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

London Service Area Office
130 Dufferin Avenue 4th floor
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130, avenue Dufferin 4ème étage
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Public Copy/Copie 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
Jul 23, 2021	2021_747725_0024	006427-21, 008214-21	Critical Incident System

Licensee/Titulaire de permis

DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Franklin Gardens Long Term Care Home
24 Franklin Road Leamington ON N8H 4B7

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

CASSANDRA TAYLOR (725), SAMANTHA PERRY (740)

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): June 21-24, 28-30, July 5-8, 2021.

During the course of this inspection the following intakes were completed;

Log #006427-21 / CIS 2602-000007-21 relating to falls prevention and management
Log #008214-21 / CIS 2602-000008-21 relating to responsive behaviours.

This inspection was conducted concurrently with Follow-up inspection #2021_747725_0023

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, the Director of Care, the Assistant Director of Care, the Infection Control Manager, the Environmental Services Manager, three Registered Nurses, four Registered Practical Nurses, three Personal Support Workers, one Housekeeper and two Screeners.

During the course of this inspection the inspector(s) also conducted observations and record review relevant to the inspection

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 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 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary assessment was completed when resident #002 required additional interventions.

June 2021, resident #002 had complained of increased pain relating to a discomfort. Additional diagnostic instruments were used to determine discomfort. According to the documentation, staff had trialed the same intervention multiple times over a specific course of time, before they were able to relieve the discomfort. During this time frame the resident had expressed increased pain. Review of the documentation indicated that the physician was not called after the first unsuccessful intervention or any other time before the discomfort was relieved.

Not ensuring an interdisciplinary assessment was completed when resident #002 expressed increased pain and staff were unable to successfully intervene placed resident #002 at increased risk of a serious medical event.

Sources: Resident #002 records and staff interview with the Administrator and Director of Care. [s. 26. (3) 18.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 residents #001, #002 and #009's pain was not relieved by initial interventions, the residents were assessed using a clinically

appropriate assessment instrument specifically designed for this purpose.

Resident #001 was identified as having responsive behaviours. During assessments it was documented that the resident would be assessed to rule out pain. On review of the documentation, no pain assessment was noted. Registered Practical Nurse (RPN) #108 reviewed the documentation and confirmed no pain assessments had been completed in 2021 or 2020.

On review of the progress notes it was documented that the resident was experiencing increased behaviours and pain. A medical directive was written to assist with pain management as other interventions were trialed and ineffective. It was documented that the resident was given an As Needed (PRN) analgesic “with poor effect”, no further pain assessment was documented. [s. 52. (2)]

2. Resident #002 was identified as having pain. During record review it was noted that the resident was experiencing an increased level of pain. The documentation indicated that interventions were trialed and unsuccessful and noted to have the next shift try. The resident was administered a PRN analgesic and it was documented as ineffective. No further pain assessment was documented.

On review of the Electronic Medication Administration Record (EMAR) it was noted that on a specific day, the resident was experiencing pain and received a PRN analgesic at specific times and both doses were documented as ineffective. The next day, the resident was noted to have still been experiencing pain and was administered a PRN analgesic at specific times and both doses were noted as ineffective. No further pain assessment was documented. [s. 52. (2)]

3. Resident #009 was identified as having pain. A pain assessment was completed a specific day. A pain scoring scale was attached to the resident's regular scheduled analgesic medication. For a specific month, the resident experienced pain scores of 4/10 or higher, sporadically. The residents pain scale was noted to be increasing over a period of time. No pain assessment was documented.

During an interview with the Director of Care and Administrator it was stated that the expectation would have been that staff complete a pain assessment, trial different methods to relieve pain, evaluate and if ineffective contact the physician for further interventions.

Not reassessing residents' #001, #002 and #009's pain after initial interventions placed them at increased risk to experience uncontrolled and unmanaged pain.

Sources: Resident #001, #002 and #009's records, staff interviews with RPN #108, the Administrator and DOC. [s. 52. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's wounds were cared for as specified in the plan of care.

Resident #002 was identified as having had wounds by Registered Nurse (RN) #103 and RPN #108. On review of the Electronic Treatment Administration Records (E-TARS) treatments were missed for specific dates.

Not completing treatments as ordered placed resident #002 at increased risk for further skin breakdown.

Sources: Resident #002 records, ETARS and staff interviews with RN #103 and RPN #108 [s. 6. (7)]

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 resident #002 and all other residents wounds are cared for as specified in the plan of care., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that weekly wound assessments were completed for resident #002.

Resident #002 was identified by RN #103 and RPN #108 has having had wounds. On review of resident #002's medical records indicated a wound assessment had been completed and treatments initiated. Further review of the assessments indicated that an assessment should have been completed during a specific time frame and were not. An interview with the Administrator and Director of Care indicated that it would be the expectation that wound assessments were completed weekly and documented.

Not completing the required weekly wound assessments placed resident #002 at risk for undetected wound deterioration.

Sources: Resident #002 clinical records, staff interviews with RN #103, RPN #108, Director of Care and Administrator. [s. 50. (2) (b) (iv)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered and assisted to complete hand hygiene prior to dining.

During an observation it was noted that residents were being assisted into the dining room and placed at their assigned dining space without first being offered or assisted to complete hand hygiene. During staff interviews with RN #103 and PSW #104 it was confirmed that the residents were not offered to complete hand hygiene prior to entrance and during their time in the dining room.

Not offering or assisting residents to complete hand hygiene prior to meal times places residents at risk for potential transmission of pathogens.

Sources: Observation of the dining rooms and staff interviews with RN #103 and PSW #104. [s. 229. (4)]

Issued on this 16th day of August, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CASSANDRA TAYLOR (725), SAMANTHA PERRY (740)
Inspection No. / No de l'inspection :	2021_747725_0024
Log No. / No de registre :	006427-21, 008214-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 23, 2021
Licensee / Titulaire de permis :	DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc. 161 Bay Street, Suite 2100, TD Canada Trust Tower, Toronto, ON, M5J-2S1
LTC Home / Foyer de SLD :	Franklin Gardens Long Term Care Home 24 Franklin Road, Leamington, ON, N8H-4B7
	Krystal Raposo

Ontario

Ministry of Long-Term Care

Ministère 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

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

To DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc., 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 :

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

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

Specifically the licensee must;

1. The licensee must ensure that the Director of Care or designate provides retraining to all Registered Nurses and Registered Practical Nurses on the homes policies or Best Practice Guidelines relating to specific interventions.

2. The licensee must ensure that the Director of Care or designate keeps a record of the training that indicates the content of the training, the staff members name that received the training and the date the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary assessment was completed when resident #002 required additional interventions.

June 2021, resident #002 had complained of increased pain relating to a discomfort. Additional diagnostic instruments were used to determine discomfort. According to the documentation, staff had trialed the same intervention multiple times over a specific course of time, before they were able to relieve the discomfort. During this time frame the resident had expressed increased pain. Review of the documentation indicated that the physician was not called after the first unsuccessful intervention or any other time before the discomfort was relieved.

Not ensuring an interdisciplinary assessment was completed when resident #002 expressed increased pain and staff were unable to successfully intervene placed resident #002 at increased risk of a serious medical event.

Sources: Resident #002 records and staff interview with the Administrator and Director of Care.

An order was made taking the following factors into account;

Severity: Resident #002 had experienced pain as documented, initial interventions to relieve their pain and discomfort were unsuccessful and no physician was contacted which placed resident #002 at actual risk for a serious medical event.

Scope: This was an isolated incident to resident #002

Compliance History: In the past 36 months the licensee has had two Compliance Orders, three Voluntary Plans of Correction and five Written Notices to different subsections of the legislation. (725)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2021

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

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 :

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 :

Specifically the licensee must:

A. Ensure when residents #001, #002, #009 and any other residents' pain is not relieved by the initial interventions, the residents are assessed using a clinically appropriate assessment instrument specifically designed for this purpose, immediately.

B. The licensee must ensure that the Director of Care or designate provides retraining to all Registered Nurses (RN) and Registered Practical Nurses (RPN) related to the home's policies on pain management.

C. The licensee must ensure that the Director of Care or designate keeps a record of the training that indicates the content of the training, the staff members name that received the training and the date the training was completed.

D. The licensee must complete weekly audits of three residents with identified pain (if available) to ensure that, if required, a pain assessment is completed. The audits will be completed for three months or until the order is complied.

E. The licensee will keep records of audits completed, any deficiencies noted and any corrective actions taken related to identified deficiencies.

Grounds / Motifs :

1. The licensee has failed to ensure that when residents #001, #002 and #009's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this

purpose.

1. Resident #001 was identified as having responsive behaviours. During assessments it was documented that the resident would be assessed to rule out pain. On review of the documentation, no pain assessment was noted. RPN #108 reviewed the documentation and confirmed no pain assessments had been completed in 2021 or 2020.

On review of the progress notes it was documented that the resident was experiencing increased behaviours and pain. A medical directive was written to assist with pain management as other interventions were trialed and ineffective. It was documented that the resident was given an As Needed (PRN) analgesic "with poor effect", no further pain assessment was documented.

2. Resident #002 was identified as having pain. During record review it was noted that the resident was experiencing an increased level of pain. The documentation indicated that interventions were trialed and unsuccessful and noted to have the next shift try. The resident was administered a PRN analgesic and it was documented as ineffective. No further pain assessment was documented.

On review of the Electronic Medication Administration Record (EMAR) it was noted that on a specific day, the resident was experiencing pain and received a PRN analgesic at specific times and both doses were documented as ineffective. The next day, the resident was noted to have still been experiencing pain and was administered a PRN analgesic at specific times and both doses were noted as ineffective. No further pain assessment was documented.

3. Resident #009 was identified as having pain. A pain assessment was completed a specific day. A pain scoring scale was attached to the resident's regular scheduled analgesic medication. For a specific month, the resident experienced pain scores of 4/10 or higher, sporadically. The residents pain scale was noted to be increasing over a period of time. No pain assessment was documented.

During an interview with the Director of Care and Administrator it was stated that the expectation would have been that staff complete a pain assessment, trial

different methods to relieve pain, evaluate and if ineffective contact the physician for further interventions.

Not reassessing residents' #001, #002 and #009's pain after initial interventions placed them at increased risk to experience uncontrolled and unmanaged pain.

Sources: Resident #001, #002 and #009's records, staff interviews with RPN #108, the Administrator and DOC.

An order was made taking the following factors into account;

Severity: There was potential harm to resident #001, #002 and #009 as a pain assessment was not completed and could have potentially addressed the pain experienced by the resident.

Scope: Three out of three residents were identified in having pain with no pain assessment completed.

Compliance History: In the past 36 months the licensee has had two Compliance Orders, three Voluntary Plans of Correction and five Written Notices to different subsections of the legislation.
(725)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2021

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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 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 23rd day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cassandra Taylor

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