Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 13, 2018	2018_395613_0006	003684-18	Resident Quality Inspection

Licensee/Titulaire de permis

Huntsville Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Muskoka Landing
65 Rogers Cove Drive HUNTSVILLE ON P1H 2L9

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

LISA MOORE (613), JENNIFER BROWN (647), JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 5 - 9, 2018.

The following intakes were completed during this inspection:

One Complaint related to concerns of improper care;

One Complaint related to concerns of neglect;

One Follow up related to CO #001 from Inspection report #2017_491647_0015, s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007, for duty to protect residents from abuse and neglect;

Seven Critical Incidents the home submitted to the Director regarding resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Co-Director of Care, Resident Assessment Instrument Coordinator (RAI Coordinator) / Unit Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs, the home's internal investigation files and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:

Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **4 WN(s)**
- **2 VPC(s)**
- **1 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 # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_491647_0015	647

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	Legendé 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observations, that could potentially trigger such altercations.

Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director in February 2017, outlining resident to resident abuse. The CI report identified that resident #009 had abused resident #020 with a device. Resident #020 was transferred to the hospital where they received treatment.

A review of resident #009's progress notes revealed the following:

-On a specific date in January 2017 – exhibited specific responsive behaviour with resident #020.

-On a specific date in January 2017 – exhibited specific responsive behaviour with resident #020, including a verbal threat to resident #020.

-On a specific date in January 2017 – resident #020 approached the nursing station and complained about resident #009. The RPN then went to their room and found that resident #009 had placed certain objects in the doorway, preventing resident #020 from entering the room. Resident #009 was exhibiting specific responsive behaviours including a verbal threat.

-On a specific date in February 2017, between specific hours – resident #009 exhibited specific responsive behaviours towards resident #020.

-On a specific date in February 2017 at a specific hour – resident #009 was found standing over resident #020 with a device in their hand. Resident #020 was observed to be bleeding and indicated that resident #009 hit them with their device.

The Inspector requested that the home provide a time line from January 2017 – February 2017, outlining any specific interventions, assessments and referrals for resident #009, to show how the home took steps to minimize the risk of altercations and potentially harmful interactions between resident #009 and resident #020. The DOC provided the Inspector a timeline which concluded mainly medication adjustments.

During an interview with the DOC, the Inspector asked what other interventions were in place after resident #009 threatened #020. The DOC indicated that they did not have any further information other than an increase in one of resident #009's medications. [s. 54. (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #542 reviewed a CI report that was submitted to the Director in April 2017, outlining resident to resident abuse. It was documented on the CI report that resident #009 was found inappropriately touching resident #018. Resident #009's device for their door was found not to be working.

An additional CI report was submitted to the Director in November 2017, outlining resident to resident abuse. It was documented that resident #009 was found inappropriately touching resident #019. The CI report also indicated that in October 2017, resident #009 was found with resident #019.

A review of resident #009's current kardex and care plan indicated the following, "device in place, staff to monitor and ensure device on and functioning when in room."

On March 7, 2018, Inspector #542 observed resident #009's room and determined that there was no device in place on their door.

During an interview with PSW #114, they verified that resident #009 did not have a device on their door and they were unsure what had happened to it.

On March 8, 2018, Inspector #542 interviewed the DOC regarding resident #009's responsive behaivours. The Inspector showed the DOC the kardex and care plan which indicated the use of a device. The DOC indicated that they would have to check if the intervention was still applicable. Later that day, the Inspector reviewed the current care plan located on Point Click Care (PCC) and noted that the device intervention had been removed. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provided direct care to the resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

Inspector #542 completed a health care record review for resident #009. The care plan located on PCC contained interventions to manage resident #009's responsive behaviours. The Inspector reviewed resident #009 kardex and identified it did not contain information regarding all of the responsive behaviours exhibited by the resident as described in the care plan located on PCC.

During an interview with PSW #114, they indicated that they have access to the kardex for each resident on the Point of Care (POC) charting, but they did not have access to the care plans for each resident.

During an interview the DOC, they confirmed that the PSW's did not have access to the care plans and that only registered staff had access to them. The DOC indicated that the

PSW's utilize the kardexes for each resident and confirmed that resident #009's kardex did not contain all of the information related to their responsive behaviours. [s. 6. (8)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Inspector #613 reviewed a CI report that was submitted to the Director in October 2017, identifying witnessed resident to resident abuse. The CI report revealed that the incident had occurred in October 2017, when PSW #102 witnessed resident #010 grab resident #015, resulting with an injury.

Inspector #613 reviewed another CI report that was submitted to the Director in October 2017, identifying another witnessed abuse by resident #010 towards resident #005. The CI report revealed that the incident had occurred in October 2017, when a visitor reported to a staff member that resident #010 had abused resident #005. Injury was noted at the time of the occurrence.

A review of resident #010's progress notes from July 2017 to October 2017, revealed that resident #010 had a specific number of altercations with different residents. One incident resulted in an injury to another resident. All other incidents, staff intervened before injury occurred to other residents.

A review of resident #010's care plan at the time of each incident and current care plan did not reveal any changes to the interventions to prevent future altercations. Resident #010's care plan identified that they displayed specific behaviours and outlined what triggered the resident to have these behaviours. There was no other documentation to identify that interventions had been added to resident #010's care plans after the October 2017 altercation incidents.

A further review of resident #010's progress notes identified that the resident had been transferred to an external service provider in November 2017, for behavioural assessment related to their multiple responsive behaviour incidents with co-residents. The external service provider assessments provided recommendations for medication changes, but did not provide behavioural strategies upon resident #010's discharge.

A review of the home's policy titled, "Resident Rights, Care and Services – Plan of Care – Plan of Care" last revised September 16, 2013, identified that the plan of care shall be

reviewed and revised when the resident's care needs change, the care set out in the plan was no longer necessary; or the care set out in the plan had not been effective and different approaches were considered in the revision of the care plan.

During interviews with RPN #103 and RN #104, they stated that registered staff were responsible for updating resident's care plans and verified that interventions had not been added to resident #010's care plan.

During an interview with the Administrator they stated that the staff must not have updated resident #010's care plans with measures after each incident. [s. 6. (10) (c)]

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 the care set out in the plan of care is provided to resident #009 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #613 reviewed a CI report that was submitted to the Director in October 2017, identifying witnessed resident to resident abuse. The CI report revealed that the incident had occurred in October 2017, when PSW #102 witnessed resident #010 grab resident #015, resulting with an injury.

A review of the investigation file revealed that PSW #102 had reported the witnessed abuse to RPN #103 and RN #120, at the time the incident had occurred.

A review of the home's policy titled, Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect – Zero Tolerance Policy for Resident Abuse and Neglect" last revised June 2, 2017, identified that the most Senior Administrative Personnel (or Charge Nurse if no manager in the home) who received a report of resident abuse or neglect would promptly notify the Administrator and /or Director of Care of the alleged, suspected or witnessed incident of abuse or neglect if they were not the most senior administrative staff member in the home at the time of the incident.

During an interview with PSW #102, they verified that they had witnessed the physical by resident #010 towards resident #015 and had immediately reported the abuse to RPN #103 and RN #120.

During an interview with RPN #103, they reported to the Inspector that the Charge Nurse was responsible for notifying the Administrator or Director of Care of any suspected, alleged or witnessed abuse. RPN #103 stated that RN #120 was an agency nurse and not a regular employee of the home and was unsure if RN #120 had notified the Administrator or Director of Care of the incident immediately.

During an interview with the Administrator, they stated that RN #120 did not report the witnessed abuse to the Director of Care or Administrator until a later date in October 2017. The Administrator confirmed that RN #120 had not followed the home's abuse policy for reporting abuse immediately to the Administrator and/or Director of Care.

2. Inspector #613 reviewed a CI report that was submitted to the Director in October 2017, identifying witnessed resident to resident abuse. The CI report revealed that the incident had occurred in October 2017, when PSW #102 witnessed resident #010 grab resident #015, resulting with an injury.

A review of the home's policy titled, "Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect – Zero Tolerance Policy for Resident Abuse and Neglect" last revised June 2, 2017, identified that the Administrator or Director of Care would ensure the incident, resident assessment, resident condition all conversations including but not limited to the resident, the resident's substitute decision-

maker, attending or on-call physician, police, Administrator, Director of Care were documented on the residents medical records. As well, the Administrator or Director of Care would report the results of the investigation to the resident or the resident's substitute decision-maker upon completion of the investigation, complete thorough documentation in the resident's medical record and complete accurate documentation of all discussions surrounding the incident and further investigation.

A review of the amended CI report and progress notes on PCC did not reveal documentation that the resident's substitute decision-maker (SDM) had been informed of the investigation completion nor the outcome.

During an interview with the Administrator, they stated that the SDM was informed of the outcome of the investigation and confirmed there was no documentation on the amended CI report or the progress notes on PCC to indicate the results of the investigation had been shared with resident #015's SDM, as per the home's policy.

3. Inspector #613 reviewed a CI report that was submitted to the Director in October 2017, identifying witnessed resident to resident abuse. The CI report revealed that the incident had occurred in October 2017, when a visitor reported to a staff member that resident #010 had abused resident #005. Injury was noted at the time of the occurrence.

A review of the amended CI report and progress notes on PCC did not reveal documentation that the resident's SDM had been informed of the investigation completion nor outcome.

During an interview with the Administrator, they stated that the SDM was informed of the outcome of the investigation and confirmed there was no documentation on the amended CI report or the progress notes on PCC to indicate the results of the investigation had been shared with resident #005's SDM, as per the home's policy. [s. 20. (1)]

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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A tour of the home had been conducted on March 5, 2018, where it had been identified at that time, that a tub room on a specific home area was able to be opened without entering the code. It had been observed that residents had been wandering in the vicinity.

An interview with Unit Coordinator #117 indicated that the lock to the door did not function and needed to be fixed.

A review of audits completed on March 7th and March 8th, 2018, indicated that the tub room door lock had not been fixed to ensure the room was not accessible to residents when unsupervised by staff.

A further interview with Unit Coordinator #117 indicated that they did not enter it in the maintenance book to be repaired and the tub room lock continued to not function leaving the room accessible to residents for the remainder of the week. [s. 15. (2) (c)]

Issued on this 17th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), JENNIFER BROWN (647), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2018_395613_0006
Log No. / No de registre :	003684-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 13, 2018
Licensee / Titulaire de permis :	Huntsville Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Muskoka Landing 65 Rogers Cove Drive, HUNTSVILLE, ON, P1H-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carrie Acton

To Huntsville Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s.54 of O.Reg 79/10.

Specifically, the licensee must ensure that for:

1. Resident #009 and any other residents demonstrating responsive behaviours, an interdisciplinary assessment is completed after each altercation between residents to determine potential triggers.

2. Resident #009 and any other residents demonstrating responsive behaviours, interventions are immediately implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observations, that could potentially trigger such altercations.

Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director in February 2017, outlining resident to resident abuse. The CI report identified that resident #009 had abused resident #020 with a device. Resident

#020 was transferred to the hospital where they received treatment.

A review of resident #009's progress notes revealed the following:

-On a specific date in January 2017 – exhibited specific responsive behaviour with resident #020.

-On a specific date in January 2017 – exhibited specific responsive behaviour with resident #020, including a verbal threat to resident #020.

-On a specific date in January 2017 – resident #020 approached the nursing station and complained about resident #009. The RPN then went to their room and found that resident #009 had placed certain objects in the doorway, preventing resident #020 from entering the room. Resident #009 was exhibiting specific responsive behaviours including a verbal threat .

-On a specific date in February 2017, between specific hours – resident #009 exhibited specific responsive behaviours towards resident #020.

-On a specific date in February 2017 at a specific hour – resident #009 was found standing over resident #020 with a device in their hand. Resident #020 was observed to be bleeding and indicated that resident #009 hit them with their device.

The Inspector requested that the home provide a time line from January 2017 – February 2017, outlining any specific interventions, assessments and referrals for resident #009, to show how the home took steps to minimize the risk of altercations and potentially harmful interactions between resident #009 and resident #020. The DOC provided the Inspector a timeline which concluded mainly medication adjustments.

During an interview with the DOC, the Inspector asked what other interventions were in place after resident #009 threatened #020. The DOC indicated that they did not have any further information other than an increase in one of resident #009's medications.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident #020. The scope of the issue was a level 2 as there was a pattern of behaviours between resident #009 towards resident #020. The home

had no previous non-compliance history with this provision in the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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