Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2019	2019_723606_0015	012186-19, 012732-19	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Grace Manor
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 8, 9, 10, 11, and 12, 2019.

The following Critical Incident System (CIS) intakes were inspected:
Log #012186-19 regarding an allegation that a medication was tampered with; and
Log #012732-19 regarding resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services (DRC), Assistant Director of Resident Services (ADRC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nursing Agency Administration and registered staff, a College RPN Student, and residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **6 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

A Critical Incident System (CIS) reported resident to resident abuse.

Resident #001's progress notes stated that resident #001 had wandered into different residents' rooms several times during an identified shift. PSW #104 found resident #001 in resident #002's room twice and witnessed resident #001 touch resident #002 in an inappropriate manner. PSW #104 redirected resident #001 back to their room. A few hours later, PSW #104 found resident #001 in resident #003's room and witnessed resident #001 touch resident #003 in an inappropriate manner. PSW #104 again redirected resident #001 back to their room. An hour after this incident, the progress notes stated that resident #001 was found in resident #004's room and had attempted to touch the resident but Agency RN #101 intervened.

Resident #001's admission records from an identified service provider including a particular assessment identified the resident with a number of specific responsive behaviours prior to admission. However, resident #001's initial plan of care did not identify that the resident had responsive behaviours as identified on their admission records. Review of the home's 24-hour daily report log on an identified date did not include any communication to the staff regarding resident #001's responsive behaviours.

Agency RN #101 confirmed that there was no heightened monitoring of resident #001 on the identified date. They stated that the intervention of redirecting resident #001 was not effective at keeping them from entering resident #002, #003, and #004's rooms.

PSW #104 stated that they witnessed resident #001 touch residents #002 and #003 in an inappropriate manner and attempted to touch resident #004.

The licensee failed to protect residents #002 and #003 from abuse by resident #001. [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 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 failed to ensure that where the Act or Regulation required the licensee to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with Ontario Regulation 79/10, s. 136(4)(a) where a drug that was to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team documents the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2.The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
8. The manner of destruction of the drug.

The licensee failed to comply with an identified home's policy. The policy stated that:
-The following information must be documented on the Controlled Substance Administration Record for every controlled substance: the prescription number, the date the drug was dispensed, the name of the resident, the medication name, strength, directions and dosage form.
-When removing the controlled substance from active supply, two registered staff members must indicate the reason for removal/destruction, the remaining quantity, and sign/date accordingly on the Controlled Substance Administration Record; and document the removal on the shift count (sign/date/quantity removed).

A CIS reported a medication incident. The CIS stated an allegation that an identified

medication in a blister card was tampered with.

Resident #007's clinical records including the progress notes, physician orders, and Electronic Medication Administration Records (E-MARs) for identified months stated that the resident refused an identified medication on a number of identified dates.

An identified medication record was reviewed for the dates that resident #007 refused an identified medication. The medication record for identified dates did not document the reason the medication was being destroyed, the date when the drug was destroyed, the manner of how the drug was destroyed, the date the drug was removed from the drug storage area, and the names of the members of the team who destroyed the drug.

RN #105, #109 and the Assistant Director of Resident Care (ADRC) stated that when a resident refused an identified medication, the medication must be destroyed and wasted in the presence of two registered staff and must be documented. The record must include the number of medication wasted and must have both the registered staff's signatures.

The ADRC acknowledged that staff did not follow the identified home's policy.

The licensee has failed to ensure that an identified home's policy was complied with. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A CIS reported resident to resident abuse.

The home's nursing staff schedule was reviewed and consisted of Personal Support Workers (PSW), Registered Practical Nurses (RPN) and Registered Nurses (RN) to cover care for a number of residents among five resident home areas.

For an identified shift, the home required a number of registered staff; one registered staff to cover three of the five resident home areas and an RN to cover the remaining two resident home areas and to be designated as In-Charge Nurse of the building.

Review of the nursing staff schedule stated that RN #111 who was an employee and a regular nursing staff of the home was scheduled to work the identified shift on an identified date but was unable to do so. Further review of the nursing staff schedule for an identified date stated that the RN and the RPN who worked the shift were both from a nursing agency.

RN #101 stated that they were from an identified nursing agency and that they worked on an identified date and was the Charge Nurse of the building. They stated that on an identified date they worked with an RPN who told them that they were also from a nursing agency and that there were no other registered staff in the home. They stated that the home's ADRC was on call for that shift. However, when they called them for assistance at the beginning of the shift, their call was not returned until closer to the end of the shift.

The ADRC confirmed that RN #101 and RPN #110 who worked the identified shift on an identified date were both from a nursing agency. They shared that they were on call during the shift and acknowledged that they did not return a call that they received from Agency RN #101 until closer to the end of the shift.

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee that could potentially trigger such altercations; and (b) identifying and implementing interventions.

A CIS reported resident to resident abuse. The CIS stated that resident #001 had wandered into resident #002, #003 and #004's rooms and inappropriately touched resident #002 and #003 and attempted to touch resident #004.

Resident #001's admission records stated that resident #001, had identified responsive behaviours prior to admission and that the resident continued to display the identified responsive behaviours.

PSW #104 and Agency RN #101 stated that resident #001 was a new admission and they did not know that the resident had responsive behaviours when they started their shift. PSW #104 stated that when a resident was newly admitted the resident was usually monitored for responsive behaviours.

Review of an identified monitoring record specific to responsive behaviours for resident #001 did not show evidence that the monitoring record was initiated for the resident on an identified date. The Director of Resident Care (DRC) confirmed that the record was not initiated for resident #001 until after the incidents.

Review of an identified home's policy stated that a behavioural plan of care would be developed for residents with actual behaviours. Review of resident #001's plan of care did not indicate that the resident had identified responsive behaviours.

RN #105 stated that at the beginning of a shift, the registered staff going off the shift provided report to the registered staff and the PSWs on the oncoming shift using a 24-hour daily report log. They revealed that when a resident was newly admitted to the home a summary of the resident's history including any responsive behaviours were shared with the staff. Agency RN #101 stated that resident #001's responsive behaviours were not reported during the shift report provided to them.

RN #105 stated that when a resident was admitted to the home, the resident's admission assessments were reviewed for history of responsive behaviours and then communicated to the staff. The resident would be monitored for the responsive behaviours. They acknowledged that resident #001 responsive behaviours had not been communicated to the staff.

The licensee has failed to ensure that that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and residents #002, #003 and #004. [s. 54. (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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee that could potentially trigger such altercations; and (b) identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider until administered to a resident or destroyed.

A CIS reported a medication incident. The home discovered that an identified medication in a blister card was found with tape on the back of the card and the identified medication in the blister pack was observed to be misshapen.

RN #109 stated they observed that the identified medication in the blister card taped up from the back and noted the medication to be misshapen. They told the inspector that the identified medication should be an identified shaped. They stated they reported the incident to the ADRC for follow up.

The ADRC stated that the home had suspected that the identified medication belonging to resident #007 had been tampered with. They stated that the content of the identified medication was altered and misshapen. They explained that they had followed up with the home's pharmacy who told them that the content of the identified medication should be an identified colour and shape.

The ADRC confirmed the medication incident occurred and the home suspected the medication had been tampered with. They stated the police removed the identified medication blister card to analyze the unidentified content.

The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider until administered to a resident or destroyed. [s. 126.]

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 drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with their home's policy to promote zero tolerance of abuse and neglect of residents.

A CIS reported resident to resident abuse.

The CIS stated that resident #001 had wandered into resident #002, #003 and #004's rooms and touched resident #002 and #003 in an inappropriate manner and attempted to touch resident #004.

An identified home's policy stated that "all staff and volunteers MUST immediately report to the Director of Resident Care all suspected alleged, witnessed, or actual incidents of resident abuse or neglect"; and VERY IMPORTANT that if the incident occurs in the evening or weekend such incidents are reported to the on-call Manager who must immediately notify the appropriate Director of Resident Care".

Agency RN #101 stated that they did not notify the on call manager about the incident immediately.

The ADOC acknowledged that Agency RN #101 did not inform them of the incidents between residents #001, #002, #003, and #004 and therefore did not comply with the home's policy in relation to immediate reporting. [s. 20. (2)]

Issued on this 14th day of August, 2019

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

Ministère de la Santé et 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 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) :	JANET GROUX (606)
Inspection No. / No de l'inspection :	2019_723606_0015
Log No. / No de registre :	012186-19, 012732-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 31, 2019
Licensee / Titulaire de permis :	Holland Christian Homes Inc. 7900 McLaughlin Road South, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	Grace Manor 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Dykstra

To Holland Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 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. 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 must be compliant with s.19 (1) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:
a) Ensure that residents #002, and #003 or any other resident are protected from abuse by resident #001.
b) Ensure that when a resident is admitted to the home, an initial plan of care for responsive behaviours is developed and includes information provided by the LHINs, Substitute Decision Maker (SDM), and/or other external healthcare providers.
c) Ensure that when a resident is being admitted to the home, that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone.

A Critical Incident System (CIS) reported resident to resident abuse.

Resident #001's progress notes stated that resident #001 had wandered into different residents' rooms several times during an identified shift. PSW #104 found resident #001 in resident #002's room twice and witnessed resident #001 touch resident #002 in an inappropriate manner. PSW #104 redirected resident #001 back to their room. A few hours later, PSW #104 found resident #001 in resident #003's room and witnessed resident #001 touch resident #003 in an inappropriate manner. PSW #104 again redirected resident #001 back to their

room. An hour after this incident, the progress notes stated that resident #001 was found in resident #004's room and had attempted to touch the resident but Agency RN #101 intervened.

Resident #001's admission records from an identified service provider including a particular assessment identified the resident with a number of specific responsive behaviours prior to admission. However, resident #001's initial plan of care did not identify that the resident had responsive behaviours as identified on their admission records. Review of the home's 24-hour daily report log on an identified date did not include any communication to the staff regarding resident #001's responsive behaviours.

Agency RN #101 confirmed that there was no heightened monitoring of resident #001 on the identified date. They stated that the intervention of redirecting resident #001 was not effective at keeping them from entering resident #002, #003, and #004's rooms.

PSW #104 stated that they witnessed resident #001 touch residents #002 and #003 in an inappropriate manner and attempted to touch resident #004.

The licensee failed to protect residents #002 and #003 from abuse by resident #001.

The severity level of this issue was determined to be a level 2, as there was minimal harm to the residents. The scope of the issue was a level 2 pattern affecting 2/3 residents reviewed. The home had a level 3 compliance history as there was previous non-compliance to the same subsection.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2019

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
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 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)
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 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 31st day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

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