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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
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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
May 23, 2018	2018_378116_0006	024805-17	Complaint

Licensee/Titulaire de permis

Southlake Residential Care Village
596 Davis Drive NEWMARKET ON L3Y 2P9

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

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 2P6

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

SARAN DANIEL-DODD (116)

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): April 9, 10, 11, 12, 18, 19, 20, 23, 2018.

This inspection was conducted concurrently with resident quality inspection (RQI) #2018_578672_0008, Log #005359-18.
The purpose of this complaint inspection was related to care concerns of resident #001.
The resident health record including the written plan of care, progress notes, physician's orders and external clinical records were reviewed.

During the course of the inspection, the inspector(s) spoke with Executive Director (E.D.), Associate Director(s) of Care (ADOC), Medical Director, Attending Physicians, Registered Dietitian (RD), food service manager (FSM), food service supervisor (FSS), social worker (SW), registered staff members, personal support workers (PSWs).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully

respected and promoted:

Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint related to care concerns regarding resident #001.

A review of resident #001's clinical records indicated that the resident was admitted to the home on an identified date, with multiple identified diagnoses and dependent upon staff for care needs.

A review of resident #001's written plan of care, under an identified focus indicated the resident had an identified condition. The interventions in place to manage the risk of the condition directed staff to conduct the identified task in a specified manner.

Resident #001's progress notes indicated that on an identified date, PSW #114 reported to RN #110 observing an identified individual administering the identified task to resident #001 in a specified manner which contravened the written plan of care. RN #110 did not intervene however, timed the process. RN #110 reported the concern to social worker #105. Upon review of the progress notes, there was no indication to support that RN #110 intervened upon observing the identified technique of the task to the resident.

The progress note for an identified date, documented that the nurse practitioner assessed the resident due to an identified symptom. Resident #001 was transferred to the hospital for further evaluation and passed away in hospital on an identified date.

An interview held with PSW #114 indicated that the observation of the specified task on an identified date, was reported to registered staff #110. Several attempts were made to interview registered staff #110 however, they were unavailable.

PSWs #107 and #114 indicated that they were the primary PSWs assigned to the resident during specified shift(s) and were responsible for providing identified tasks for the resident. PSW #'s 114, #107 and registered staff #'s 108 and #109 indicated being aware of the identified risk present for resident #001 with the associated task and the requirement to conduct the identified task in a manner which mitigates the identified risk for resident #001.

Interviews held with PSW #107, #114 and registered staff #'s 108 and #109 indicated that an identified individual of resident #001 was actively involved in conducting the specified task for resident #001 and repeatedly performed the task in a manner that contravenes with the written plan of care.

Resident #001's progress notes were reviewed over an identified period, which revealed several documented incidents where the identified individual was observed performing the specified task to resident #001 in a manner that was not consistent with the care needs of the resident.

Review of the clinical record indicated that attempts to provide education to the identified individual surrounding safe administration of the identified task were unsuccessful on an identified date, whereby an external specialist advised the identified individual of safe practices for the identified task and subsequently on a separate date, where the registered dietitian reviewed dietary concerns with the identified individual. Although efforts were made to educate the identified individual on safe practices for the identified task, the identified individual continued to perform the task without the assistance of staff.

Interviews with the registered dietitian and the ED indicated that they had knowledge of the identified individuals manner in performing the identified technique prior to the incident that occurred on an identified date, and were aware of the identified individuals practices throughout the resident's admission to the home.

The licensee has failed to ensure that resident #001 had been provided with identified techniques and cared for in a manner consistent with their needs. The ADOC's and the E.D confirmed that resident #001's right to be cared for in a manner consistent with their needs had not been fully respected and promoted and as a result placed resident #001 at risk of injury. [s. 3. (1) 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

On an identified date, the MOHLTC received a complaint related to assessments and treatment provided to resident #001.

A review of resident #001's clinical records indicated that the resident was admitted to the home on an identified date, with multiple diagnoses.

A review of resident #001's written plan of care initiated on an identified date, under a specified focus indicated the resident had an identified condition. The interventions in place to manage the identified risk directed staff to perform an identified task in a specified manner.

On an identified date, resident #001 was seen by an external specialist for concerns related to the identified condition. The external specialist identified the resident to be at risk for identified conditions. Review of the progress note for an identified date documented recommendations made by the external specialist to reduce the risk associated with the identified condition(s).

Review of the written plan of care did not include the identified risk(s) and the recommendations made by the external specialist. Interviews held with the registered dietitian, ADOC and the ED confirmed that the written plan of care did not set out clear directions to staff and others who provided direct care to resident #001 in relation to an identified requirement and the recommended interventions to mitigate risk. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Residents are given sufficient time to eat at their own pace.

On an identified date, the MOHLTC received a complaint related to assessments and treatment provided to resident #001.

A review of resident #001's clinical records indicated that the resident was admitted to the home on an identified date, with multiple identified diagnoses.

Review of resident #001's written plan of care initiated on an identified date, under a specified focus indicated the resident had an identified condition. The interventions in place to manage the identified risk directed staff to perform an identified task in a specified manner.

On an identified date, resident #001 was seen by an external specialist for concerns related to the identified condition. The external specialist identified the resident to be at

risk for identified conditions. During the observation, the external specialist advised an identified individual of safe practices to be used with the resident however, the external specialist documented that the identified individual did not follow these recommendations while the specialist was present. Review of the progress note for an identified date documented recommendations made by the external specialist to reduce the risk associated with the identified condition(s). Review of the written plan of care did not identify the recommended interventions.

Review of the progress note for an identified date, documented that PSW #114 reported to registered staff #110 observing the identified individual performing an identified task in a manner which contravened the written plan of care for resident #001. The resident was observed to display an identified symptom during the task. Registered staff #110 did not intervene while observing the identified individual perform the task. Registered staff #110 reported the concern to social worker #105. Upon review of the progress notes, there was no indication to support that RN #110 intervened upon observing the specified task provided to the resident. The progress note dated on an identified date, documented that the nurse practitioner assessed the resident due to an identified symptom and resident #001 was transferred to the hospital for further evaluation. The resident passed away in hospital.

Several attempts were made to interview registered staff # 110 however, they were unavailable.

Interviews held with the FSM, RD, ADOC and the ED acknowledged that the home's expectation would be for staff #'s 114 and #110 to have intervened upon observing the identified task provided to resident #001 by the identified individual on the specified date. Further interviews held with the ADOC and the ED confirmed that the home did not ensure that resident #001 was given sufficient time to complete a specified task at their own pace and that the resident was not provided with personal assistance and encouragement required to safely complete the identified task.

An interview held with RD #106 indicated that the home's procedure is for an interdisciplinary referral to be sent to dietary services for any dietary concerns involving residents. Interviews held with RD #106 revealed and record review confirmed that the resident was referred on an identified date, by food service manager (FSM) #113 related to observing the identified individual not following the prescribed diet or RD recommendations. The RD indicated that if the concerns regarding specified practices were still present a subsequent referral should have been made. Further review of

progress notes for an identified period document several incidents where the identified individual was observed performing a specified task to resident #001 in a manner that contravenes to the plan of care and placed the resident at an identified risk.

Interviews held with PSW staff #'s 114, #107 and registered staff #'s 108 and #109 indicated being aware of the identified risk(s) of resident #001 and the requirement to perform an identified task in a specified manner to mitigate the risk(s).

Further interviews held with the ADOC and the ED confirmed that the home did not ensure that resident #001 was given sufficient time to complete a specified task at their own pace and that the resident was not provided with personal assistance and encouragement required to safely complete the identified task. [s. 73. (1) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
- residents are given sufficient time to complete an identified requirement at their own pace, to be implemented voluntarily.

Issued on this 18th day of June, 2018

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) :	SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2018_378116_0006
Log No. / No de registre :	024805-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 23, 2018
Licensee / Titulaire de permis :	Southlake Residential Care Village 596 Davis Drive, NEWMARKET, ON, L3Y-2P9
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, NEWMARKET, ON, L3Y-2P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra-McNamara

To Southlake Residential Care Village, 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. 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with s. 3 (1) 4, of the LTCHA, 2007.

Specifically, the licensee shall develop and submit a plan that includes the following requirements and the person(s) responsible for completing the tasks.

1. Provide education and/or re-education on the Residents' Bill of Rights to all direct care and registered staff members of the home.
2. The training should provide a focus on the following Resident Bill of Rights:

- Every resident has the right to be properly fed and cared for in a manner consistent with their needs.
3. Senior management must communicate the importance of ensuring identified tasks are provided to residents in a manner consistent with their needs to all individuals involved in the resident's care.

The plan is to be submitted via email to: centraleastSAO.MOH@ontario.ca no later than June 8, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted:

Every resident has the right to be properly sheltered, fed, clothed, groomed and

cared for in a manner consistent with their needs.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint related to care concerns regarding resident #001.

A review of resident #001's clinical records indicated that the resident was admitted to the home on an identified date, with multiple identified diagnoses and dependent upon staff for care needs.

A review of resident #001's written plan of care, under an identified focus indicated the resident had an identified condition. The interventions in place to manage the risk of the condition directed staff to conduct the identified task in a specified manner.

Resident #001's progress notes indicated that on an identified date, PSW #114 reported to RN #110 observing an identified individual administering the identified task to resident #001 in a specified manner which contravened the written plan of care. RN #110 did not intervene however, timed the process. RN #110 reported the concern to social worker #105. Upon review of the progress notes, there was no indication to support that RN #110 intervened upon observing the identified technique of the task to the resident.

The progress note for an identified date, documented that the nurse practitioner assessed the resident due to an identified symptom. Resident #001 was transferred to the hospital for further evaluation and passed away in hospital on an identified date.

An interview held with PSW #114 indicated that the observation of the specified task on an identified date, was reported to registered staff #110. Several attempts were made to interview registered staff #110 however, they were unavailable.

PSWs #107 and #114 indicated that they were the primary PSWs assigned to the resident during specified shift(s) and were responsible for providing identified tasks for the resident. PSW #'s 114, #107 and registered staff #'s 108 and #109 indicated being aware of the identified risk present for resident #001 with the associated task and the requirement to conduct the identified task in a manner which mitigates the identified risk for resident #001.

Interviews held with PSW #107, #114 and registered staff #'s 108 and #109 indicated that an identified individual of resident #001 was actively involved in conducting the specified task for resident #001 and repeatedly performed the task in a manner that contravenes with the written plan of care.

Resident #001's progress notes were reviewed over an identified period, which revealed several documented incidents where the identified individual was observed performing the specified task to resident #001 in a manner that was not consistent with the care needs of the resident.

Review of the clinical record indicated that attempts to provide education to the identified individual surrounding safe administration of the identified task were unsuccessful on an identified date, whereby an external specialist advised the identified individual of safe practices for the identified task and subsequently on a separate date, where the registered dietitian reviewed dietary concerns with the identified individual. Although efforts were made to educate the identified individual on safe practices for the identified task, the identified individual continued to perform the task without the assistance of staff.

Interviews with the registered dietitian and the ED indicated that they had knowledge of the identified individuals manner in performing the identified technique prior to the incident that occurred on an identified date, and were aware of the identified individuals practices throughout the resident's admission to the home.

The licensee has failed to ensure that resident #001 had been provided with identified techniques and cared for in a manner consistent with their needs. The ADOC's and the E.D confirmed that resident #001's right to be cared for in a manner consistent with their needs had not been fully respected and promoted and as a result placed resident #001 at risk of injury.

The severity of harm is actual. The scope is isolated and the home has no previous compliance history with s. 3.[s. 3. (1) 4.]
(116)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 23rd day of May, 2018

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 : SARAN Daniel-Dodd

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