Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport 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 03, 2022	2021_977754_0033 (A1)	015576-21, 016120-21, 016837-21	Critical Incident System

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

Amended by TAWNIE URBANSKI (754) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001 due date changed to February 15, 2022.

Issued on this 3 rd day of February, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 03, 2022	2021_977754_0033 (A1)	015576-21, 016120-21, 016837-21	Critical Incident System

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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

Amended by TAWNIE URBANSKI (754) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): On-site December 17, 20, 21, 23, 2021, January 13, 17, 2022, and off-site December 22, 2021, January 4-7, 10-12, 2022.

The following intakes were completed during this Critical Incident (CI) inspection:

Log #015576-21, and

Log #016837-21, related to falls prevention and management, and

Log #016120-21, related to an allegation of improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeper, and residents.

The inspector also toured the home, observed resident and staff interactions and meal services, reviewed relevant clinical records, the home's related policies and documentation and completed staff and resident interviews.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 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. 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 failed to ensure that anyone who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm to the resident was immediately reported to the Director.

A resident experienced incompetent care, which resulted in an area of altered skin integrity.

The home failed to report the incident until approximately two months later.

The DOC acknowledged that the Critical Incident (CI) was submitted late.

By not reporting the incident immediately to the Director, the Director was unable to respond to the incident in a timely manner.

Sources: CIS #M526-000025-21, progress notes and skin/wound assessments for a resident, and interview with the DOC. [s. 24. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident was left by staff without access to their call bell. The resident was left in a position that resulted in them having an area of altered skin integrity.

The care plan directed staff to ensure that the resident had access to their call bell at all times when they were left unattended.

The DOC said they were unaware that the resident did not have access to their call bell at the time of the incident.

By not ensuring that the resident had access to their call bell at the time of the incident resulted in the resident being unable to call staff for help. As a result, the resident was received an area of altered skin integrity.

Sources: A resident's plan of care, progress notes, CIS #M526-000025-21, investigation notes, emails, skin/wound assessments, and an interview with the DOC. [s. 6. (7)]

2. The licensee failed to ensure that different approaches were considered when a resident's plan of care was ineffective related to falls prevention and management interventions.

A resident #004 had had several falls over a period of approximately six months. The resident was documented to fall in a similar pattern of unwitnessed falls in their room.

The resident experienced a final fall requiring medical attention where they were diagnosed with a severe injury. The resident was made palliative and passed away.

No revisions were made to the resident’s plan of care related to fall prevention interventions over the period of six months when they were having multiple falls.

Registered Practical Nurse (RPN) #111 said that no new fall interventions were tried for the resident after they had previously fallen. They said new fall preventions were implemented after the residents final fall.

Failure to consider different approaches when a resident fell four times over a six month period, may have contributed to recurrent falls.

Sources: Risk management notes, progress notes, assessments, interview with PSW #110, and RPN #111. [s. 6. (11) (b)]

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 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 failed to ensure that when a resident exhibited altered skin integrity, they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The home's policy Skin and Wound Care Management Protocol, directed staff to provide immediate treatment and interventions to reduce pain, promote healing, and prevent infection for any resident exhibiting altered skin integrity, including skin tears.

Staff noted that a resident had an area of altered skin integrity and pain during care. No skin or wound assessment or treatment was completed at this time related to the resident's new area of altered skin integrity.

A weekly skin treatment assessment was first completed three days later, related to the resident's new area of altered skin integrity. A treatment plan was initiated at this time.

During the investigation by the home a delay was noted in treatment interventions.

Not ensuring immediate treatment was provided to a resident increased their risk of pain and infection related to their altered skin integrity.

Sources: CIS #M526-000025-21 and investigation notes related to this CI, progress notes and skin/wound care assessments, and interview with the DOC, and the home's Skin and Wound Care Management Protocol. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure that weekly skin assessments were completed for a resident.

The home's policy Skin and Wound Care Management Protocol, directed staff to initiate electronic weekly skin assessments for any resident exhibiting altered skin integrity, including skin tears.

A resident had a new area of altered skin integrity.

A one-month review period was completed for the resident. One initial skin assessment was documented. No further skin assessments were documented for this area of altered skin integrity during the review period.

The DOC said they would expect weekly skin assessments for the resident with skin and they could not find weekly skin/wound assessments, after the initial assessment for this resident during the one month review period.

Not ensuring that weekly skin/wound assessments were completed increased the risk of the resident's skin condition worsening.

Sources: Progress notes and skin/wound assessments, interview with the DOC, and the home's Skin and Wound Care Management Protocol. [s. 50. (2) (b) (iv)]

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 any residents exhibiting altered skin integrity receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required,, to be implemented voluntarily.

Issued on this 3 rd day of February, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TAWNIE URBANSKI (754) - (A1)
Inspection No. / No de l'inspection :	2021_977754_0033 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015576-21, 016120-21, 016837-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 03, 2022(A1)
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 :	Tracee Givens

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre: 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. 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 all alleged, suspected, or witnessed incidents of improper care, abuse, or neglect of a resident, by anyone, are immediately reported to the Director. Pursuant to s. 152 (2) the licensee is vicariously liable for the staff members failing to comply with subsection 24 (1).

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

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

Grounds / Motifs :

1. The licensee failed to ensure that anyone who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm to the resident was immediately reported to the Director.

A resident experienced incompetent care, which resulted in an area of altered skin integrity.

The home failed to report the incident until approximately two months later.

The DOC acknowledged that the Critical Incident (CI) was submitted late.

By not reporting the incident immediately to the Director, the Director was unable to respond to the incident in a timely manner.

Sources: CIS #M526-000025-21, progress notes and skin/wound assessments for a resident, and interview with the DOC.

An order was made by taking the following factors into account:

Severity: There was potential risk to residents in the home. By not reporting incidents immediately, the Director was not aware and not able to respond to the incidents.

Scope: Pattern- two out of three incidents reviewed were not reported immediately to the Director.

Compliance History: This subsection was issued as a Voluntary Plan of Correction (VPC) on September 9, 2021, during inspection #2021_823653_0022, as a Written Notification (WN) on June 9, 2021, during inspection #2021_796754_0017, as a WN July 19, 2019, during inspection #2019_755728_0012, and as a Compliance Order (CO) on October 10, 2018, during inspection #2018_750539_0006. (754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2022(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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

(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).

Order / Ordre :

The licensee must be compliant with s. 6 (11) of the LTCHA.

Specifically, the licensee must:

a) Ensure that when a resident's fall prevention interventions are ineffective leading to recurrent falls, that different falls prevention approaches are considered in the revision of the plan of 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

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

Grounds / Motifs :

1. The licensee failed to ensure that different approaches were considered when a resident's plan of care was ineffective related to falls prevention and management interventions.

A resident had several falls over a period of approximately six months. The resident was documented to fall in a similar pattern of unwitnessed falls in their room.

The resident experienced a final fall requiring medical attention where they were diagnosed with a severe injury. The resident was made palliative and passed away.

No revisions were made to the resident’s plan of care related to fall prevention interventions over the period of six months when they were having multiple falls.

Registered Practical Nurse (RPN) #111 said that no new fall interventions were tried for the resident after they had previously fallen. They said new fall preventions were implemented after the residents final fall.

Failure to consider different approaches when a resident fell four times over a six month period, may have contributed to recurrent falls.

Sources: Risk management notes, progress notes, assessments, interview with PSW #110, and RPN #111.

An order was made by taking the following factors into account:

Severity: There was actual harm to the resident.

Scope: Isolated- one out of three residents reviewed did not have revisions to their plan of care related to falls interventions when the plan of care was not effective.

Compliance History: This subsection was issued as a Voluntary Plan of Correction (VPC) on January 16, 2019, during inspection #2018_723606_0024. (754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 08, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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(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

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

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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

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

Ordre(s) de l'inspecteur

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

Health 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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 3 rd day of February, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by TAWNIE URBANSKI (754) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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