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
Nov 7, 2017	2017_683126_0016	007634-17, 007715-17, 023061-17, 023568-17	Complaint

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

ÉLISABETH-BRUYÈRE RESIDENCE
75 BRUYERE STREET OTTAWA ON K1N 5C8

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 16, 17, 18 and 19, 2017

During this inspection the following three Critical Incidents logs were inspected: Log #007715, #023568-17 and #023061-17.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Administrator, the Acting Director of Care (DOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Care Aids (PCA), two residents and a family member.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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	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 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 has failed to ensure that resident #002 was protected from emotional abuse from Personal Care Aid (PCA) #107.

As per O. Reg 79/10, s. 2. (1) (a) defines emotional abuse as:
"any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident"

Log # 023061-17:
A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term-Care (MOHLTC) Director on a specified date in 2017 related to an allegation of staff to resident emotional abuse.

Resident #002 was admitted to the home with several diagnosis which include dementia. Resident #002 was known to have responsive behaviors.

On a specified date in 2017, after supper, while PCA #107 was cleaning the table, resident #002 threw a glass of liquid at PCA #107. PCA #107 responded by saying to her/his colleagues in the dining room, "have you seen what resident #002 has done to me" and threw a cup of liquid at resident #002's face.

On a specified date in 2017, after the incident, PCA #108 reported what he/she had witnessed in the dining room to Registered Nurse (RN) #105 and Registered Practical Nurse (RPN) #104.

On October 17, 2017, RPN #104 indicated to Inspector #126 that PCA #108 reported the incident he/she had witnessed in the dining room that evening in 2017. At that time, RPN #104 indicated that he/she was not sure what to do and what needed to be done. RPN #104 indicated that RN #105 contacted the Director of Care (DOC) and left a message with the Executive Director(ED).

On October 17, 2017, RN #105 indicated to Inspector #126 that in response to the reporting of the incident in 2017, resident #002 was assessed and did not sustain any injury. RN #105 indicated that he/she sent an email to the DOC and left a voice mail to the ED.

On October 19, 2017, the Acting DOC indicated to Inspector #126 that she was informed by the ED the following day of the incident in 2017. RN #105 had left a voice mail to the ED, the previous evening to call him/her back and had not left any details. The Acting DOC indicated that she reviewed the daily report and there was no documentation

regarding any incident for the previous day. The next day , the Acting DOC interviewed RN #105 who informed her of the incident of PCA #107 throwing a cup of liquid at resident #002's face. At that time, the Acting DOC immediately removed PCA #107 from the unit and reported the incident to the MOHLTC's Director.

Resident #002 was not protected from emotional abuse from PCA #107 as both registered nursing staff working that specific evening in 2017 did not know how to respond to the incident of emotional abuse.

The licensee also failed to comply with the following section related to the prevention of abuse:

As per LTCHA, 2007, s.24.(1), for not immediately reporting to the Director (Refer to WN #02)

As per O. Reg 79/10, r.97.(1), for not immediately reporting to the Substitute Decision Maker (SDM) (Refer to WN #04)

As per O. Reg. 79/10, r.98, for not reporting to the appropriate police force (Refer to WN #05) [s. 19. (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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of physical abuse was reported immediately to the Director.

Log # 007634-17 & 007715-17:

On a specified date in 2017, resident #001 indicated to the private sitter that a Resident Care Aid (RCA) was rough with him/ her and grabbed him/her by the arm to sit him/her in the wheelchair (w/c) when providing care that morning. The private sitter reported the incident to Registered Nurse (RN) #101 that same day.

On October 17, 2017, during a telephone interview, resident #001's Substitute Decision Maker (SDM) indicated to Inspector #126 that he/she was made aware of the allegation of physical abuse toward resident #001 by e-mail from the private sitter that evening in 2017.

RN #101 did not immediately notify the Director of the allegation of physical abuse. [s. 24. (1)]

2. The licensee has failed to ensure that staff to resident emotional abuse was reported immediately to the Director.

Log #023061-17:

On a specified date in 2017, after supper, while PCA #107 was cleaning the table, resident #002 threw a glass of liquid at PCA #107. PCA #107 responded by saying to her/his colleagues in the dining room, "have you seen what resident #002 has done to me" and threw a cup of liquid at resident's #002's face.

On a specified date in 2017, after the incident, PCA #108 reported what he/she had witnessed in the dining room to Registered Nurse (RN) #105 and Registered Practical Nurse (RPN) #104.

On October 17, 2017, RPN #104 indicated to Inspector #126 that PCA #108 reported the incident he/she had witnessed in the dining room that evening in 2017. At that time, RPN #104 indicated that he/she was not sure what to do and what needed to be done. RPN #104 indicated that RN #105 contacted the Director of Care (DOC) and the left a message with the Executive Director(ED).

On October 17, 2017, RN #105 indicated to Inspector #126 that in response to the reporting of the incident of that specified date in 2017, he/she sent an email to the DOC and left a voice mail for the ED.

On October 19, 2017, the Acting DOC indicated to Inspector #126 that she was informed by the ED the next day of the incident of that specified date in 2017. RN #105 had left a voice mail to the ED, the previous evening, to call him/her back and had not left any details. The Acting DOC indicated that she reviewed the daily report and there was no documentation regarding any incident for the previous day. On that same day, the Acting DOC interviewed RN #105 who informed her of the incident of PCA #107 throwing a cup of liquid at resident #002's face. Following these interviews, the Acting DOC notified the MOHLTC's Director that evening.

RN #105 did not immediately notify the Director of the abuse that evening in 2017. [s. 24. (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 all allegation, suspected, witnessed abuse and neglect is immediately reported to the Director,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or in the medication cart that is secure and locked.

On October 16, 2017 (1310 hours), resident #001 was sitting in the dining room finishing her/his dessert. On the table, a medication cup containing 2 tablets of acetaminophen was observed. No registered nursing staff was in the dining room or in the hallway.

Resident #001 indicated that it was his/her medications and that the nurse was aware and left the medications on the table so he/she could take them later on.

On October 16, 2017 (1315 hours), Inspector #126 took the medication cup containing the acetaminophen tablets to the Registered Practical Nurse (RPN) #100 in charge of the unit. RPN #100 indicated that he/she gave the medications to resident #001 and that the two acetaminophen tablets were left on resident 001's table so he/she can take them when he/she wanted to.

Two acetaminophen tablets were left on the table unattended and were not stored in an area that was secured and locked. [s. 129. (1) (a)]

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 drugs are kept locked and secures at all times,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident was immediately notified upon becoming aware of alleged physical abuse.

Log # 007634-17 & 007715-17:

On a specified date in 2017, resident #001 reported to the private sitter, that on that day, a Personal Care Aid (PCA) was rough with him/her when transferring him/her to the wheelchair. The private sitter immediately notified Registered Nurse (RN) #101 about the allegation of physical abuse and sent an email in the evening to resident #001's SDM.

The next day, resident #001's SDM came to the home and questioned RN #101 about the allegation of physical abuse and why was he/she was not notified.

On that specified date in 2017, RN #101 did not immediately notified resident #001's SDM of the allegation of physical abuse. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident was immediately notified upon becoming aware of staff to resident #002 emotional abuse.

Log # 023061-17:

On a specified date in 2017, after supper, while PCA #107 was cleaning the table, resident #002 threw a glass of liquid at PCA #107. PCA #107 responded by saying to his/her colleagues in the dining room, "have you seen what resident #002 has done to me" and threw a cup of liquid at resident #002's face.

On October 17, 2017, RPN #104 indicated to Inspector #126 that PCA #108 reported the incident he/she had witnessed in the dining room that evening in 2017. At that time, RPN #104 indicated that he/she was not sure what to do and what needed to be done. RPN #104 indicated that RN #105 contacted the Director of Care (DOC) and the left a message with the Executive Director(ED).

On October 17, 2017, RN #105 indicated to Inspector #126 that in response to the reporting of the incident, resident #002 was assessed and did not sustained any injury. RN #105 indicated that he/she sent an email to the DOC and left a voice mail to the ED.

On October 19, 2017, the Acting DOC indicated to Inspector #126 that she was informed by the ED on the next day of the incident in 2017. RN #105 had left a voice mail for the ED, the previous evening, to call him/her back and had not left any details. The Acting DOC indicated that she reviewed the daily report and there was no documentation regarding any incident for the previous day. On that day, the Acting DOC interviewed RN #105 who informed her of the incident of PCA #107 throwing a cup of liquid at resident #002's face. At that time, the Acting DOC immediately removed PCA #107 from the unit and reported the incident to the MOHLTC's Director. Resident #002 's SDM was contacted that evening.

On a specified date in 2017, RN #105 and RPN #104 did not immediately notified resident #002's SDM of the incident of emotional abuse that occurred that evening. [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an allegation of physical abuse.

Log #007634-17 & 007715:

On a specified date in 2017, resident #001 reported to the private sitter, that on that day, a Personal Care Aid (PCA) was rough with him/her when transferring him/her to the wheelchair. The private sitter notified Registered Nurse (RN) #101 that same day about the allegation of physical abuse. RN #101 indicated that he/she went to talk to resident #001 and completed an assessment.

As of this date, October 19, 2017, the licensee had not contacted the appropriate police force regarding the allegation of physical abuse staff to resident of that specified date in. [s. 98.]

2. The licensee has failed to ensure that the appropriate police force was immediately notified of an incident of staff to resident emotional abuse.

Log# 023061:

On a specified date in 2017, after supper, while PCA #107 was cleaning the table, resident #002 threw a glass of liquid at PCA #107. PCA #107 responded by saying to his/her colleagues in the dining room, "have you seen what resident #002 has done to me" and threw a cup of liquid at resident's #002's face.

As of this date, October 19, 2017, the licensee has not contacted the appropriate police force regarding the incident of staff to resident emotional abuse that occurred on that specific day of September 2017 [s. 98.]

Issued on this 8th day of November, 2017

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) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2017_683126_0016
Log No. / No de registre :	007634-17, 007715-17, 023061-17, 023568-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 7, 2017
Licensee / Titulaire de permis :	BRUYERE CONTINUING CARE INC. 43 BRUYERE STREET, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	ÉLISABETH-BRUYÈRE RESIDENCE 75 BRUYERE STREET, OTTAWA, ON, K1N-5C8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Danielle Levac

To BRUYERE CONTINUING CARE 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall develop, submit and implement a plan to ensure:

1. All staff that provide direct care to residents have a clear understanding of the definitions of abuse and neglect as per O. Reg. 79/10, s. 2. (1). definitions of "Abuse", (5) definition of "Neglect", and the requirement related to the duty to report as per LTCA, 2007, S.O. 2007, c.8, s.24. (1)
2. Registered Nursing staff demonstrate a clear understanding of their role and responsibilities upon the receipt of information about an incident of alleged, suspected, witnessed abuse or neglect in accordance with the licensee " Abuse and Neglect, Long-Term Care", policy # CLIN CARE 32 LTC, last revised.

This plan must be submitted in writing by November 22, 2017 to Linda Harkins, LTCH Inspector, Nursing at 347 Preston Street, 4th floor, Ottawa Ontario K1S 3J4 OR by fax at 613-569-9670.

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Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #002 was protected from emotional abuse from Personal Care Aid (PCA) #107.

As per O. Reg 79/10, s. 2. (1) (a) defines emotional abuse as:
"any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident"

Log # 023061-17:
A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term-Care (MOHLTC) Director on a specified date in 2017 related an allegation of staff to resident emotional abuse.

Resident #002 was admitted to the home with several diagnosis which include dementia. Resident #002 was known to have responsive behaviors.

On a specified date in 2017, after supper, while PCA #107 was cleaning the table, resident #002 threw a glass of liquid at PCA #107. PCA #107 responded by saying to her/his colleagues in the dining room, "have you seen what resident #002 has done to me" and threw a cup of liquid at resident #002's face.

On a specified date in 2017, after the incident, PCA #108 reported what he/she had witnessed in the dining room to Registered Nurse (RN) #105 and Registered Practical Nurse (RPN) #104.

On October 17, 2017, RPN #104 indicated to Inspector #126 that PCA #108 reported the incident he/she had witnessed in the dining room that evening in 2017. At that time, RPN #104 indicated that he/she was not sure what to do and what needed to be done. RPN #104 indicated that RN #105 contacted the Director of Care (DOC) and left a message with the Executive Director(ED).

On October 17, 2017, RN #105 indicated to Inspector #126 that in response to the reporting of the incident in 2017, resident #002 was assessed and did not sustain any injury. RN #105 indicated that he/she sent an email to the DOC and left a voice mail to the ED.

On October 19, 2017, the Acting DOC indicated to Inspector #126 that she was informed by the ED the following day of the incident in 2017. RN #105 had left a voice mail to the ED, the previous evening to call him/her back and had not left any details. The Acting DOC indicated that she reviewed the daily report and there was no documentation regarding any incident for the previous day. The next day , the Acting DOC interviewed RN #105 who informed her of the incident of PCA #107 throwing a cup of liquid at resident #002's face. At that time, the Acting DOC immediately removed PCA #107 from the unit and reported the incident to the MOHLTC's Director.

Resident #002 was not protected from emotional abuse from PCA #107 as both

registered nursing staff working that specific evening in 2017 did not know how to respond to the incident of emotional abuse.

The licensee also failed to comply with the following section related to the prevention of abuse:

As per LTCHA, 2007, s.24.(1), for not immediately reporting to the Director (Refer to WN #02)

As per O. Reg 79/10, r.97.(1), for not immediately reporting to the Substitute Decision Maker (SDM) (Refer to WN #04)

As per O. Reg. 79/10, r.98, for not reporting to the appropriate police force (Refer to WN #05)

In this matter, the scope is isolated, however, a Compliance Order is supported due to the potential risk of harm to resident #002. [s. 19. (1)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 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 7th day of November, 2017

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 : LINDA HARKINS

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