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 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
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
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500 rue Weber Nord
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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
Dec 21, 2018	2018_735659_0021	015886-17, 001629-18, 003662-18, 008613-18, 017931-18, 031267-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Huron
77722A London Rd R. R. #5 CLINTON ON N7A 1M2

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

Huronlea Home for the Aged
820 Turnberry Street South BRUSSELS ON N0G 1H0

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

JANETM EVANS (659)

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): October 29, 30, 31 and November 5, 6, 7 and 8, 2018.

The following intakes were included with this inspection:
Log #015886-17\M601-000010-17 Critical incident related to fall with injury.
Log #001629-18\M601-000001-18 Critical incident related to verbal/emotional abuse.
Log #003662-18\M601-000002-18 Critical incident related to fall with injury.
Log #008613-18\M601-000004-18 Critical incident related to fall with injury.
Log #017931-18\M601-000005-18\ IL-58140-AH related to abuse.
Log #031267-18\M601-000008-18 related to alleged abuse.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 24.(1) was identified in this inspection and has been issued in Inspection Report 2018_735659_0022, dated October 29, 2018, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses, Registered Practical Nurse,RAI Coordinator, Personal Support Workers, Housekeepers, police and residents.

The inspector (s) also made observations related to mandatory postings, provision of care, staff to resident interactions and a medication pass and reviewed clinical records, staffing
records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
5 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 has failed to ensure that residents were protected from abuse by anyone.

Review of the clinical record for an identified resident showed the resident was known to exhibit responsive behaviours.

On a specified date the identified resident was found in a another identified resident's room and was observed to be exhibiting responsive behaviours. Staff reported the concern to the Director of Care (DOC).

Review of progress notes for a ten week period for the identified resident, showed seven instances of responsive behaviours. Review of the identified resident's care plan showed interventions had not been in place prior to the incident to address all of the resident's responsive behaviours.

Immediate actions taken to prevent further occurrence included enhanced resident monitoring for the specified timeframe and behavioural charting. In addition to this, a specified device was implemented to prevent a responsive behaviour.

Review of the home's investigation into this incident documented that police were not notified of the incident.

Three PSWs and one Registered Nurse (RN) said the identified resident occasionally exhibited responsive behaviours towards both staff and residents. Staff stated that with the identified resident's behaviours, they were known to gravitate to the second resident. The RN stated that following this incident interventions were put in place to assist with managing the identified resident's responsive behaviours.

2. From interviews and a review of the identified resident's history of responsive behaviours an alleged incident involving the identified resident and a second resident was noted.

Interviews and a review of the clinical record for the identified resident showed an incident where the identified resident exhibited the same type of responsive behaviour toward a second resident, several months following the first incident. It was observed by a PSW who intervened and separated the two residents. The PSW stated they observed the second resident try to push the identified resident away.

The licensee had failed to ensure that two identified residents were protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care was provided to the resident as specified in the plan.

A critical incident (CI) reported to the Ministry of Health and Long-term Care stated an identified resident had sustained a fall with injury, which resulted in a significant change and transfer to hospital.

Progress note review for the identified resident for possible contributing factors to the fall, showed a medication incident which indicated that the the resident had been found to have two times the amount of a specified medication.

Review of the medication incident notification documented the incident occurred early morning on an identified date but was not discovered during the afternoon shift.

Review of the physician's orders for the specified date related to this incident, documented enhanced monitoring vital signs every hour for six hours, including oxygen levels.

Review of progress notes for the identified resident documented the enhanced monitoring was completed for four of the six hours.

The DOC acknowledged that staff had not followed the physician's order related to monitoring the identified resident's vital signs and oxygen saturation every hour for six hours.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

A Critical Incident (CI) was received which stated the identified resident had a fall which resulted in an injury for which the resident was transferred to hospital, and a significant change in the resident's health status.

Review of the clinical record on Point Click Care (PCC) for the identified resident, showed they were assessed as at risk for falls and required extensive assistance of two persons with their activities of daily living (ADLs). Their outcome score identified some degree of cognitive impairment.

Interventions to address the resident's fall risk were identified in the plan of care.

The CI analysis and follow up of immediate actions included several new interventions to address falls risk, however, these interventions were not documented in the resident's plan of care. A physiotherapy referral documented supervised transfers and ambulation for short distances only.

During a four month period the identified resident's progress notes indicated the resident had several falls.

One PSW and one Registered Nurse (RN) stated the resident may have difficulty with some interventions given their cognitive impairment.

The DOC acknowledged that given the resident's cognitive impairment level, they may have difficulty with some of the interventions. The plan of care had not been revised or updated to include alternative interventions related to fall prevention.

The licensee had failed to ensure that the identified resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective [s. 6. (10) (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 care set out in the plan of care for the identified resident and all other residents is provided to the resident as specified in the plan. In addition to this the the licensee will ensure that all residents are reassessed and their care plan is updated when the resident's care needs change or care set out in the plan is no longer necessary, 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 there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

Review of home's staffing plan identified when there was a shortage of RNs the action plan was to pull an RN from other shifts and try to replace those shifts, increase the RN hours to cover the vacant shifts, use agency or the home's RPN and have an RN on call.

Resident Care Administrative Assistant (RCAA) stated RNs work eight hour shifts and there should be one on each shift for days, evenings and nights. The home would ask their RNs to work overtime before they would use agency staff. If they were unable to cover with agency RNs, they would ask the home's RPNs to work and have an RN on call, or have the DOC cover the shift.

Review of the staffing schedule for a nine week period in 2017, showed agency RNs worked 17/216 shifts or eight percent of shifts.
Review of the staffing schedule for a 10 week period in 2018, showed agency RNs or the home's RPNs worked 12/264 shifts or five percent of shifts.

The Business manager stated that the home was down two part-time RN lines in 2018.

The DOC acknowledged that the home had not had an RN who was a member of the regular staff present at all times.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement. [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 The licensee will ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A Critical incident (CI) was received by the Ministry of Health and Long-term Care which documented an identified resident fell and sustained an injury which resulted in a significant change in the resident's health status and they were transferred to hospital.

The home's Falls Prevention and Management Program stated: Persons witnessing the fall or finding the resident after the fall should initiate a Head Injury Routine (HIR) for all unwitnessed falls except for those residents who have a CPS of three or less and indicated they have not hit their head.

Review of the clinical record for the identified resident documented an unwitnessed fall on a specified date, where the identified resident had a head injury.

There was no evidence of a head injury routine (HIR) being initiated for the resident.

A Registered Practical Nurse (RPN) said if they thought the resident hit their head or there was visual evidence of the resident hitting their head, then automatically vitals would be taken for 24 hours.

The DOC said the expectation was to complete the HIR every half hour, for one hour and acknowledged this had not been completed for the identified resident.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. [s. 8. (1) (a),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 otherwise put in place was complied with, specifically: the home's Head Injury Routine (HIR), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A Critical Incident (CI) was reported to the Ministry of Health and Long Term Care which alleged responsive behaviour from one identified resident toward a second resident.

Review of two months of progress notes for the identified resident showed a history of numerous responsive behaviours.

Review of the plan of care for the identified resident showed that interventions were not included for all identified responsive behaviours.

On a specified date there was a witnessed incident of responsive behaviours directed from the identified resident towards a second resident.

Following the incident enhanced behaviour monitoring was ordered and implemented for a specified timeframe, as well as referrals to external community resources.

Review of documentation for the enhanced monitoring, showed ongoing responsive behaviours.

The clinical record showed a second witnessed incident of responsive behaviours from the identified resident to another resident. Interventions were put in place but the resident continued to exhibit the behaviours.

Two PSWs stated they were not familiar with any triggers for behaviours for the identified resident. One PSW said that the identified resident exhibited responsive behaviours towards both staff and residents of the home.

A Registered Nurse (RN) stated the identified resident exhibited behaviours and a specified intervention was put in place to address one of the behaviours..

The DOC stated that the identified resident had not really demonstrated behaviours prior to these incidents and they had not been aware of one of the resident's responsive behaviours until after the enhanced monitoring had been completed. The DOC acknowledged that responsive behaviours and interventions to address the responsive behaviours should be documented in the plan of care at the time the behaviours were identified.

The licensee had failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours. [s. 53. (4) (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 strategies are developed and implemented to respond to the identified resident and all other resident's who are demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the the appropriate police force was immediately notified of the witnessed incident of abuse of residents.

A Critical Incident (CI) was reported to the Ministry of Health and Long Term Care which alleged responsive behaviours directed from an identified resident toward another resident.

Review of the clinical record for a specified date, stated there had been a witnessed incident of responsive behaviours by the identified resident towards a second resident. The concern was reported to Director of Care (DOC).

Review of the home's investigation file showed the home completed an investigation into the incident but did not notify police of the witnessed incident.

2. Review of the clinical record for a specified date showed a second witnessed incident of the same type of responsive behaviour directed from the identified resident towards a second resident.

The home's investigation did not show that police were notified of the witnessed incident.

The Administrator and DOC acknowledged that authorities had not been notified for these incidents and they should have been notified.

The licensee has failed to ensure that the appropriate police force was immediately notified of the witnessed incident of abuse of residents.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the proper authorities were notified of any alleged, suspeced or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence., to be implemented voluntarily.

Issued on this 11th day of January, 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

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

Ministère 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) :	JANETM EVANS (659)
Inspection No. / No de l'inspection :	2018_735659_0021
Log No. / No de registre :	015886-17, 001629-18, 003662-18, 008613-18, 017931-18, 031267-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 21, 2018
Licensee / Titulaire de permis :	Corporation of the County of Huron 77722A London Rd, R. R. #5, CLINTON, ON, N7A-1M2
LTC Home / Foyer de SLD :	Huronlea Home for the Aged 820 Turnberry Street South, BRUSSELS, ON, N0G-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Steadman

To Corporation of the County of Huron, 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) (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 comply with s. 19 (1) of the LTCHA.

Specifically, the licensee must
a) Ensure that the identified residents and all other residents are protected from abuse by anyone.
b) Ensure that the identified resident and all other residents that exhibit responsive behaviours have strategies and interventions in place to mitigate the risk of altercations with other residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Review of the clinical record for an identified resident showed the resident was known to exhibit responsive behaviours.

On a specified date the identified resident was found in a another identified resident's room and was observed to be exhibiting responsive behaviours. Staff reported the concern to the Director of Care (DOC).

Review of progress notes for a ten week period for the identified resident, showed seven instances of responsive behaviours. Review of the identified resident's care plan showed interventions had not been in place prior to the incident to address all of the resident's responsive behaviours.

Immediate actions taken to prevent further occurrence included enhanced resident monitoring for the specified timeframe and behavioural charting. In

addition to this, a specified device was implemented to prevent a responsive behaviour.

Review of the home's investigation into this incident documented that police were not notified of the incident.

Three PSWs and one Registered Nurse (RN) said the identified resident occasionally exhibited responsive behaviours towards both staff and residents. Staff stated that with the identified resident's behaviours, they were known to gravitate to the second resident. The RN stated that following this incident interventions were put in place to assist with managing the identified resident's responsive behaviours.

2. From interviews and a review of the identified resident's history of responsive behaviours an alleged incident involving the identified resident and a second resident was noted.

Interviews and a review of the clinical record for the identified resident showed an incident where the identified resident exhibited the same type of responsive behaviour toward a second resident, several months following the first incident. It was observed by a PSW who intervened and separated the two residents. The PSW stated they observed the second resident try to push the identified resident away

The licensee had failed to ensure that two identified residents were protected from abuse by anyone. [s. 19. (1)]

The severity of this issue was a level two, minimal harm or potential for actual harm. The scope of the issue was a pattern as it related to two of four incidents reviewed. The home had a level two history of unrelated non compliance. (659)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 21st day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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