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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
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Amended Public Copy/Copie modifiée 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
Jun 19, 2020	2020_818502_0004 (A1)	021255-19, 022670-19, 022717-19, 000630-20	Critical Incident System

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Élisabeth-Bruyère Residence
75 Bruyère Street OTTAWA ON K1N 5C8

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

Amended by JULIENNE NGONLOGA (502) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Due to the current emergency orders in place amid the coronavirus pandemic, we will be extending the compliance order #001 issued under s. 6 from inspection report #2020_818502_0004 to October 31, 2020.

Issued on this 19th day of June, 2020 (A1)

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

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

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

Amended by JULIENNE NGONLOGA (502) - (A1)

Amended 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): January 30 and 31, 2020, February 3, 4 and 5, 2020. February 6, 2020 (off-site).

During the course of this inspection, the following Critical Incident System Reports (CIS) were inspected:

- CIS #2759-000025-19 (log #021255-19) related to fall with injury,

- CIS #2759-000028-19 (log #022670-19) related to improper transfer,

- CIS #2759-000029-19 (log #022717-19) related to injury with unknown cause, and

- CIS #2759-000001-20 (log #000630-20) related to abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Private Caregivers, and Alternacare Coordinator and Recruiter.

During the course of this inspection, the inspector(s) observed the resident care, staff and resident interactions, interviewed staff, and reviewed the residents' health care records, home's record, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Personal Support Services

During the course of the original 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report system (CIS) report related to an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of resident #004’s progress notes indicated that:
- On an identified date and time, the resident had a fall with injury.
- Five months prior to the resident fall, the Occupational Therapist (OT) noted that resident #004 was unsafe when ambulating in the morning. The OT directed staff to use a wheelchair in the morning until the resident regain their stability and able to ambulate safely without any support or mobility aid during the day. On the same day, the physician ordered a seat belt to be applied when the resident was seated on the wheelchair and to be released after an identified meal.

Review of the resident’s written plan of care, at the time of incident, indicated that the resident required set-up or supervision only to ambulate within the unit.

Further review of the resident's plan of care did not identify morning safety measures recommended by the OT and the physician.

In an interview, PSW #108 stated that resident #004 walks independently without any support or mobility aid in the evening. The resident's evening routine was to provide evening care and then left them ambulate back to the hallway. On the day of the incident, PSW #108 provided morning care to the resident following their evening routine, and then let the resident ambulate independently in the hallway. The resident attempted to ambulate but lost their balance and fell. The PSW indicated that they were not aware of the morning safety measures in place that required the resident to be transferred in the wheelchair for the first part of the morning and applied the seat belt.

In separate interviews, PSW #105 and RPN #106 indicated that the resident has an unsteady gait in the morning, therefore, they followed the morning safety routine in place until they resident become steady to ambulate independently.

In June 2019, the home had identified that resident #004 was at high risk of fall in the morning due to an unsteady gait. They implemented the use of wheelchair and seatbelt to prevent re-occurrence of fall and injury. During an identified period, the resident had four falls, one with injury. The plan of care did not provide clear direction to PSW #108, who provided the morning care on the day of the last fall. PSW #108 did not follow the morning safety routine in place during morning care to prevent the fall. [s. 6. (1) (c)]

2. The license has failed to ensure that resident #004 was reassessed and the plan of care revised at any other time when the resident's care needs changed.

The MLTC received a CIS report related to an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

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Review of resident #004’s progress notes for an identified period outlined four incidents of falls that occurred when the resident attempted to ambulate independently.

Review of resident #004's written plan of care under "risk of fall" indicated that staff place the bed at correct bed height and ensure the resident wears proper and non slip footwear.

In an interview, RPN #106 indicated that the resident's morning safety routine implemented in June 2019 includes a wheelchair and a seat belt. The RPN stated they assumed that the resident's written plan of care was revised to include the safety routine mentioned above, as it was the RN's responsibility to revise the resident's written plan of care.

In a joint interview, the DOC and the ED acknowledged that the plan of care was not revised, to include the morning safety measure implemented in June 2019. Therefore, resident #004's written plan of care was not revised after each fall during the identified period to include the safety measure and reduce the resident's risk of fall. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

The MLTC received a CIS report on related to abuse. The CIS report and the home’s investigation indicated that on an identified date, resident #002 became verbally abusive to staff #109, who was providing close monitoring to them and attempted to take a picture with a tablet. Staff #109 took away the resident’s tablet, went and hid in an identified room. The resident got out of their wheelchair and followed staff #109 as they tried to get their tablet back. Staff #109 threw the resident’s tablet on the ground and it was chipped when the resident pick it up. The resident fell resulting in injury and pain.

In separate interviews, the resident and staff #109 confirmed the incident mentioned above. Staff #109 indicated that they did not have intention of putting the resident at risk or hurting the resident as the resident's responsive behaviour was known and their role was to monitor the resident.

In an interview, ED indicated there was a power imbalance as the staff was standing and the resident was in the wheelchair. They indicated that staff #109 did not act appropriately by treating the resident as mentioned above. They should have treated the resident with respect. Therefore, the licensee had not fully promoted resident #002’s right to be treated with respect and courtesy. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #002's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted, to be implemented voluntarily.

WN #3: 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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 52 (2) the licensee was required to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Specifically, staff did not comply with the licensee's Pain Management, #CLIN Care 42 LTC, revised on December 29, 2019 of the home pain assessment, which is part of the licensee's Pain Management policy.

A CIS was submitted to the MLTC related to improper transfer resulting in injury. The CIS indicated that on identified date, the assigned PSW transferred the resident unassisted using one-person pivot technique during care. Later on the

same day, staff documented that resident #001 was having pain on the knees, and an identified cream was applied.

Review of the licensee's policy (under 1.2.c.) indicated that all residents must be assessed for pain on a quarterly basis and when a resident exhibits a significant change in health status or pain is not relieved by initial interventions, using the Pain Assessment in PCC.

Review of the resident's progress notes indicated that the resident had pain during an identified period and the identified cream was applied. The resident continue to have pain and was diagnosed with specified injury.

Review of the assessment record on PCC did not identify a completed pain assessment after the initial intervention, application of the identified cream, which was not effective and the resident continued to complain of pain.

In an interview, RPN #106 stated that a PSW reported to them that the resident was in pain during care, they observed the resident and confirmed that the resident had pain. The RPN indicated that they reported their observation to the RN who has the responsibility to complete the pain assessment.

In an interview, RN #107 stated that the RPN and the resident's SDM reported to them that the resident was in pain. The RN acknowledged that they did not completed the pain assessment in PCC.

In joint interview, DOC and ED indicated that registered staff were expected to complete a pain assessment as per policy. The ED, after review of the assessment record acknowledged that the assessment was not completed as per home's policy. [s. 8. (1) (b)]

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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #103 used safe transferring and positioning devices or techniques when assisting resident #001.

A CIS Report was submitted to the MLTC related to improper transfer resulting in injury. The CIS indicated that on an identified date the assigned PSW transferred the resident unassisted using one-person pivot technique during morning care. Later on the same day staff documented that resident #001 was having pain on the knees. Four days later, the resident was diagnosed with a specified injury.

Review of the resident's current written plan of care indicated that resident #001 required total assistance of two staff using mechanical lift.

In an interview, PSW #103 indicated that they transferred the resident unassisted from bed to chair using one-person pivot.

In a joint interview, DOC and ED acknowledged that PSW #103 used unsafe transferring technique as they transferred the resident unassisted using pivot technique. [s. 36.]

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 ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 19th day of June, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIENNE NGONLOGA (502) - (A1)
Inspection No. / No de l'inspection :	2020_818502_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021255-19, 022670-19, 022717-19, 000630-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2020(A1)
Licensee / Titulaire de permis :	Bruyère Continuing Care Inc. 43 Bruyère Street, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	Élisabeth-Bruyère Residence 75 Bruyère Street, OTTAWA, ON, K1N-5C8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantale Cameron

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

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.6 (1) (c).

Specifically, the licensee shall ensure that the plan of care of resident #004 set out clear directions to staff and others who provide direct care to the resident related to the resident's morning safety measure put in place in June 2019 to minimize the risk of falls.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report system (CIS) report related to an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of resident #004's progress notes indicated that:
- On an identified date and time, the resident had a fall with injury.
- Five months prior to the resident fall, the Occupational Therapist (OT) noted that resident #004 was unsafe when ambulating in the morning. The OT directed staff to use a wheelchair in the morning until the resident regain their stability and able to ambulate safely without any support or mobility aid during the day. On the same day,

the physician ordered a seat belt to be applied when the resident was seated on the wheelchair and to be released after an identified meal.

Review of the resident's written plan of care, at the time of incident, indicated that the resident required set-up or supervision only to ambulate within the unit.

Further review of the resident's plan of care did not identify morning safety measures recommended by the OT and the physician.

In an interview, PSW #108 stated that resident #004 walks independently without any support or mobility aid in the evening. The resident's evening routine was to provide evening care and then left them ambulate back to the hallway. On the day of the incident, PSW #108 provided morning care to the resident following their evening routine, and then let the resident ambulate independently in the hallway. The resident attempted to ambulate but lost their balance and fell. The PSW indicated that they were not aware of the morning safety measures in place that required the resident to be transferred in the wheelchair for the first part of the morning and applied the seat belt.

In separate interviews, PSW #105 and RPN #106 indicated that the resident has an unsteady gait in the morning, therefore, they followed the morning safety routine in place until they resident become steady to ambulate independently.

In June 2019, the home had identified that resident #004 was at high risk of fall in the morning due to an unsteady gait. They implemented the use of wheelchair and seatbelt to prevent re-occurrence of fall and injury. During an identified period, the resident had four falls, one with injury. The plan of care did not provide clear direction to PSW #108, who provided the morning care on the day of the last fall. PSW #108 did not follow the morning safety routine in place during morning care to prevent the fall.

The severity of this issue was an Actual Harm to resident #004. The scope of the issue was one out of three residents reviewed was affected, and the home had a previous non-compliance to the same subsection of the LTCHA. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A1)

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

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:

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

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

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

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 19th day of June, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JULIENNE NGONLOGA (502) - (A1)

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

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