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

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
Télécopieur: (705) 564-3133

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
Apr 24, 2018	2018_565647_0012	012380-17, 012383-17	Follow up

Licensee/Titulaire de permis

Lakeland Long Term Care Services Corporation
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care Services
6 Albert Street PARRY SOUND ON P2A 3A4

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

JENNIFER BROWN (647), MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 9 - 12, 2018.

This inspection was related to a follow up inspection for Compliance Order #001 that was served on June 14, 2017, from Inspection report #2017_616542_0005, related to s. 6. (7) plan of care, and Compliance Order #002 that was served on June 14, 2017, from Inspection report #2017_616542_0005, related to s. 6. (10)(b)(c) plan of care.

A Complaint Inspection, #2018_565647_0010 and a Critical Incident Inspection, #2018_565647_0011, were conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Social Service Worker, Behaviour Response Lead, Supervisor of Support Services, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Residents, Family Members and Substitute Decision Makers.

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

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2017_616542_0005	679

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Compliance order CO #001 from inspection #2017_616542_0005 was served on June 14, 2017, with a compliance date of July 14, 2017, ordered the licensee to:

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 6. (7).

Specifically, the licensee shall ensure that:

a) Ensure that resident #010 is provided with proper continence care in order to maintain their level of comfort, is offered three meals a day everyday and provided with any nutritional supplements according to their plan of care.

b) Ensure that resident #011 receives oral hygiene care and prevention of fall interventions as specified in their plan of care.

c) Ensure that all care plans are based on individual resident care needs.

The licensee completed steps (a), (b), and (c) in CO #001.

While the licensee complied steps (a), (b), and (c), additional findings of non-compliance were identified.

A Critical Incident (CI) report was submitted to the Director on an identified date, alleging improper care to resident #001 from Registered staff member #110. The report indicated that Registered staff member #110 had used an inappropriate intervention to resident #001, to prevent them from exhibiting a responsive behaviour, during an identified shift

and date.

Inspector #627 reviewed the care plan in effect at the time of the alleged incident which indicated that staff were to monitor resident #001 for an increase in responsive behaviours, and if present, staff were to re-approach resident #001 at a later time.

Inspector #627 reviewed the home's investigation notes which indicated that Personal Support Worker (PSW) #109 had reported that Registered staff member #110 had been afraid that resident #001 was going to exhibit responsive behaviours, so the Registered staff member used an inappropriate intervention to manage the responsive behaviours and provide care. The same investigation notes also revealed that Registered staff member #110 had reported that they had tried to stop the resident from exhibiting responsive behaviours by using the inappropriate intervention. The Registered staff member indicated that they hadn't known what else to do at the time to help the PSW from being exposed to the responsive behaviours by the resident.

Inspector #627 interviewed PSW #104 who stated that resident #001 exhibited responsive behaviours frequently when staff attempted to provide care. When the resident demonstrated responsive behaviours, staff were to ensure that the resident was safe, leave and re-approach at a later time.

Inspector #627 interviewed Registered staff member #111 who stated that they had been made aware of an incident of improper care by Registered staff member #110 to resident #001. Registered staff member #111 indicated that resident #001 exhibited many responsive behaviours since their admission. Staff were to walk away after ensuring the resident was safe and return later to provide the care. It was very standard to stop and re-approach resident #001 when providing care to them, and that they were often more accepting of the care at a later time. This was indicated in the care plan.

Inspector #627 interviewed the Acting Director of Care (DOC) who stated that it was determined during the investigation that Registered staff member #110 had used an inappropriate intervention to resident #001 to prevent them from exhibiting the responsive behaviours. When resident #001 exhibited responsive behaviours during care, the directives in the care plan were to leave and re-approach at a later time, thereby, giving the resident time to calm down. The Acting DOC acknowledged that Registered staff member #110 had not provided care to resident #001 as indicated in the resident's care plan. [s. 6. (7)]

2. A CI report was submitted to the Director on an identified date, for an alleged incident of abuse/neglect.

A review of the CI report by Inspector #684 indicated that at an identified date and time, resident #004 had been upset and reported to the Acting DOC that two PSW's later identified as #119 and #120, forced resident #004 to use a specific assistive device to transfer. Resident #004 reported to a family member that they did not want to use the assistive device and that it was painful.

Inspector #684 reviewed the investigation notes post incident. The investigation notes identified that the Acting DOC met with PSW #119, the PSW admitted to using a specific assistive device with resident #004 despite the care plan stating they did not require it, and that they did not read resident #004's care plan.

The investigation notes further identified that on an identified date, the Acting DOC also met with PSW #120. PSW #120 indicated that they attempted to get resident #004 to transfer but resident #004 was too tired to stand. The PSW admitted that they did not read the care plan and they do not know what transfer care plan for resident #004 stated.

The Inspector reviewed resident #004's care plan which indicated that the resident needed specific assistance and use of a different assistive device for transferring.

Inspector #684 reviewed the Policy for: Care Plan, RSL-DOC-045, last reviewed in December 2017. Purpose: The care plan shall give clear directions to direct care staff providing care to the resident.

During an interview with Inspector #684 the Acting DOC confirmed that during the abuse investigation both PSW's #119 and #120 admitted to the Acting DOC that they did not provide the care as set out in the plan for resident #004 related to transfers. [s. 6. (7)]

3. A CI report was submitted to the Director, indicating that there had been an incident to a resident, that resulted in injury, transfer to hospital, and later the resident was diagnosed with a fracture.

A review of the CI report by Inspector #647, indicated that resident #020 had been assisted to bed on an identified date and time. Resident #020 had then been found at a later time, on the floor, and upon assessment had complained of pain and had been guarding an identified area on their body. Resident #020 had been transferred to

hospital, and diagnosed with a lower body injury.

The progress notes indicated that the resident had been admitted to the home using an assistive device and required assistance from staff to transfer. The progress notes and admission records further indicated that resident #020 had been utilizing an intervention as part of their plan of care at their previous placement.

Interviews with Registered staff member's #113 and #137 indicated that when the resident had been found on the floor, there had not been the identified interventions in place, which had allowed resident #020 the ability to self transfer without staff assistance. The Registered staff members further indicated that they were aware of the requirement for the identified intervention for resident #020 and acknowledged it had never been implemented as part of the plan of care.

During an interview with the Acting DOC, they acknowledged that the identified intervention had been on resident #020's plan of care however indicated that it had not been implemented. [s. 6. (7)]

4. A CI report was submitted to the Director, for an incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident.

Inspector #679 reviewed the CI report which identified that RPN #118 was made aware by the PSW team that resident #007's incontinence product was found saturated with urine, and that they had identified that they had not been helped to the bathroom after lunch. Resident #008's urinals were full and had not been emptied; and, resident #009 and #010 were found in bed with linens which were wet with urine. The four residents were under the care of PSW #116.

A review of the electronic care plans in place at the time of the incident for resident #007 identified that they required limited assistance related to continence. Resident #008's electronic care plan identified that they utilized an identified intervention to assist with continence. Further, resident #009 and #010 required assistance from staff for their continence needs.

Inspector #679 reviewed a discipline letter which identified allegations that PSW #116 neglected to provide care and assistance to four residents, violating their right to safe and competent care. The letter further identified that the investigation determined that PSW #116 had failed to provide care and assistance to four residents as per their plan of

care.

A review of the written investigation identified that PSW #116 acknowledged that they did not check resident #009's continence needs. When asked if they checked resident #010, PSW #116 identified they went for their break.

In an interview with PSW #140 they identified that the care that resident's #007, #008, #009, and #010 had not been delivered in a manner consistent with their needs specifically relating to continence care as specified in their plan of care.

In an interview with the Acting DOC, they identified that the allegations were found to be credible, and that resident's #007, #008, #009, and #010 did not receive their care at the time in which they were supposed to. The Acting DOC indicated that the home identified that the actions by PSW #116 were not meeting their care needs, as specified in their plan of care. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 1st day of May, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647), MICHELLE BERARDI (679)
Inspection No. / No de l'inspection :	2018_565647_0012
Log No. / No de registre :	012380-17, 012383-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 24, 2018
Licensee / Titulaire de permis :	Lakeland Long Term Care Services Corporation 6 Albert Street, PARRY SOUND, ON, P2A-3A4
LTC Home / Foyer de SLD :	Lakeland Long Term Care Services 6 Albert Street, PARRY SOUND, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve White

To Lakeland Long Term Care Services Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_616542_0005, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6(7) of the LTCHA.

Specifically, the licensee shall ensure:

a) The plan of care for resident #004 relating to lifts and transfers, is provided as specified in the plan.
b) The plan of care for resident's #007, #008, #009, and #010 relating to continence care, is provided as specified in the plan.
c) Fall prevention strategies for all residents at risk of falls are implemented within 24 hours of admission.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Compliance order CO #001 from inspection #2017_616542_0005 was served on June 14, 2017, with a compliance date of July 14, 2017, ordered the licensee to:

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 6. (7).

Specifically, the licensee shall ensure that:

a) Ensure that resident #010 is provided with proper continence care in order to maintain their level of comfort, is offered three meals a day everyday and

provided with any nutritional supplements according to their plan of care.

b) Ensure that resident #011 receives oral hygiene care and prevention of fall interventions as specified in their plan of care.

c) Ensure that all care plans are based on individual resident care needs.

The licensee completed steps (a), (b), and (c) in CO #001.

While the licensee complied steps (a), (b), and (c), additional findings of non-compliance were identified.

A CI report was submitted to the Director, for an incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident.

Inspector #679 reviewed the CI report which identified that RPN #118 was made aware by the PSW team that resident #007's incontinence product was found saturated with urine, and that they had identified that they had not been helped to the bathroom after lunch. Resident #008's urinals were full and had not been emptied; and, resident #009 and #010 were found in bed with linens which were wet with urine. The four residents were under the care of PSW #116.

A review of the electronic care plans in place at the time of the incident for resident #007 identified that they required limited assistance related to continence. Resident #008's electronic care plan identified that they utilized an identified intervention to assist with continence. Further, resident #009 and #010 required assistance from staff for their continence needs.

Inspector #679 reviewed a discipline letter which identified allegations that PSW #116 neglected to provide care and assistance to four residents, violating their right to safe and competent care. The letter further identified that the investigation determined that PSW #116 had failed to provide care and assistance to four residents as per their plan of care.

A review of the written investigation identified that PSW #116 acknowledged that they did not check resident #009's continence needs. When asked if they checked resident #010, PSW #116 identified they went for their break.

In an interview with PSW #140 they identified that the care that resident's #007, #008, #009, and #010 had not been delivered in a manner consistent with their needs specifically relating to continence care as specified in their plan of care.

In an interview with the Acting DOC, they identified that the allegations were found to be credible, and that resident's #007, #008, #009, and #010 did not receive their care at the time in which they were supposed to. The Acting DOC indicated that the home identified that the actions by PSW #116 were not meeting their care needs, as specified in their plan of care. [s. 6. (7)] (647)

2. A CI report was submitted to the Director, indicating that there had been an incident to a resident, that resulted in injury, transfer to hospital, and later the resident was diagnosed with a fracture.

A review of the CI report by Inspector #647, indicated that resident #020 had been assisted to bed on an identified date and time. Resident #020 had then been found at a later time, on the floor, and upon assessment had complained of pain and had been guarding an identified area on their body. Resident #020 had been transferred to hospital, and diagnosed with a lower body injury.

The progress notes indicated that the resident had been admitted to the home using an assistive device and required assistance from staff to transfer. The progress notes and admission records further indicated that resident #020 had been utilizing an intervention as part of their plan of care at their previous placement.

Interviews with Registered staff member's #113 and #137 indicated that when the resident had been found on the floor, there had not been the identified interventions in place, which had allowed resident #020 the ability to self transfer without staff assistance. The Registered staff members further indicated that they were aware of the requirement for the identified intervention for resident #020 and acknowledged it had never been implemented as part of the plan of care.

During an interview with the Acting DOC, they acknowledged that the identified intervention had been on resident #020's plan of care however indicated that it had not been implemented. [s. 6. (7)] (647)

3. A CI report was submitted to the Director on an identified date, for an alleged

incident of abuse/neglect.

A review of the CI report by Inspector #684 indicated that at an identified date and time, resident #004 had been upset and reported to the Acting DOC that two PSW's later identified as #119 and #120, forced resident #004 to use a specific assistive device to transfer. Resident #004 reported to a family member that they did not want to use the assistive device and that it was painful.

Inspector #684 reviewed the investigation notes post incident. The investigation notes identified that the Acting DOC met with PSW #119, the PSW admitted to using a specific assistive device with resident #004 despite the care plan stating they did not require it, and that they did not read resident #004's care plan.

The investigation notes further identified that on an identified date, the Acting DOC also met with PSW #120. PSW #120 indicated that they attempted to get resident #004 to transfer but resident #004 was too tired to stand. The PSW admitted that they did not read the care plan and they do not know what transfer care plan for resident #004 stated.

The Inspector reviewed resident #004's care plan which indicated that the resident needed specific assistance and use of a different assistive device for transferring.

Inspector #684 reviewed the Policy for: Care Plan, RSL-DOC-045, last reviewed in December 2017. Purpose: The care plan shall give clear directions to direct care staff providing care to the resident.

During an interview with Inspector #684 the Acting DOC confirmed that during the abuse investigation both PSW's #119 and #120 admitted to the Acting DOC that they did not provide the care as set out in the plan for resident #004 related to transfers. [s. 6. (7)] (647)

4. A Critical Incident (CI) report was submitted to the Director on an identified date, alleging improper care to resident #001 from Registered staff member #110. The report indicated that Registered staff member #110 had used an inappropriate intervention to resident #001, to prevent them from exhibiting a responsive behaviour, during an identified shift and date.

Inspector #627 reviewed the care plan in effect at the time of the alleged incident

which indicated that staff were to monitor resident #001 for an increase in responsive behaviours, and if present, staff were to re-approach resident #001 at a later time.

Inspector #627 reviewed the home's investigation notes which indicated that Personal Support Worker (PSW) #109 had reported that Registered staff member #110 had been afraid that resident #001 was going to exhibit responsive behaviours, so the Registered staff member used an inappropriate intervention to manage the responsive behaviours and provide care. The same investigation notes also revealed that Registered staff member #110 had reported that they had tried to stop the resident from exhibiting responsive behaviours by using the inappropriate intervention. The Registered staff member indicated that they hadn't known what else to do at the time to help the PSW from being exposed to the responsive behaviours by the resident.

Inspector #627 interviewed PSW #104 who stated that resident #001 exhibited responsive behaviours frequently when staff attempted to provide care. When the resident demonstrated responsive behaviours, staff were to ensure that the resident was safe, leave and re-approach at a later time.

Inspector #627 interviewed Registered staff member #111 who stated that they had been made aware of an incident of improper care by Registered staff member #110 to resident #001. Registered staff member #111 indicated that resident #001 exhibited many responsive behaviours since their admission. Staff were to walk away after ensuring the resident was safe and return later to provide the care. It was very standard to stop and re-approach resident #001 when providing care to them, and that they were often more accepting of the care at a later time. This was indicated in the care plan.

Inspector #627 interviewed the Acting Director of Care (DOC) who stated that it was determined during the investigation that Registered staff member #110 had used an inappropriate intervention to resident #001 to prevent them from exhibiting the responsive behaviours. When resident #001 exhibited responsive behaviours during care, the directives in the care plan were to leave and re-approach at a later time, thereby, giving the resident time to calm down. The Acting DOC acknowledged that Registered staff member #110 had not provided care to resident #001 as indicated in the resident's care plan. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual

harm to identified residents. The scope of the issue was a level 2 as it related to more than the fewest number of residents affected. The home had a level 4 history as they had a related non-compliance with this section of the LTCHA that included:

-compliance order (CO) issued February 13, 2017 (2017_616542_0005),
-written notification (WN) issued April 4, 2016 (2016_264609_0012). (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 04, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 24th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Jennifer Brown

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