident #001's care plan identified the resident to be at risk of falling related to their medical condition and has had a history of falls. The care plan provided a number of interventions for the staff to implement to manage the resident from falling but did not show any evidence that any other interventions were initiated to manage the resident's fall risks.

Registered Staff #105, #107, and #108 stated that although resident #001's care plan was reviewed after they fell, they indicated that there were no new interventions tried to manage the resident's risk of falling.

The licensee has failed to ensure that when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: 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. The licensee has failed to ensure that 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 was complied with.

In accordance with O. Reg. 79/10, 30. (1) every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation there must be procedures and protocols that provides for methods to reduce and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A complaint submitted to the MOHLTC reported an allegation of improper care related to the falls management of resident #001.

The home's policy entitled, "Falls Prevention", stated if there is an injury to the resident after a fall, the physician should be notified by phone. If there is no injury to the resident after a fall, the physician should be notified via Medical Doctor (MD) list for review for the next scheduled visit.

RPN #105 stated that resident #001 had a fall with no observations of injury, the physician should have been notified via Medical Doctor (MD) list to review for their next scheduled visit and confirmed that they did not do this.

Resident #001's progress notes during an identified time did not show evidence that the physician was aware of resident's #001 fall and injury until after the SDM had alerted the home about their observation.

The Administrator acknowledged that after a resident has had a fall with no injuries, it is the home's policy to notify the physician via MD list for their review at the next scheduled visit. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy entitled, "Falls Prevention", states a referral to the physiotherapist (PT) will be initiated and that the PT will complete their respective assessments and discuss the appropriate interventions with the multidisciplinary care team.

Registered Staff #105, #107, and #108 stated that a referral to the physiotherapist is initiated each time a resident has had a fall for the physiotherapist to assess the resident. The PT stated that they did not assess the resident after they fell.

The licensee has failed to ensure that the home's falls prevention policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the licensee is required to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, it is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint submitted to the MOHLTC reported an allegation of improper care related to the falls management of resident #001.

Resident #001's progress notes stated the resident had fallen and was assessed with no injury and did not verbalize any pain. The next two days the resident complained of pain to an identified area of their body and verbalized their pain level higher than their baseline.

The home's policy entitled, "Pain and Symptom Management" directed the registered staff will conduct and document a pain assessment when the resident reports pain or symptoms greater than a specified level and when it is being reported by the resident that pain is present.

Resident #001's Point Click Care (PCC) did not show evidence that a pain assessment was initiated to assess the pain the resident verbalized on the identified dates.

Registered Staff #111 stated that resident #001 did not usually complain of pain but was capable of letting the staff know when they were in pain.

The Clinical Care Coordinator (CCC) stated that when a resident verbalize that they are in pain, it is the home's expectation to complete a pain assessment.

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment with respect to the resident's vision.

An observation and an interview with resident #006 confirmed that they had visual impairment and required eye glasses.

Resident #006's written plan of care did not have a plan of care to address the resident's vision impairment.

The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment with respect to the resident's vision. [s. 26. (3) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During the inspection, the inspector was informed the home has had no RN on duty during a number of shifts during a time period reviewed.

The inspector requested to review the home's Staffing Plan Annual Evaluation.

The DOC and Administrator stated that the home did not complete an annual evaluation of the home's staffing plan.

The licensee has failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as eye glasses, labelled within 48 hours of admission and of acquiring, in the case of new items.

A complaint submitted to the MOHLTC reported allegations of mishandling resident #001's eye glasses.

Resident #001's SDM stated that during a visit they observed that the resident was wearing eye glasses that did not belong to them. They were told by staff that they had mixed up the resident's eye glasses with resident #007's eye glasses.

Registered Staff #117 stated that the SDM brought to their attention that resident #001 that the eyeglasses the resident was wearing were not theirs. They revealed that they searched for resident #001 eye glasses and discovered that a staff member had mistakenly switched resident #001 and resident #007's eye glasses. RPN #117 stated that both residents' eye glasses were not labelled.

2. The inspector along with Staff #113 observed that resident #006's eye glasses were not labelled.

Resident #006 acknowledged that their eye glasses were not labelled.

The Administrator stated the home's practice is to ensure that residents' eye glasses are labelled with their name on them. [s. 37. (1) (a)]

WN #8: 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 failed to ensure that resident #001's substitute decision-maker was promptly notified of a serious injury.

A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported an allegation of improper care related to the falls management of resident #001.

A Critical Incident (CI) reported resident #001 had a number of falls in an identified month. The resident was transferred to the hospital a few days after they fell and was diagnosed with a serious injury.

The SDM stated that they visited resident #001 and observed that the resident was injured. They stated that the home notified them of the resident's falls but did not tell them of the resident's injury.

Registered Staff #106 stated that they noted signs of injury to resident #003 but did not notify the SDM.

The Administrator acknowledged that the staff should have notified resident #001's SDM about the resident's injury. [s. 107. (5)]

Issued on this 18th day of January, 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

Ministère de la Santé et des Soins de longue durée

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

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) :	JANET GROUX (606)
Inspection No. / No de l'inspection :	2018_723606_0024
Log No. / No de registre :	024466-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 16, 2019
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Gateway Haven Long Term Care Home 671 Frank Street, P.O. Box 10, WIARTON, ON, N0H-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tolleen Parkin

To Corporation of the County of Bruce, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8.(3) of the Long Term Care Homes Act (LTCHA).
Specifically, the licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported an allegation of improper care related to the falls management of resident #001 resulting in a serious injury.

During resident #001's falls inspection, the inspector was informed that when the resident fell, the home did not have a registered nurse (RN) on duty.

Review of the home's RN schedule for a specified time period revealed the home did not consistently have an RN for a number of day, evening, and night shifts.

Registered Staff #105 stated that they did not have an RN in the building when resident #001 fell.

The Director of Care (DOC) confirmed that they did not have an RN in the building when resident #003 fell and stated the home had operated the home as mentioned above having an RN absence for part of or the entire shift.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The order was issued based on the following:
Severity of Harm is level 2 Minimal Harm/ Risk or Potential for Harm;
Scope is level 3 Widespread; and
The home's Compliance History was level 3-Ongoing non-compliance with a VPC. (606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 16, 2019

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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:

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

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 16th day of January, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Janet Groux

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