

**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**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 20, 2023	2021_977754_0032 (A1)	014405-21, 018807- 21, 020060-21	Complaint

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**Licensee/Titulaire de permis**

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

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**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

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

Helene Desabrais (615)

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**Amended Inspection Summary/Résumé de l'inspection modifié**

Reason for Amendment: Compliance order #002 is being removed based on the outcome of the HSARB appeal. The Written Notification will remain.

**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): 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 Complaint inspection:  
Log #018807-21, related to concerns with resident discharge and re-admissions,  
Log #020060-21, related to care concerns and personal support services, and  
Log #014405-21, a follow up intake related to responsive behaviors, with a  
Compliance Due Date (CDD) of November 15, 2021, from inspection  
#2021\_823653\_0022.**

**During the course of the inspection, the inspector(s) spoke with the Administrator,  
Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Care  
Coordinator (CCC), Restorative Care Staff, Warton Hospital Physician, Home and  
Community Care Support Manager, Registered Practical Nurses (RPNs), Behavior  
Support Lead/RPN, Personal Support Workers (PSWs), 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:  
Admission and Discharge  
Pain  
Personal Support Services  
Responsive Behaviours**

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

**5 WN(s)  
2 VPC(s)  
2 CO(s)  
0 DR(s)  
0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #001	2021_823653_0022		754

### NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
<p>WN - Written Notification VPC - Voluntary Plan of Correction DR - Director Referral CO - Compliance Order WAO - Work and Activity Order</p>	<p>WN - Avis écrit VPC - Plan de redressement volontaire DR - Aiguillage au directeur CO - Ordre de conformité WAO - Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: 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 three resident's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for pain.

1) A resident had nerve pain and pain in an identified area. Pain management was part of the interventions for when the resident demonstrated responsive behaviors.

During a one month review period the resident received their as needed (PRN) pain medication. Four of the doses were documented to be ineffective in the electronic medication administration record (eMAR).

RN #108 said a comprehensive pain assessment was not completed for the resident when their pain was not relieved by initial interventions during the one month review period.

2) A resident had pain related to an injury. The resident was given a dose of their PRN pain medication. The dose was documented to be ineffective in the resident's eMAR.

3) A resident had pain related to an injury requiring medical intervention. The resident received three doses of their PRN pain medication throughout one day. All three of those doses were documented to be ineffective. On another date the resident received a PRN dose of pain medication, which was documented to be ineffective.

There were no records that comprehensive pain assessments were completed when the resident's pain was not relieved by their scheduled pain medications or after receiving a

PRN pain medication.

The DOC said that comprehensive pain assessments did not have to be completed every time after an initial pain intervention was found to be ineffective. This was not part of the home's policy.

Failing to complete a comprehensive pain assessment to include a description of pain, location, factors that made the pain worse, current pain medications and non-pharmacological regime when the residents' pain was not relieved by initial interventions resulted in a lack of understanding of the pain and poor management.

Sources: eMAR documentation, progress notes, care plan and assessments for residents, interviews with DOC and RN #108. [s. 52. (2)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee**

**Specifically failed to comply with the following:**

**s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:**

- 1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).**
- 2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).**

**Findings/Faits saillants :**

1. The licensee failed to respond within five business days after receiving the request for readmission to give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act.

A complaint was received by the Ministry of Long Term Care, that alleged a resident was wrongfully discharged from Gateway Haven and had not been re-admitted to the home.

The Administrator said they received the priority re-admission application on a specified date and responded back to the placement coordinator that the home required more information eight business days later.

The response from Gateway Haven was not within five business days.

The DOC said that before a decision could be made for the resident's re-admission application the DOC and Administrator would need more information. The DOC said that they still needed to gain this information and they were not waiting on anything from the Local Health Integration Network (LHIN).

Gateway Haven confirmed that they had not made an appointment to gain the additional required information. This was approximately five weeks after Gateway Haven responded to the re-admission application requiring more information.

Placement Team Manager #116 said that the priority re-admission application for the resident was submitted and that they had completed everything and were just waiting for Gateway Haven staff to gain the additional information they required.

By not ensuring that Gateway Haven responded to the priority re-admission application within five business days or attempt to gather the additional information required for the re-admission application, this delayed the decision for the resident's re-admission to the home, and required them to remain at their alternative residence.

Sources: Emails between Inspector #754 and the Administrator, Complaint log # 018807-21, Interviews with the Administrator, DOC, and Placement Coordinator Manager. [s. 162. (3)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:  
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident received care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

A complaint was received, related to concerns that a resident was having pain and an area of altered skin integrity when they required care to maintain their mobility. They said the resident would refuse certain cares or activities of daily living.

The resident said they had pain when they were transferred. They said every time they had to be transferred it felt horrible.

Observations of staff transferring the resident identified that the resident experienced pain.

PSW #110 said that the resident had pain when being transferred. They said the resident had an area of altered skin integrity related to them maintaining their mobility.

The resident's plan of care documented the resident required a device to help with their mobility. The resident would often refuse care due to the pain they experienced to maintain their mobility. This caused the resident to require additional products to manage their aspects of daily life.



The ADOC said if there was pain or areas of altered skin integrity as a result of maintaining a residents mobility there should be a physiotherapy referral to ensure the correct method of maintaining a residents mobility was used.

Restorative Care Staff (RCS) #113 said they would not do assessments for mobility and that physiotherapy would complete these.

No physiotherapy referrals or assessments were completed related to this resident's mobility status.

By not ensuring the resident received care and assistance towards independence led to them having pain and areas of altered skin integrity, and refusing cares and aspects of daily life.

Sources: Interviews with the resident, the complainant, ADOC, RCS #113, progress notes and assessments for the resident, observations. [s. 3. (1) 12.]

***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 every resident receives care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 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:**

- 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
- 2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
- 3. The program must 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. 30 (1).**
- 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that equipment, supplies, devices, assistive aids, or positioning aids, used for the personal support services program were appropriate for a resident based on their condition.

A resident was observed in their room, when they were transferred from their bed to mobility device.

The resident said their mobility device was uncomfortable and not the right size for them. They said they had pain while in their mobility device.

PSW #110 said that the mobility device did not fit the resident.

Restorative Care had not completed an assessment for the resident related to their mobility device. They had adjusted the device at one time and observed the resident in their mobility device where they appeared to be hunched over and possibly fatigued.

Documentation reported the resident had trouble with aspects of daily life while in their mobility device and that the equipment did not seem appropriate for the resident.

By not ensuring that the resident's mobility device was appropriate for them, the resident experienced discomfort and had difficulties with aspects of daily life.

Sources: Progress notes for the resident, Inspector #754 observations, and interviews with the resident, PSW #110, and RCS #113. [s. 30. (1) 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 where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all residents on a home area were offered a between meal beverage in the morning for one day during January 2022.

A resident expressed concerns that they had not received any beverages since their breakfast meal. The inspector observed the resident's room and did not observe any beverages or empty beverage cups in their room.

Personal Support Worker (PSW) #110 said that normally juice and water is offered to all residents in the morning around 1000-1030 hours. They said that on this particular day, the beverage cart was missed, and not provided to any residents on the unit.

Documentation showed that the resident did not consume any beverages at the morning beverage cart time of 1000-1030 hours.

By not ensuring a between meal beverage was offered to all residents on home area two east resulted in an increased risk of dehydration of the residents.

Sources: Inspector #754 observation, Interview with a resident and PSW #110, tasks documentation for a resident. [s. 71. (3) (b)]

**Issued on this 20<sup>th</sup> day of December, 2023**

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

**Helene Desabrais**

**Original report signed by the inspector.**

**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 Licensee Copy/Copie modifiée du rapport du titulaire de permis**

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**Name of Amending  
Inspector (ID #) / Nom de  
l'inspecteur (No) :**

Helene Desabrais (615)

**Inspection No. /  
No de l'inspection :**

2021\_977754\_0032 (A1)

**Log No. /  
No de registre :**

014405-21, 018807-21, 020060-21 (A1)

**Type of Inspection /  
Genre d'inspection:**

Complaint

**Report Date(s) /  
Date(s) du Rapport :**

Dec 20, 2023

**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, Warton, ON, N0H-2T0

**Name of Administrator /  
Nom de l'administratrice**

**ou de l'administrateur :** Jacob Presseault

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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(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

**Order # /****No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, 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).

**Order / Ordre :**

The licensee must comply with s. 52 (2) of O. Reg. 79/10.

Specifically, the licensee must :

a) Ensure that the residents are assessed using a clinically appropriate assessment instrument specifically designed for pain, when pain is not relieved by initial interventions.

b) Review and ensure that the home's Pain Management Policies direct staff to complete comprehensive pain assessments specifically designed for pain, when a resident's pain is not relieved by initial interventions.

**Grounds / Motifs :**

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

1) A resident had nerve pain and pain in an identified area. Pain management was part of the interventions for when the resident demonstrated responsive behaviors.

During a one month review period the resident received their as needed (PRN) pain medication. Four of the doses were documented to be ineffective in the electronic medication administration record (eMAR).

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
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2007, c. 8

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2007, chap. 8

RN #108 said a comprehensive pain assessment was not completed for the



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resident when their pain was not relieved by initial interventions during the one month review period.

2) A resident had pain related to an injury. The resident was given a dose of their PRN pain medication. The dose was documented to be ineffective in the resident's eMAR.

3) A resident had pain related to an injury requiring medical intervention. The resident received three doses of their PRN pain medication throughout one day. All three of those doses were documented to be ineffective. On another date the resident received a PRN dose of pain medication, which was documented to be ineffective.

There were no records that comprehensive pain assessments were completed when the resident's pain was not relieved by their scheduled pain medications or after receiving a PRN pain medication.

The DOC said that comprehensive pain assessments did not have to be completed every time after an initial pain intervention was found to be ineffective. This was not part of the home's policy.

Failing to complete a comprehensive pain assessment to include a description of pain, location, factors that made the pain worse, current pain medications and non-pharmacological regime when the residents' pain was not relieved by initial interventions resulted in a lack of understanding of the pain and poor management.

Sources: eMAR documentation, progress notes, care plan and assessments for residents, interviews with DOC and RN #108.

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

**Severity:** There was minimal harm or risk of harm to three residents that did not receive pain assessments when they expressed pain that was not relieved by initial interventions

**Scope:** Widespread- three out of three residents reviewed were not assessed

**Order(s) of the Inspector**

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

after their pain was unrelieved by initial interventions.

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 25, 2022

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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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**

**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 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](http://www.hsarb.on.ca).

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2007, chap. 8

**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****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
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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 révision  
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](http://www.hsarb.on.ca).

**Issued on this 20<sup>th</sup> day of December, 2023**

**Signature of Amending Inspector /**

**Signature de l'inspecteur :** Helene Desabrais (615)

**Name of Amending Inspector /**

**Nom de l'inspecteur :** Helene Desabrais (615)

**Service Area Office /**

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