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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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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
Nov 15, 2017	2017_535557_0010	024938-17	Critical Incident System

Licensee/Titulaire de permis

THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

THE PINES
98 PINE STREET BRACEBRIDGE ON P1L 1N5

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

VALERIE PIMENTEL (557)

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): November 1 and 2, 2017

Log #024938-17: related to a fall with injury,

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Service Manager (EMS), Physio Therapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Maintenance Workers.

During the course of the inspection, the inspectors conducted observation in home and residents' area, observation of care delivery processes and review of the home's policies and procedures, and the resident's health record.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with: All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The home submitted a Critical Incident Report (CI), on an identified day in 2016, indicating that an identified resident had a fall. The resident was found lying on the ground in an identified courtyard located within an identified home area. The CI indicated the resident entered the unlocked identified courtyard through the doors off of the lounge area in the identified home area. The CI further indicated that the resident fell face forward from a loss of balance or from the weight of the identified courtyard door.

Record review of the identified resident revealed he/she had an identified Cognitive Performance Scale (CPS) score and a diagnosis of an identified cognitive impairment. It was identified that he/she may require supervision of one staff to provide oversight, encouragement and cuing to assist the resident to ambulate with an ambulatory assistive

device. At the time of the incident the resident was using his/her ambulatory assistive device independently. The progress notes identified the resident was found lying on his/her stomach. The ambulatory assistive device was on the ground beside him/her and the identified courtyard door was closed behind him/her. A second assistive device had caused an injury to an identified body part, as well as, he/she obtained an alteration to his/her skin integrity and to three other identified body parts.

Review of the home's policy, titled: "Secure Outdoor Areas and Balconies", policy reference #: OPER-04-02-09, review date June 2014, identified all doors leading to secured outdoor area and balcony must be equipped with locks and be locked during times specified by the home. The policy further identified the time frames the doors are too be opened and locked must be posted on or near the entrances. The inspector did not observe any signs posted to reveal when the doors are too be opened and or locked in the secured courtyard.

Review of the home's written note by an identified registered staff nurse that was given to the director of care (DOC), identified he/she was at the computer in the nursing station when he/she observed the resident walk by using his/her ambulatory assistive device without any issues and walked over to the courtyard doors. The identified registered staff nurse did not see the identified resident go through the unlocked door out into the identified courtyard. The identified registered staff nurse identified he/she went to look for the resident and was found lying on the ground outside and his/her ambulatory assistive device was in front of them. The inspector was not able to reach identified registered staff nurse by telephone and therefore, was not able to interview him/her.

Interview with a second identified registered staff nurse confirmed that the evening charge nurse checks and locks the courtyard door during the door check rounds at approximately 2030 hours (hrs) and indicated the doors are normally unlocked during the nice weather. He/she indicated that after the identified incident the doors were always locked unless a staff member or program was attended and supervised by someone.

Interview with identified staff member identified that the identified resident was ambulatory with his/her ambulatory assistive device and that the staff supervised through observation of the resident walking in the hallways when present. He/she further identified the resident was not a high risk for falls. The identified staff member confirmed the door to the courtyard was not locked nor was it supervised at the time of the incident.

The inspector and an identified service worker observed the functioning mechanism of

the installed safety intervention on the handicapped exit door to the identified courtyard where the incident with the identified resident occurred. The inspector observed where the surface met with the door was level. The surface was flush with a small gap approximately a quarter inch between where the building ends and the outdoor surface meets.

Interview with a second identified service worker revealed after the time of the incident on the identified day in 2016, with the identified resident, he/she was paged to the home area to test the door to the identified courtyard. He/she indicated that he/she readjusted the timing on the door closure to make it longer, as the timing of the door may have contributed to the resident's fall which occurred at the entrance into the courtyard. He/she further identified that a contractor was called in to identify options for safety interventions.

Interview with DOC identified the home was not sure what caused the identified resident to fall, he/she suggested that the door was heavy and the resident may have been identified on the frail side in comparison to the weight of the exit door. He/she further identified through the discussion that the weight of the door may have caused the incident, the wind may have caught and blown the door closed as he/she thought it was windy that day, and or the resident because of these two possibilities lost his/her balance and fell.

The DOC confirmed the identified registered staff nurse had a key to the courtyard, as well as, a second identified registered staff nurse to lock and or unlock the door to the identified courtyard and revealed it is the activation program that normally unlocks the door to the identified courtyard as they provide programing outdoors in the identified courtyard. The DOC confirmed the door to the identified courtyard was not locked nor was the courtyard supervised at the time of the incident.

Interview with the Administrator confirmed the identified courtyard is equipped with locks but the doors were not kept locked during the day at the time of the incident nor were there staff supervising the courtyard. He/she further explained the home wanted to allow the residents' to have a sense of autonomy and be able to use the courtyard when they wanted. He/she further indicated since the incident the home has installed a safety intervention on the door so that when it senses anything in the way of the door closing, the door will re-open and not come into contact with the object that may prevent the door from closing. He/she confirmed that the door to the courtyard was not locked and did not restrict access to the courtyard when there was no supervision by staff at the time of injury to the identified resident.

The severity of harm was actual harm to the resident, the home failed to lock the doors that lead to the identified courtyard in order to prevent the resident from entering the unsupervised courtyard. The resident on an identified day in 2016, entered the courtyard and was found on the ground. The resident sustained multiple severe injuries to an identified body part and passed away on an identified day in 2016, as complications related to a fall. A review of the compliance history identified the non-compliance's were unrelated. The scope was isolated. [s. 9. (1) 1.1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

The home submitted a CI, on an identified day in 2016, indicating that and identified resident had a fall. The identified resident was found lying on the ground in the identified courtyard in an identified home area. The CI indicated the resident entered the unlocked courtyard through the doors off of the identified lounge area.

Review of the home's Administration manual, Environmental Health and Safety, titled:

"Secure Outdoor Areas and Balconies", policy reference #: OPER-04-02-09, review date June 2014, identified all doors leading to secured outdoor area and balcony must be equipped with locks and be locked during times specified by the home and by whom. The policy further identified the time frames the doors are too be opened and locked must be posted on or near the entrances.

Observation of the identified secured courtyard confirmed the doors to the identified courtyard are equipped with locks, however, there was no posted times of when the doors are to be locked and unlocked on or near the entrance to the identified courtyard.

Interview with the Administrator confirmed there were no posted signs indicating when the identified courtyard is to be locked and unlocked on or near the entrance to the identified courtyard and confirmed the policy was incomplete as the home had not completed and filled in the identified locations that were to be locked, at what time and by whom.

The home's Administration manual, Environmental Health and Safety, subject "Security", policy reference #: ADMI-04-02-01, review date December 2002, identified all staff to monitor all exit doors and doors to the stairwells, the charge nurse is to conduct inspection rounds of the facility twice on each of the evening an night shift following the night checklist, and document on the surveillance tool.

The home's Resident Care manual, subject "Nurse in Charge Job Routine 1430-2245 for all units", policy #: 01-21-01-B and the "Nurse in Charge Job Routine 2230-0645 for all units", policy #: 01-21-01-C, review date March 2013, identified the nurse in charge is to complete a building security round and ensure all doors/balconies and courtyards are locked and to sign off the door check sheets. This is done once by the evening nurse in charge at 2030 hours (hrs) and once by the night nurse in charge at 2300 hrs.

Interview with the assistant director of care (ADOC) confirmed the home uses a Door Checks checklist. He/she produced the checklist for the identified home area for the identified month in 2016. The surveillance checklists was completed once a shift by the evening and night nurse in charge and includes the identified courtyard on the identified home area. He/she confirmed that the nurse in charge does not check the doors more than once on the evenings and night shift.

The ADOC, DOC and the Administrator confirmed that the above identified polices were not complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place is complied with,, to be implemented voluntarily.

Issued on this 27th day of November, 2017

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) :	VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2017_535557_0010
Log No. / No de registre :	024938-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 15, 2017
Licensee / Titulaire de permis :	THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA 98 Pine Street, BRACEBRIDGE, ON, P1L-1N5
LTC Home / Foyer de SLD :	THE PINES 98 PINE STREET, BRACEBRIDGE, ON, P1L-1N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Katheine Rannie

To THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA, 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 :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. The licensee shall provide a plan to the inspector on how the home will ensure that no resident will enter a secured courtyard within the home unsupervised.

2. The plan must also include how staff will be educated, on the home's plan as mentioned in step 1.

3. The plan must also include a review of the home's corporate policies and procedures related to secure outdoor areas and are individualized to the home in order to meet the requirements of the Long Term Care Act and Regulations.

4. Minutes of the policy review and attendance of the required staff education to be documented and maintained.

5. The plan(s) shall include time lines and the name of the person(s) responsible for completing the tasks and the time lines for completion. The plan shall be submitted on or before November 30, 2017, to valerie.pimentel@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the following rules are complied with: All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The home submitted a Critical Incident Report (CI), on an identified day in 2016, indicating that an identified resident had a fall. The resident was found lying on the ground in an identified courtyard located within an identified home area. The CI indicated the resident entered the unlocked identified courtyard through the doors off of the lounge area in the identified home area. The CI further indicated that the resident fell face forward from a loss of balance or from the weight of the identified courtyard door.

Record review of the identified resident revealed he/she had an identified Cognitive Performance Scale (CPS) score and a diagnosis of an identified cognitive impairment. It was identified that he/she may require supervision of one staff to provide oversight, encouragement and cuing to assist the resident to ambulate with an ambulatory assistive device. At the time of the incident the

resident was using his/her ambulatory assistive device independently. The progress notes identified the resident was found lying on his/her stomach. The ambulatory assistive device was on the ground beside him/her and the identified courtyard door was closed behind him/her. A second assistive device had caused an injury to an identified body part, as well as, he/she obtained an alteration to his/her skin integrity and to three other identified body parts.

Review of the home's policy, titled: "Secure Outdoor Areas and Balconies", policy reference #: OPER-04-02-09, review date June 2014, identified all doors leading to secured outdoor area and balcony must be equipped with locks and be locked during times specified by the home. The policy further identified the time frames the doors are too be opened and locked must be posted on or near the entrances. The inspector did not observe any signs posted to reveal when the doors are too be opened and or locked in the secured courtyard.

Review of the home's written note by an identified registered staff nurse that was given to the director of care (DOC), identified he/she was at the computer in the nursing station when he/she observed the resident walk by using his/her ambulatory assistive device without any issues and walked over to the courtyard doors. The identified registered staff nurse did not see the identified resident go through the unlocked door out into the identified courtyard. The identified registered staff nurse identified he/she went to look for the resident and was found lying on the ground outside and his/her ambulatory assistive device was in front of them. The inspector was not able to reach identified registered staff nurse by telephone and therefore, was not able to interview him/her.

Interview with a second identified registered staff nurse confirmed that the evening charge nurse checks and locks the courtyard door during the door check rounds at approximately 2030 hours (hrs) and indicated the doors are normally unlocked during the nice weather. He/she indicated that after the identified incident the doors were always locked unless a staff member or program was attended and supervised by someone.

Interview with identified staff member identified that the identified resident was ambulatory with his/her ambulatory assistive device and that the staff supervised through observation of the resident walking in the hallways when present. He/she further identified the resident was not a high risk for falls. The identified staff member confirmed the door to the courtyard was not locked nor was it supervised at the time of the incident.

The inspector and an identified service worker observed the functioning mechanism of the installed safety intervention on the handicapped exit door to the identified courtyard where the incident with the identified resident occurred. The inspector observed where the surface met with the door was level. The surface was flush with a small gap approximately a quarter inch between where the building ends and the outdoor surface meets.

Interview with a second identified service worker revealed after the time of the incident on the identified day in 2016, with the identified resident, he/she was paged to the home area to test the door to the identified courtyard. He/she indicated that he/she readjusted the timing on the door closure to make it longer, as the timing of the door may have contributed to the resident's fall which occurred at the entrance into the courtyard. He/she further identified that a contractor was called in to identify options for safety interventions.

Interview with DOC identified the home was not sure what caused the identified resident to fall, he/she suggested that the door was heavy and the resident may have been identified on the frail side in comparison to the weight of the exit door. He/she further identified through the discussion that the weight of the door may have caused the incident, the wind may have caught and blown the door closed as he/she thought it was windy that day, and or the resident because of these two possibilities lost his/her balance and fell.

The DOC confirmed the identified registered staff nurse had a key to the courtyard, as well as, a second identified registered staff nurse to lock and or unlock the door to the identified courtyard and revealed it is the activation program that normally unlocks the door to the identified courtyard as they provide programing outdoors in the identified courtyard. The DOC confirmed the door to the identified courtyard was not locked nor was the courtyard supervised at the time of the incident.

Interview with the Administrator confirmed the identified courtyard is equipped with locks but the doors were not kept locked during the day at the time of the incident nor were there staff supervising the courtyard. He/she further explained the home wanted to allow the residents' to have a sense of autonomy and be able to use the courtyard when they wanted. He/she further indicated since the incident the home has installed a safety intervention on the door so that when it senses anything in the way of the door closing, the door will re-open and not

come into contact with the object that may prevent the door from closing. He/she confirmed that the door to the courtyard was not locked and did not restrict access to the courtyard when there was no supervision by staff at the time of injury to the identified resident.

The severity of harm was actual harm to the resident, the home failed to lock the doors that lead to the identified courtyard in order to prevent the resident from entering the unsupervised courtyard. The resident on an identified day in 2016, entered the courtyard and was found on the ground. The resident sustained multiple severe injuries to an identified body part and passed away on an identified day in 2016, as complications related to a fall. A review of the compliance history identified the non-compliance's were unrelated. The scope was isolated.
(557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

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 15th day of November, 2017

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 : Valerie Pimentel

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