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
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
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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
Apr 7, 2021	2021_643111_0005	017498-20, 019784-20, 021062-20, 002228-21	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 Lindsay ON K9V 5R8

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

Victoria Manor Home for the Aged
220 Angeline Street South Lindsay ON K9V 4R2

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

LYNDA BROWN (111)

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): March 4-5, 10-11, 2021

There were four critical incident reports(CIR) inspected concurrently during this inspection related to falls with injury for which the resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers (HSK) and residents.

During the course of the inspection, the inspector: toured the home, reviewed resident health records, falls prevention committee meeting minutes, observed falls prevention equipment, observed a meal service, and reviewed the following policies: falls prevention management, Infection prevention and control (IPAC) and restraints/Personal Assistive Safety Devices (PASDs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Resident Charges
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home is a safe and secure environment for its residents, related to the use of restraints.

Resident #003 sustained a fall with an injury and was transferred to hospital. The resident died in hospital a number of days later. From admission, to the time of their death, a number of months later, the resident had sustained a number of falls. The resident was using a restraining alarm device and had a number of near-miss incidents involving the device. After the first near-miss incident, the Physiotherapist (PT) contacted the supplier to have the device adjusted. After a number of incidents involving the device, the PT determined the restraining alarming device was a high-risk for injury to the resident and recommended the alarming device was replaced with a different alarming device. There was no indication the supplier was contacted at that time to have the restraining alarm device removed and a number of weeks later, the device was found in use again and the PT attached a note for staff not to use.

The PT indicated the alarming device for resident #003 had not been assessed for use as a restraint, despite the resident not being able to remove the device. The PT confirmed the device had not been applied correctly, they had no manufacturer's instruction for use and resulted in a number of high-risk, near miss incidents. Observation of resident #004 indicated the resident was using the same alarming device, the resident was not able to remove and had been applied incorrectly. The alarming device was not activated. Both nursing and physiotherapy staff were aware that the alarming device had not been applied correctly to both resident #003 and resident #004 and no immediate actions were taken to address the risk for injury. Resident #003 had a number of near-miss incidents involving the restraining device and the device remained on their mobility aid even after the decision was made to discontinue the device to address the risk for injury. Failing to ensure that restraining alarming devices are applied correctly or immediately discontinued when they are unable to be properly adjusted, and when there were incidents of high-risk for injury, results in an unsafe environment for the residents.

Sources: observation of resident #004, review of progress notes, restraint/PASD assessments, care plan for resident #003 and #004, manufacturer’s instructions for alarming device and interview of staff.

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. 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 :

The licensee has failed to ensure that the falls prevention and management policy was complied with for resident #001.

Resident #001 had sustained a fall and was assessed by an RPN. The resident complained of pain to a specified area (evidence of an injury) and was transferred back to bed with staff assistance. The resident continued to complain of pain to the same area, their condition had deteriorated and the RN notified the physician and Substitute Decision Maker (SDM), a number of hours later, when the resident was sent to hospital for assessment. The SDM expressed frustration that they were not informed of the fall until a number of hours later. The falls prevention policy indicated after a resident sustained a fall, the nurse was to ensure the resident was not moved if suspicion or evidence of injury, the physician contacted, arrange for immediate transfer to the hospital and the SDM notified. Failure to immediately notify the physician, SDM and transfer to hospital after the resident has a serious injury, could lead to further complications and prolonged pain.

Sources: CIR # M589-000025-20, progress notes and x-ray reports for resident #001, Falls Prevention and Management policy (revised February 2020) and interview with staff.

2. The licensee has failed to ensure that the falls prevention and management policy was complied with for resident #003.

Resident #004 had sustained a fall and was assessed by two RPNs.The resident complained of pain to a specified area and was assisted back to bed. A number of hours later, the resident continued to complain of pain with movement and was offered pain medication. The resident sustained a second fall a number of hours later, had visible injuries noted to specified areas and returned to bed with staff assistance. A number of hours later, the resident continued to complain of pain to the same area, had reduced range of motion (ROM), was transferred to hospital and died a number of days later. The falls prevention policy indicated after a resident sustained a fall, the nurse was to assess the resident for injury, limited range of motion, ensure the resident was not moved if suspicion or evidence of injury, the physician contacted and arrange for immediate transfer to the hospital. Failure to immediately notify the physician and transfer the resident to hospital after two falls with pain and suspected injury, lead to prolonged pain and possible further complications.

Sources: CIR, progress notes for resident #003, Falls Prevention and Management policy (revised February 2020) and interview with staff.

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 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, to be implemented voluntarily.

WN #3: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to safety risks for resident #003 and #004.

Resident #003 had sustained a number of falls during a number of months, that they resided in the home. The last fall resulted in an injury for which the resident was transferred to hospital, diagnosed with a specified injury and died a number of days later. In addition, the assessments completed for resident #003 indicated the alarming device was assessed as a PASD, despite the resident being unable to remove the device. The resident had a number of near-miss, high-risk for injury incidents before the device was reassessed and replaced with a different alarming device. The resident was not offered additional fall protective equipment until after a number of falls and the recommended fall protective safety equipment had not been put in place until a number of weeks later. Resident #004 was also identified as using the same alarming device, but was assessed as a restraining device. An RPN confirmed awareness that resident #003 and #004 both used the same alarming device, but was unable to indicate why one resident's device was considered a PASD and the other was considered a restraint despite both resident's being unable to remove the device. Resident #004’s alarming device was also applied incorrectly. Nursing and physiotherapy staff failed to address or identify the safety risks in the plan of care related to the use of the restraining alarming device for both resident #003 and #004, and despite resident #003 having a number of near-miss incidents involving the use of the alarming device, before any actions were taken, placing them at risk for injury. Failing to ensure the plan of care is based on an interdisciplinary assessment that includes addressing the safety risks, placed resident #003 and #004 at risk for injury.

Sources: CIR, progress notes, restraint/PASD assessments and care plan of resident #003 and #004, observation of resident #004 and interviews with staff.

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 the plan of care is based on an interdisciplinary assessment with respect to the resident safety risks, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program in the home related to use of AGMPs.

Observations by the Inspector on March 10 and 11, 2021 at various times, noted resident #005's room had an Aerosol Generating Medical Procedure (AGMP). There was no signage to indicate am AGMP was used, the risk of AGMPs and no personal protective equipment (PPE) available for staff use when entering the room. A PSW confirmed resident #005's AGMP was applied and removed at specified times by the PSWs and was unaware of IPAC procedures surrounding the use of the AGMP. The ADOC (IPAC lead) was aware of IPAC requirements with the use of AGMPs when the home was in outbreak, but was unaware of the IPAC procedures that were to be implemented on any resident with an AGMP, regardless of the outbreak status and based on the point of care risk assessment (PCRA). Failing to implement IPAC procedures around the use of an AGMP, poses a risk of infection to other residents and staff.

Resources: observations of resident #005, PRHC AGMP COVID-19 FAQs, COVID-19 Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (dated March 30, 2020) and interview with staff.

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 all staff participate in the implementation of the infection prevention and control (IPAC) program in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee has failed to ensure that residents were not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network, related to safety devices.

During review of the progress notes for resident #003 for a critical incident related to falls, the Inspector noted that on a specified date, the Physiotherapist (PT) had contacted the Power of Attorney (POA), regarding the use of fall protective safety equipment and would have to be purchased by the family. The PT confirmed they were directed by the ADOC to have the families purchase the safety devices. The PT confirmed that resident #003's POA had purchased the safety equipment and they were aware of other current and deceased residents in the past yea who had also purchased the same equipment. The ADOC was unaware the home was to provide the safety equipment and the safety equipment had recently been purchased by the home for resident use. The Administrator indicated there were a number of residents identified as being charged for goods (safety equipment) and later verified that all of those residents, including resident #003, had been reimbursed for those charges as a result of the inspection.

Resources: progress notes of resident #003, billing invoices and interview of staff.

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 residents are not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network., to be implemented voluntarily.

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

Issued on this 12th day of April, 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) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2021_643111_0005
Log No. / No de registre :	017498-20, 019784-20, 021062-20, 002228-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 7, 2021
Licensee / Titulaire de permis :	The Corporation of the City of Kawartha Lakes 26 Francis Streeet, P.O. Box 9000, Lindsay, ON, K9V-5R8
LTC Home / Foyer de SLD :	Victoria Manor Home for the Aged 220 Angeline Street South, Lindsay, ON, K9V-4R2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Kulas

To The Corporation of the City of Kawartha Lakes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.5 and ensure that the home is a safe and secure environment for its residents.

Specifically, the licensee shall:
1. Reassess all residents in the home currently using seat belts or alarming seat belt devices to ensure the device is applied correctly.
2. Complete the restraint/PASD assessment tool for each of those same residents, to ensure they are correctly assessed for use as either a PASDs or restraint.
3. Ensure all safety devices, including seat belts and alarming seat belts have manufacturers instructions available for staff review.
4. Educate all nursing and physiotherapy staff on the correct use of all seat belt devices (including alarming devices) and keep a documented record, to ensure all staff are aware of the correct use of the devices and proper application.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents related to the use of restraints.

The licensee has failed to ensure that the home is a safe and secure environment for its residents, related to the use of restraints.

Resident #003 sustained a fall with an injury and was transferred to hospital. The resident died in hospital a number of days later. From admission, to the time of their death, a number of months later, the resident had sustained a number of falls. The resident was using a restraining alarm device and had a number of near-miss incidents involving the device. After the first near-miss incident, the

Physiotherapist (PT) contacted the supplier to have the device adjusted. After a number of incidents involving the device, the PT determined the restraining alarming device was a high-risk for injury to the resident and recommended the alarming device was replaced with a different alarming device. There was no indication the supplier was contacted at that time to have the restraining alarm device removed and a number of weeks later, the device was found in use again and the PT attached a note for staff not to use.

The PT indicated the alarming device for resident #003 had not been assessed for use as a restraint, despite the resident not being able to remove the device. The PT confirmed the device had not been applied correctly, they had no manufacturer's instruction for use and resulted in a number of high-risk, near miss incidents. Observation of resident #004 indicated the resident was using the same alarming device, the resident was not able to remove and had been applied incorrectly. The alarming device was not activated. Both nursing and physiotherapy staff were aware that the alarming device had not been applied correctly to both resident #003 and resident #004 and no immediate actions were taken to address the risk for injury. Resident #003 had a number of near-miss incidents involving the restraining device and the device remained on their mobility aid even after the decision was made to discontinue the device to address the risk for injury. Failing to ensure that restraining alarming devices are applied correctly or immediately discontinued when they are unable to be properly adjusted, and when there were incidents of high-risk for injury, results in an unsafe environment for the residents.

Sources: observation of resident #004, review of progress notes, restraint/PASD assessments, care plan for resident #003 and #004, manufacturer's instructions for alarm device and interview of staff.

An order was made by taking the following factors into account:
Severity: There was actual risk to the residents, as resident #003 had a number of near-miss incidents involving the improper use of the alarming device and resident #004 also had the same device improperly applied and no actions were taken.
Scope: This non-compliance was a pattern as two residents were determined to have the same device improperly applied.
Compliance History: The home has had previous non-compliance to different

subsections in the past 36 months.
(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 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
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 7th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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