Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2020	2020_740621_0021 (A2)	006280-20, 013760-20, 016666-20, 017445-20, 019403-20, 019491-20, 019534-20, 020965-20	Critical Incident System

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Pinecrest (Kenora)
1220 Valley Drive KENORA ON P9N 2W7

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

Amended by JULIE KUORIKOSKI (621) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Narrative change required to grounds of order for r.49(2), consistent with amendment made in (A1) to inspection finding for same legislation.

Issued on this 18th day of November, 2020 (A2)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Pinecrest (Kenora)
1220 Valley Drive KENORA ON P9N 2W7

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

Amended by JULIE KUORIKOSKI (621) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 19 - 23, and 26 - 29, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

- Seven intakes, regarding resident-to-resident abuse; and

- One intake, regarding falls prevention and management.

Complaint inspection #2020_740621_0020 was conducted concurrently with this CIS inspection.

Findings of non-compliance related to Ont. Reg. 79/10, s. 8 (1) (b), will be found in Complaint inspection #2020_740621_0020.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Nurse Practitioner (NP), the Registered Dietitian (RD), the Outreach Behavioural Support Ontario (BSO) PSW, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff-to-resident, as well as resident-to-resident interactions, reviewed relevant resident health care records, the home's investigation records, BSO consultation notes, and relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **5 WN(s)**
- **0 VPC(s)**
- **2 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident falls, that the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director for a resident fall with injury. On review of falls documentation, the resident was found to have also had a specified number of falls one month prior. While safety reports for these falls was found, a clinically appropriate post falls assessment for each fall was not found. During an interview with the DOC, they reported that registered staff completed a “PN-IF” note in the resident’s EMR after each fall, however, this report did not serve as a clinically appropriate post falls assessment tool.

Sources: resident's plan of care, including “PN-IF” notes for a specific number of dates; minutes of the Falls Committee for specified dates, a policy; interviews with DOC and other staff. [s. 49. (2)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with 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 steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #006, and other specified residents, by identifying factors, based on interdisciplinary assessments, and on information provided to the licensee or staff through observation, that could potentially have triggered such altercations.

During a review of CIS reports submitted by the home to the Director, it was identified that resident #006 was involved in altercations with resident's #007 and #008 on specified dates in September 2020, and resident #011 on a specified date in October 2020. A PSW, as well as a specified number of RPNs indicated that resident #006 could be triggered by co-residents for specified reasons, and that resident #007 was known to trigger to resident #006. These known triggers however, were not identified in resident #006's care plan. Resident #006 was also observed on multiple occasions during the inspection, in certain proximity to resident #007, within a specific location of the home, with no staff present.

The Outreach BSO PSW was found to have provided recommendations in October 2020, for resident #006, in an attempt to minimize the risk of resident-to-resident altercations, including the use of a specific number of safety interventions for resident #006. At the time inspection, these interventions had not been trialed. The DOC confirmed that the home had not attempted to implement the suggestions made by the Outreach BSO PSW at that time, and on a subsequent date in October 2020, another altercation with injury was identified between resident #006 and #011. Consequently, there was actual harm to residents #007, #008, and #011, as a result of the licensee not taking steps to identify factors for resident #006's responsive behaviours.

Sources: CIS reports; resident #006's healthcare record, and Outreach BSO PSW consultation notes; observations; interviews with a PSW, RPNs, the Outreach BSO PSW, DOC, and other staff. [s. 54. (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that allegations of abuse were immediately reported to the Director.

A review of the home's CIS report to the Director identified that on a date in September 2020, for a resident-to-resident altercation, resulting in injury. The CIS report was not submitted until a specified number of days later, and it indicated that the after-hours pager was not contacted. An RN indicated that they had not called the after-hours pager to report the resident-to-resident abuse, and the DOC indicated that they had not immediately submitted the CIS report. Additionally, on a subsequent date in September 2020, the resident perpetrator was witnessed in an altercation with the same resident, which resulted in another injury. The additional CIS report was not submitted until a specified number of days later. An RPN reported that they had immediately informed the DOC of the incident, however, the DOC indicated that the incident had not been immediately reported to the Director, and should have been.

Sources: CIS reports; policy titled "Critical incident Reporting"; interviews with an RPN, an RN, the DOC and other staff. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program had been evaluated annually and updated in accordance with evidence-based practices, or prevailing practices.

The Inspector reviewed the home's policy titled "Responsive Behaviour Program". In separate interviews with the ADOC and DOC, they both indicated that based on the policy, the responsive behaviour program had not been evaluated or updated in 2018, or 2019, and should have been.

Sources: License's policy titled "Responsive Behaviour Program"; interviews with the ADOC, DOC, and other staff. [s. 53. (3) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report submitted to the Director related to resident-to-resident abuse included the outcome of the incident.

On review of a CIS report submitted to the Director for a fall of a resident, as a result of an altercation with another resident, was identified to have not been amended with details concerning the outcome of the incident. An interview with an RPN identified that the resident had a significant change in condition post fall. Further, progress notes for the resident indicated that, the significant change in condition occurred a specified number of days after the fall incident. The DOC indicated that they were unaware of the requirement to amend the CIS report with the outcome or status of the resident(s) involved in the incident.

Sources: CIS report; progress notes for the resident who fell; interviews with an RPN, the DOC and other staff. [s. 104. (1) 3.]

Issued on this 18th day of November, 2020 (A2)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE KUORIKOSKI (621) - (A2)
Inspection No. / No de l'inspection :	2020_740621_0021 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006280-20, 013760-20, 016666-20, 017445-20, 019403-20, 019491-20, 019534-20, 020965-20 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 18, 2020(A2)
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	Pinecrest (Kenora) 1220 Valley Drive, KENORA, ON, P9N-2W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kevin Queen

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Board of Management of the District of Kenora, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must comply with s. 49 (2) of O. Reg. 79/10.

Additionally, the licensee must:

a) Provide education to all registered nursing staff on how to complete the required elements of a post-fall assessment consistent with evidence based practice, and the home's falls program policy;

b) Ensure immediate follow up action is documented in the resident's plan of care, for any and all risk areas identified from the post-fall assessment, as a result of a resident fall; and

c) Develop and implement a process for auditing the completion of resident post-fall assessments, to ensure timely action and that any and all risk areas identified for each resident are addressed. The home is to keep a record of audits completed, including the date of audit, person completing the audit, any discrepancies found and actions taken.

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

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that when a resident falls, that the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director for a resident fall with injury. On review of falls documentation, the resident was found to have also had a specified number of falls one month prior. While safety reports for these falls was found, a clinically appropriate post falls assessment for each fall was not found. During an interview with the DOC, they reported that registered staff completed a "PN-IF" note in the resident's EMR after each fall, however, this report did not serve as a clinically appropriate post falls assessment tool.

Sources: resident's plan of care, including "PN-IF" notes for a specific number of dates; minutes of the Falls Committee for specified dates, a policy; interviews with DOC and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident #001.

Scope: The scope of this non-compliance was wide spread with three out of three (100%) of resident falls affected.

Compliance History: One voluntary plan of correction (VPC) was issued to the home related to s. 49 (2) in the past 36 months. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

The licensee must comply with s. 54 of O. Reg. 79/10.

Additionally, the licensee must:

a) Ensure that steps are taken to prevent resident-to-resident altercations involving resident #006 and other residents;

b) Develop a tracking system to ensure that identified triggers for resident #006, and any other resident displaying responsive behaviours, is identified in the resident's care plan;

c) Develop an internal system to ensure that recommendations from the BSO team for residents are trialled; and

d) Trial recommendations made by the BSO team for resident #006, and keep track of their effectiveness.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #006, and other

specified residents, by identifying factors, based on interdisciplinary assessments, and on information provided to the licensee or staff through observation, that could potentially have triggered such altercations.

During a review of CIS reports submitted by the home to the Director, it was identified that resident #006 was involved in altercations with resident's #007 and #008 on specified dates in September 2020, and resident #011 on a specified date in October 2020. A PSW, as well as a specified number of RPNs indicated that resident #006 could be triggered by co-residents for specified reasons, and that resident #007 was known to trigger to resident #006. These known triggers however, were not identified in resident #006's care plan. Resident #006 was also observed on multiple occasions during the inspection, in certain proximity to resident #007, within a specific location of the home, with no staff present.

The Outreach BSO PSW was found to have provided recommendations in October 2020, for resident #006, in an attempt to minimize the risk of resident-to-resident altercations, including the use of a specific number of safety interventions for resident #006. At the time inspection, these interventions had not been trialed. The DOC confirmed that the home had not attempted to implement the suggestions made by the Outreach BSO PSW at that time, and on a subsequent date in October 2020, another altercation with injury was identified between resident #006 and #011. Consequently, there was actual harm to residents #007, #008, and #011, as a result of the licensee not taking steps to identify factors for resident #006's responsive behaviours.

Sources: CIS reports; resident #006's healthcare record, and Outreach BSO PSW consultation notes; observations; interviews with a PSW, RPNs, the Outreach BSO PSW, DOC, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident's #007, #008 and #011 by resident #006.

Scope: The scope of this non-compliance was wide spread, with three out of three (100%) of resident's who were inspected, being affected.

Compliance History: The licensee was found to be non-compliance with different

sections of the legislation within the past 36 months. (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of November, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JULIE KUORIKOSKI (621) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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