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
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Public Copy/Copie 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
Oct 21, 2021	2021_745690_0021	010438-21, 010954-21, 011085-21, 011380-21	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

TRACY MUCHMAKER (690), CHAD CAMPS (609)

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): September 27-29, October 1, and October 4-8, 2021.

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

-One intake, related to a fall with injury, and transfer to hospital that resulted in a significant change in the resident's health status, and

-Three intakes, related to allegations of resident to resident abuse.

A Complaint inspection #2021_745690_0020 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Staff Scheduler, Physiotherapist, Environmental Services Manager, Behavioural Supports Ontario Staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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 a specified strategy was implemented to respond to a resident's demonstrated responsive behaviours.

a) A resident, was prescribed an identified medication to be given as needed in response to identified responsive behaviours. The resident was given the medication on an identified date for a specified type of responsive behaviour, which was found to be ineffective. The resident's behaviours continued to escalate, and the resident was having identified responsive behaviours towards a staff member and other residents. The resident later was found in a co-resident's room demonstrating a responsive behaviour towards the resident, which caused pain and injury to the co-resident.

The resident's plan of care indicated that a specified strategy was to be implemented for a specified type of responsive behaviour. Registered staff indicated that when the resident could not be redirected or required distraction, the specified strategy should be implemented. Only after the co-resident was injured was the specified strategy implemented.

The Director of Care (DOC) verified that staff should have implemented the specified strategy on that day in response to the resident's demonstrated responsive behaviours prior to the incident.

b) Five days later, the resident was given the specified medication for escalating responsive behaviours. Approximately two hours later, the resident was found in a co-resident's room demonstrating a responsive behaviour towards them which caused an

injury to the co-resident. The home's policy required consistent implementation of behavioural interventions, yet the resident did not have the strategy implemented when they were able to enter the co-resident's room and cause the injury.

c) During the inspection, the Inspector observed the resident for one hour. They were seen demonstrating responsive behaviours, after they entered a co-resident's room. Soon after, a staff member entered the room and brought the resident to another location and left them alone.

The resident continued to demonstrate specified responsive behaviours in a specified location. A staff member noticed the resident four minutes later, provided care and brought the resident to another location. The resident was left alone again, and continued to demonstrate responsive behaviours, towards co-residents in the area that staff took them to. A staff member passed by, noticed, and distracted them away from the co-resident. At no time during the increasing responsive behaviours was the specified strategy provided to the resident.

Despite the resident’s need for specified strategy, the DOC had not attempted to provide the specified strategy because they felt there was no staff available to provide the strategy.

The home’s failure to ensure the specified strategy was consistently implemented to respond to the resident's demonstrated responsive behaviours on the three identified dates, resulted in actual harm to two residents, and actual risk of harm to two other residents.

Sources: Observations of a resident, Two Critical Incident System (CIS) reports, a resident's electronic/paper clinical records and plan of care report, staffing records, the home’s policy titled “Responsive Behaviours” #RC-17-01-04 last updated December 2020, interviews with a resident, the Scheduler, a PSW, a Registered Practical Nurse (RPN), and the DOC. [s. 53. (4) (b)]

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's identified fall prevention intervention was provided to the resident as specified in their plan of care.

During the inspection, the Inspector observed a resident's bed and found a fall prevention intervention in place, however the intervention was not implemented correctly and not working properly. RPN staff verified to the inspector that the intervention was not implemented correctly and not working properly at the time.

The resident's plan of care required that the identified fall prevention intervention be provided to the resident, and that it had been in place for over two months. The Administrator verified that the intervention was not provided as specified in the resident's plan of care nor as the home's policy required, and that they would be fixing it right away.

The home's failure to ensure that a resident's fall prevention intervention was provided as specified in their plan of care presented actual risk of harm to the resident.

Sources: Observations of a resident's room, a resident's plan of care report, the home's policy titled "Fall Prevention and Management Program" #RC-15-01-01 last updated December 2020, interviews with an RPN and the Administrator. [s. 6. (7)]

2. The licensee has failed to ensure staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

a) Two CIS reports were submitted to the Director related to injuries that two residents sustained because of a resident’s responsive behaviours. The plan of care for the resident at the time of the injuries indicated that staff were to refer to the plan of care interventions from an external agency.

PSW staff acknowledged that they were unaware of what the interventions were identified by the external agency for the resident and verified they did not know where to access them.

Sources: Two CIS reports, a resident’s electronic/paper clinical records and plan of care report, the home’s policy titled “Plan of Care” #RC-05-01-01 last updated June 2021, interviews with PSW staff, RPN staff and the DOC.

b) Two CIS reports were submitted to the Director related to injuries that two residents sustained because of a different resident’s responsive behaviours. The plan of care for the resident at the time of the injuries indicated that staff were to refer to the plan of care interventions from an external agency.

PSW staff acknowledged that they were unaware of what interventions were in place as per the plan of care from the external agency for this resident, and verified they did not know where to access them. RPN staff indicated that only registered staff could access the interventions from the external agency in the electronic health records, which was not accessible to the other direct care staff. The DOC acknowledged that PSW staff did not have convenient and immediate access to the resident's responsive behaviour plan of care interventions.

The home’s failure to ensure that all direct care staff had convenient and immediate access to two resident's interventions in the external agencies plan of care, presented actual risk of harm to residents from their responsive behaviours.

Sources: Two CIS reports, a resident’s electronic/paper clinical records and plan of care report, the home’s policy titled “Plan of Care” #RC-05-01-01 last updated June 2021, interviews with a PSW, an RPN, and the DOC. [s. 6. (8)]

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 care is provided to residents as per the plan of care, and that staff who provide direct care to residents are kept aware of the contents of the plan of care and have convenient and immediate access to it, to be implemented voluntarily.

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of one resident by another resident that resulted in harm or a risk of harm was immediately reported to the Director.

Pursuant to the Long-Term Care Homes Act (LTCHA) 2007, c. 8, s.152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

On an identified date and time, a resident had been found demonstrating responsive behaviours towards a co-resident causing an injury to the co-resident, that an RN had to provide a treatment for. The Director was notified of the incident by the RN through the After-Hours Infoline 19.5 hours later, when the resident began displaying specified symptoms. The DOC verified that the incident should have been immediately reported to the Director.

The home’s failure to ensure that the RN immediately reported grounds to suspect abuse of a resident to the Director presented minimal risk of harm to the resident.

Sources: A CIS report, and After-Hours notification record, Licensee Reporting of Physical Abuse Decision Tree, dated May 2012, home’s policy titled “Zero Tolerance of Resident Abuse and Neglect: Response and Reporting” #RC-02-01-02 last updated June 2021, and an interview with the DOC. [s. 24. (1) 2.]

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 person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm, immediately reported the suspicion to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified that a resident's personal belonging was broken and required repair.

During the inspection, a resident was observed to be without a specified personal belonging applied, as indicated in the resident's plan of care. The resident's personal belonging was found in a specified area on the unit, and was broken. RPN staff verified that the resident's specified personal belonging had been broken for months and that family should have been notified. A review of the resident's clinical records found no mention that the resident's personal belonging being broken or that the SDM was notified.

The Administrator verified that the specified personal belonging was broken, that their SDM should have been notified, and indicated they would ensure that the personal belonging would be repaired.

The home's failure to ensure that the resident's SDM was notified of their broken personal belonging and the need for repair presented actual risk of harm to the resident who had a specified diagnosis and was at risk of falls.

Sources: Observations of a resident, the resident's electronic clinical records and plan of care report, interviews with RPN staff, and the Administrator. [s. 38. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the SDM of a resident was notified when personal items required repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that that all hazardous cleaning substances at the home were always kept inaccessible to residents.

During the inspection, the Inspector observed an unlocked, unattended cleaning cart on the first floor beside the home’s bistro. The cart contained chemicals that were labelled as potentially hazardous substances. Approximately 10 minutes later the Environmental Services Manager (ESM) passed by and verified that the cart should have been locked when not in use or if they were unattended. Housekeeping staff outlined how they were “swamped” with work and had forgotten to lock the cart as the home’s policy required.

The home's failure to ensure that hazardous substances were always kept inaccessible to residents presented a minimal risk of harm to residents.

Sources: Observations of the cart, the home’s policy titled "Housekeeping Cart" #HL-05-01-06 last updated February 2021, interviews with a Housekeeper and the ESM. [s. 91.]

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 all hazardous substances in the home are kept inaccessible to residents at all times, to be implemented voluntarily.

Issued on this 22nd day of October, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY MUCHMAKER (690), CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2021_745690_0021
Log No. / No de registre :	010438-21, 010954-21, 011085-21, 011380-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 21, 2021
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 :	Jennifer Ridgley

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(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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 53 (4) (b).

Specifically, the licensee shall:

a) Ensure that strategies are implemented in response to a resident's demonstrated responsive behaviours.

b) Ensure that alternative strategies are implemented if a specified strategy is no longer effective or the home is unable to implement the strategy in response to the resident's demonstrated responsive behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure that a specified strategy was implemented to respond to a resident's demonstrated responsive behaviours.

a) A resident, was prescribed an identified medication to be given as needed in response to identified responsive behaviours. The resident was given the medication on an identified date for a specified type of responsive behaviour, which was found to be ineffective. The resident's behaviours continued to escalate, and the resident was having identified responsive behaviours towards a staff member and other residents. The resident later was found in a co-resident's room demonstrating a responsive behaviour towards the resident,

which caused pain and injury to the co-resident.

The resident's plan of care indicated that a specified strategy was to be implemented for a specified type of responsive behaviour. Registered staff indicated that when the resident could not be redirected or required distraction, the specified strategy should be implemented. Only after the co-resident was injured was the specified strategy implemented.

The Director of Care (DOC) verified that staff should have implemented the specified strategy on that day in response to the resident's demonstrated responsive behaviours prior to the incident.

b) Five days later, the resident was given the specified medication for escalating responsive behaviours. Approximately two hours later, the resident was found in a co-resident's room demonstrating a responsive behaviour towards them which caused an injury to the co-resident. The home's policy required consistent implementation of behavioural interventions, yet the resident did not have the strategy implemented when they were able to enter the co-resident's room and cause the injury.

c) During the inspection, the Inspector observed the resident for one hour. They were seen demonstrating responsive behaviours, after they entered a co-resident's room. Soon after, a staff member entered the room and brought the resident to another location and left them alone.

The resident continued to demonstrate specified responsive behaviours in a specified location. A staff member noticed the resident four minutes later, provided care and brought the resident to another location. The resident was left alone again, and continued to demonstrate responsive behaviours, towards co-residents in the area that staff took them to. A staff member passed by, noticed, and distracted them away from the co-resident. At no time during the increasing responsive behaviours was the specified strategy provided to the resident.

Despite the resident's need for specified strategy, the DOC had not attempted to provide the specified strategy because they felt there was no staff available to provide the strategy.

The home's failure to ensure the specified strategy was consistently implemented to respond to the resident's demonstrated responsive behaviours on the three identified dates, resulted in actual harm to two residents, and actual risk of harm to two other residents.

Sources: Observations of a resident, Two Critical Incident System (CIS) reports, a resident's electronic/paper clinical records and plan of care report, staffing records, the home's policy titled "Responsive Behaviours" #RC-17-01-04 last updated December 2020, interviews with a resident, the Scheduler, a PSW, a Registered Practical Nurse (RPN), and the DOC. [s. 53. (4) (b)]

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

Severity: Actual harm was identified related to a resident's demonstrated responsive behaviours towards two residents, and risk of harm towards two different residents.

Scope: The scope of this non-compliance was isolated, as it affected one resident that was reviewed.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with Ontario Regulation 79/10 s. 53 (4) (b), and one Voluntary Plan of Correction (VPCs) was issued to the home. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tracy Muchmaker

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