Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central East Service Area Office
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Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
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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
Aug 17, 2021	2021_595110_0010	005336-21, 010517-21	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

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

Rockcliffe Care Community
3015 Lawrence Avenue East Scarborough ON M1P 2V7

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

DIANE BROWN (110)

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): July 16, 22, 23, 26, 30, 2021. August 3 & 4, 2021.

The following intakes were inspected during this Critical Incident (CI) inspection:
Log #010517-21 related to a fall resulting in transfer to hospital.
Log #005336-21 related to an allegation of staff to resident abuse
A Cooling and Air Temperature Inspection and Infection Prevention and Control audit was also completed.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Team Member Coordinator, Assistant Director of Care, Director of Food Service, Director of Resident Programs, Environmental Services Manager, Physiotherapist, Registered Practical Nurses (RPN), Registered Nurses (RN), Program Assistant, Personal Support Workers (PSW) and residents.

During the course of the Inspection the inspector toured resident home areas, conducted resident and staff observations, reviewed clinical health records, menus, surveillance camera footage and relevant home policies and audits.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O.Reg. 70/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The homes' 'Falls Prevention and Management' policy directed registered staff to conduct a thorough investigation of the fall incident including all contributing factors. An interview with the ADOC and the lead of the falls prevention program revealed that a thorough investigation meant looking at what went on and was happening at the time of the resident's fall.

Resident #001 fell and was later transferred to the hospital. Interviews with PSWs described the resident as only speaking a language other than English, frequently using the washroom and not using their call bell for assistance when walking or toileting. The resident's plan of care identified the resident using an mobility aid when walking and that they may require supervision. The placement of the resident's mobility aid was not specified in the written plan of care.

Interviews with PSWs, present at the time of the resident's fall, identified where the resident fell. When asked they revealed the location of the resident's mobility aid which was not within reaching distance of the resident. PSW staff revealed that this was the usual location of the resident's mobility aid at night. A review of the post fall documentation failed to include a thorough investigation of the resident's fall and did not include placement of the resident's mobility aide; their frequent unsupervised nightly

washroom visits and the lack of call bell use as possible contributing factors to the resident's fall. RPN #106 documented a follow-up intervention to advise the resident to call for assistance when they wanted to go to the toilet and frequent monitoring. An interview with RPN #106 shared they were unaware of the placement of the residents mobility aid and had not considered the resident's frequent unsupervised trips to the washroom and lack of call bell assistance as contributing factors until discussed with the Inspector. An interview with ADOC #108 confirmed that a thorough investigation had not been completed at the time of resident #001's fall.

An interview with RPN #106 shared that given the resident's frequent unsupervised trips to the washroom a bed alarm would have been warranted after the resident fall and that a thorough investigation into the fall was missing. The resident had another fall four weeks later when they were found on the floor in their room and no investigation into the placement of the resident's mobility aid was documented.

Sources: the home’s Fall Prevention and Management policy #VII-G-30.10, risk management reports, post fall incident form, post fall huddle form, plan of care, MDS assessment, progress notes and interviews with PSWs #100, #101, #104, #105, RN #106, PT #103. [s. 8. (1)]

2. Resident #003 fell and was later transferred to the hospital and diagnosed with a significant change in status. A record review identified the resident as having three prior falls in leading up to the reported fall with injury.

A review of the post fall documentation of the residents reported fall failed to include a thorough investigation of the resident's fall, only that the resident reported they were bending on their mobility aid when they fell. An interview with the responding RPN identified that an investigation into why the resident bent on their aid was not considered and that the resident's medications and hydration status could have been reviewed.

Sources: risk management report, post fall incident form, post fall huddle form, plan of care, MDS assessment, progress notes and interviews with RPN #109 and PSW #110. [s. 8. (1)]

3. Resident #004 fell in their room when attempting to self- transfer. They did not sustain an injury.

A review of the resident’s fall history revealed multiple falls leading up to the fall being

inspected.

Interviews with full time PSW and RPN shared that the resident falls were related to self transfers, in their room to bed or toilet, as the resident does not remember to call for assistance. Staff interviews also revealed the high number of agency staff working on this resident's unit.

A review of the Physiotherapist's (PT) post fall assessment months prior identified a plan to place the resident on a toileting schedule as the resident, when alone in their room, tried to self transfer to bed or to the washroom; to place the resident at the nursing station for close monitoring and provide shoes with close toes and heels and not their identified footwear. The PT continued to make recommendations of a toileting schedule and increase supervision after three prior falls leading up to the fall being inspected.

A review of the resident's plan of care failed to identify a toileting schedule, proper footwear as described by the PT or the need for increased supervision and monitoring, especially for communication with agency staff.

The inspector observed resident #004 during the inspection wearing the footwear the PT had requested not be worn.

A review of the post fall documentation failed to include a thorough investigation of the resident's fall and did not identify the lack of the PT's recommended toileting schedule, proper footwear and care plan intervention for increased monitoring. An interview with ADOC #108 confirmed that a thorough investigation had not been completed.

Sources: Interviews with PSW #116, RPN #117, #118, PT, ADOC #108. Observations of resident for hip protectors, bed/chair alarm, and footwear with PT. Record review of risk management report, post fall incident form, post fall huddle form, plan of care, progress notes and the home's Fall Prevention and Management policy #VII-G-30.10. [s. 8. (1)]

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).

Findings/Faits saillants :

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

A Critical Incident (CI) was forwarded to the Ministry of Long-Term Care reporting staff to resident #001 abuse. The CI stated that surveillance camera footage identified concerns at a mealtime when PSW #114 was providing assistance to resident #001.

Resident's plan of care revealed the resident's mealtime preference and level of assistance.

A review of video footage identified the resident #001's mealtime preference and level of assistance were not provided.

The licensee failed to provide the resident with their mealtime preferences and needs as directed by the plan of care.

Sources: Video footage, resident #001's plan of care and menu. PSW interviews #111, #114. [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 the care set out in the plan of care provided to the resident 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and Regulations, O.Reg. 79/10, s. 5 "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviors or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident (CI) was forwarded to the Ministry of Long-Term Care reporting staff to resident #001 abuse. The CI stated that surveillance camera footage identified concerns at a mealtime when PSW #114 was providing assistance to resident #001.

A review of video footage identified resident #001's being assisted by PSW #114. The footage identified evidence of emotional abuse.

Staff interviews identified the resident's preference at mealtimes and their communication style with staff.

The licensee failed to ensure that resident #001 was acknowledged at lunch on the identified date.

Sources: PSW and RPN interviews, video footage, resident #001’s plan of care. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

A Critical Incident (CI) was forwarded to the Ministry of Long-Term Care reporting staff to resident #001 abuse. The CI stated that surveillance camera footage identified concerns at a mealtime when PSW #114 was providing assistance to resident #001.

A review of the video footage and staff interviews revealed the resident was not offered milk, water tea or coffee and dessert at the lunch mealservice as planned.

Sources: video surveillance, lunch menu, resident #001's plan of care including their dietary profile. Staff interviews including the Director of Food Services and PSWs. [s. 71. (4)]

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 planned menu items offered and available at each meal and snack, to be implemented voluntarily.

Issued on this 22nd day of November, 2021

[redacted]

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) :	DIANE BROWN (110)
Inspection No. / No de l’inspection :	2021_595110_0010
Log No. / No de registre :	005336-21, 010517-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 17, 2021
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Rockcliffe Care Community 3015 Lawrence Avenue East, Scarborough, ON, M1P-2V7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Denise Bulmer

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Vigour Limited Partnership on behalf of Vigour General Partner 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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 8. (1)(b).

Specifically, the licensee must:
1. Ensure that the home implements their Fall Prevention and Management policy with the aim of reducing the incidence of falls and the risk of injury.
2. Ensure that physiotherapist recommendations for as resident's fall prevention have been reviewed by registered staff and implemented as required.
3. In the internal reporting of fall incidents, the registered staff along with the home's falls lead shall investigate and document the suspected cause of the resident's fall; determine if all interdisciplinary fall interventions were being followed prior to the fall; evaluate their ongoing effectiveness and consider new approaches to minimize the resident's risk of further falls. Upon receipt of this order, the falls lead shall participate for a period of 3 months in the falls investigation with the aim of training and mentoring registered staff.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O.Reg. 70/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The homes' 'Falls Prevention and Management' policy directed registered staff to conduct a thorough investigation of the fall incident including all contributing factors. An interview with the ADOC and the lead of the falls prevention program revealed that a thorough investigation meant looking at what went on and was happening at the time of the resident's fall.

Resident #001 fell and was later transferred to the hospital. Interviews with PSWs described the resident as only speaking a language other than English, frequently using the washroom and not using their call bell for assistance when walking or toileting. The resident's plan of care identified the resident using an mobility aid when walking and that they may require supervision. The placement of the resident's mobility aid was not specified in the written plan of care.

Interviews with PSWs, present at the time of the resident's fall, identified where the resident fell. When asked they revealed the location of the resident's mobility aid which was not within reaching distance of the resident. PSW staff revealed that this was the usual location of the resident's mobility aid at night. A review of the post fall documentation failed to include a thorough investigation of the resident's fall and did not include placement of the resident's mobility aide; their frequent unsupervised nightly washroom visits and the lack of call bell use as possible contributing factors to the resident's fall. RPN #106 documented a follow-up intervention to advise the resident to call for assistance when they wanted to go to the toilet and frequent monitoring. An interview with RPN #106 shared they were unaware of the placement of the residents mobility aid and had not considered the resident's frequent unsupervised trips to the washroom and lack of call bell assistance as contributing factors until discussed with the Inspector. An interview with ADOC #108 confirmed that a thorough investigation had not been completed at the time of resident #001's fall.

An interview with RPN #106 shared that given the resident's frequent unsupervised trips to the washroom a bed alarm would have been warranted after the resident fall and that a thorough investigation into the fall was missing. The resident had another fall four weeks later when they were found on the floor in their room and no investigation into the placement of the resident's mobility aid was documented.

Sources: the home's Fall Prevention and Management policy #VII-G-30.10, risk

management reports, post fall incident form, post fall huddle form, plan of care, MDS assessment, progress notes and interviews with PSWs #100, #101, #104, #105, RN #106, PT #103. [s. 8. (1)]

(110)

2. Resident #003 fell and was later transferred to the hospital and diagnosed with a significant change in status. A record review identified the resident as having three prior falls in leading up to the reported fall with injury.

A review of the post fall documentation of the residents reported fall failed to include a thorough investigation of the resident's fall, only that the resident reported they were bending on their mobility aid when they fell. An interview with the responding RPN identified that an investigation into why the resident bent on their aid was not considered and that the resident's medications and hydration status could have been reviewed.

Sources: risk management report, post fall incident form, post fall huddle form, plan of care, MDS assessment, progress notes and interviews with RPN #109 and PSW #110. [s. 8. (1)]

(110)

3. Resident #004 fell in their room when attempting to self- transfer. They did not sustain an injury.

A review of the resident's fall history revealed multiple falls leading up to the fall being inspected.

Interviews with full time PSW and RPN shared that the resident falls were related to self transfers, in their room to bed or toilet, as the resident does not remember to call for assistance. Staff interviews also revealed the high number of agency staff working on this resident's unit.

A review of the Physiotherapist's (PT) post fall assessment months prior identified a plan to place the resident on a toileting schedule as the resident,

when alone in their room, tried to self transfer to bed or to the washroom; to place the resident at the nursing station for close monitoring and provide shoes with close toes and heels and not their identified footwear. The PT continued to make recommendations of a toileting schedule and increase supervision after three prior falls leading up to the fall being inspected.

A review of the resident's plan of care failed to identify a toileting schedule, proper footwear as described by the PT or the need for increased supervision and monitoring, especially for communication with agency staff.

The inspector observed resident #004 during the inspection wearing the footwear the PT had requested not be worn.

A review of the post fall documentation failed to include a thorough investigation of the resident's fall and did not identify the lack of the PT's recommended toileting schedule, proper footwear and care plan intervention for increased monitoring. An interview with ADOC #108 confirmed that a thorough investigation had not been completed.

Sources: Interviews with PSW #116, RPN #117, #118, PT, ADOC #108. Observations of resident for hip protectors, bed/chair alarm, and footwear with PT. Record review of risk management report, post fall incident form, post fall huddle form, plan of care, progress notes and the home's Fall Prevention and Management policy #VII-G-30.10. [s. 8. (1)]

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

Severity: There was actual risk of harm to residents #001, #003 and #004 when a thorough investigation was not undertaken to identify residents #001's failure to call for assistance with frequent bathroom visits or the location of the resident's walker to prevent further falls or the lack of a toileting schedule, enhanced supervision and proper footwear as possible contributing factors to resident #004's multiple falls and the circumstances around why resident #003 was bending on their walker.

Scope: The scope of this non-compliance was widespread as three out of three

residents reviewed did not have a thorough investigation of their fall incident.

Compliance History: The home has had previous non compliance to the same subsection.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 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
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:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

Issued on this 17th day of August, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Diane Brown

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