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
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Telephone: (705) 564-3130
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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
Nov 20, 2020	2020_565647_0019	015523-20, 015528-20, 018838-20, 020378-20	Critical Incident System

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), AMY GEAUVREAU (642), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

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

The following intakes were completed in this Critical Incident inspection (CIS):

-two intakes related to improper care of a resident,

-two intakes related to an improper transfer of a resident, and

-one intake related to an adverse reaction of a medication incident.

A Written Notification and Compliance Order related to O. Reg. 79/10, s. 36 was identified during this inspection (two intakes) and issued in the FU inspection (2020_565647_0020) report.

Follow Up inspection 2020_565647_0020 and Complaint inspections 2020_565647_0018 and 2020_565647_0021 were completed concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Administrative Assistant (AA), Physician (MD), Restorative Care Coordinator (RCC), Registered Dietitian (RD), Physiotherapist (PT), Nursing Support Assistant, Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Housekeepers, and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed medication administration, observed dining and snack service, observed staff to resident interactions, resident to resident interactions, and the provisions of care, reviewed internal documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **5 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 the Medication Reconciliation policies and procedures included in the Medication Management Program were complied with, specifically for three residents.

O. Reg. 79/10, s. 114 (2) required the licensee to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the home's policy and procedure "Medication Reconciliation – Long Term care Homes", revised dated December 2016, which indicated that "The nurse would document all relevant sources used to create the best possible medication history from the list provided in the upper right-hand corner of the form as this process was crucial to compare the orders in monitoring for any discrepancies. The policy further indicated that the medication orders were first and second checked by two different nurses and available source documents were to be reviewed".

a) A Critical Incident System (CIS) report was submitted to the Director regarding a resident's incorrect transcription of their admission medication by a Registered Practical Nurse (RPN) which resulted in a change in health status.

The Director of Care (DOC) verified that when the resident was admitted, the RPN incorrectly transcribed their medications, which resulted in them receiving 16 incorrect medications for seven days. The DOC acknowledged that the two registered staff were required to verify the accuracy of the resident's medication, and this did not occur.

b) Another resident was identified as a new admission. A review of the resident's Medication Reconciliation and Admission Order Form, identified that the registered staff who prepared the form did not complete the resident specific information and did not sign the form.

The DOC, acknowledged that the registered staff who prepared the resident's admission medication reconciliation were required to sign it and complete the resident-specific information as stated in the home's policy for Medication Reconciliation.

c) Another resident was identified as a new admission. A review of the resident's Medication Reconciliation and Admission Order Form, identified that the form was partially completed and that the first nurses check was completed six days after the resident's admission. There was no second nurses check identified.

The DOC, acknowledged that the resident's first check by a nurse on their admission medication reconciliation was completed six days later and did not receive a second check.

Sources: CIS report, one resident's electronic Medication Administration Records (MAR), internal investigation notes, review of two residents Medication Reconciliation and Admission Order Form and medication source from Parry Sound Health Centre, review of the home's policy and procedure "Medication Reconciliation – Long Term care Homes", revised dated December 2016, and interviews with the DOC, Assistant Director of Care (ADOC), and other staff members. [s. 8. (1) (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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to three residents in accordance with the directions for use specified by the prescriber.

An RPN, stated that all residents in a specific home area had medications scheduled however; did not receive their medications as specified by the prescriber.

Another RPN further stated that residents in the home area, included the three identified residents, had received their medications approximately three hours late.

During multiple observations conducted, two of the identified residents displayed agitated behaviour.

Sources: Multiple home area observations, interview with two RPNs, and the DOC, Medication Administration Records (MARs) for three residents, and the home's policy titled "Administering Routine Medications", revised date November 2015. [s. 131. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with.

Specifically, the staff did not comply with the home's policy titled "ADM-RF Abuse Definition", last revised July 31, 2019, which indicated that "The home would ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents". The policy further indicated that "Zero tolerance would mean that any behaviour or conduct that would be detrimental to the resident and would not be tolerated under any circumstance or reason".

A resident was identified struggling to ambulate, holding on to the hand rails in their home area. A Personal Support Worker (PSW), stopped, looked at the resident and continued their way to another resident. The resident was later found on the floor by a housekeeper.

The DOC, stated that the PSW had neglected the resident by not providing the required assistance which resulted to their fall.

Sources: CIS report, review of the internal investigation notes, a resident's progress notes and care plan, interview with a Housekeeper, RPN, Nurse Manager and DOC, review of the home's policy titled "ADM-RF Abuse Definition". [s. 20. (1)]

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 home's policy to promote zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #4: 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 immediately inform the Director regarding the improper care of a resident who was at risk of harm related to a transfer.

A PSW had transferred a resident, who was identified as a high risk for falls, alone from one chair to another.

An RPN stated that the resident was to be transferred by two staff at all times as stated in the resident's plan of care due to their risk of fall.

The DOC, stated that the PSW had improperly transferred the resident from one chair to another, thus, putting the resident at risk for falls. The DOC acknowledged that the CIS report was not completed when required.

Sources: CIS report, review of the internal investigation notes, a resident's progress notes and care plan, interview with a Housekeeper, RPN, Nurse Manager and DOC, review of the home's policy titled "ADM-OP Reporting Process for Critical Incidents", last revised October 31, 2018. [s. 24. (1)]

2. The licensee has failed to immediately inform the Director regarding neglect of a resident which resulted to their fall.

A resident was found on the floor along the hallway of their home area by a Housekeeper. A review of the home's internal investigation identified the PSW did not provide the needed assistance to the resident which led to their fall.

The DOC acknowledged the CIS report was not initiated until four days after the incident.

Sources: CIS report, review of the internal investigation notes, a resident's progress notes and care plan, interview with a Housekeeper, RPN, Nurse Manager and DOC, review of the home's policy titled "ADM-OP Reporting Process for Critical Incidents", last revised October 31, 2018. [s. 24. (1)]

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 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 is based to the Director: (1) Improper care of a resident who was at risk of harm, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director within 10 days of becoming aware of the incident a description of the individuals involved in the incident including names of any staff members who were present at the incident.

A CIS report was submitted to the Director which indicated a medication transcription incident for a resident that resulted in a change in health status.

A review of the CI report and the resident's electronic MAR, identified that there were eight registered staff involved in this incident and five registered staff names were not identified in the CI report.

During an interview with the DOC, they acknowledged that they were supposed to include all the names of staff members who were involved in the CI as per their policy for CIS reporting but this did not occur.

Sources: CIS report, a resident's electronic MAR and the internal investigation, interview with the DOC and the ADOC, review of the policy titled, "ADM-OP Reporting Process for Critical Incidents", last revised on October 31, 2018. [s. 107. (4) 2. ii.]

Issued on this 23rd day of November, 2020

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) :	JENNIFER BROWN (647), AMY GEAUVREAU (642), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2020_565647_0019
Log No. / No de registre :	015523-20, 015528-20, 018838-20, 020378-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 20, 2020
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:

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

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of O. Reg 79/10.

Specifically, the licensee must:

1) Ensure that all registered staff review the home's current Medication Reconciliation policy (titled "Medisystem Policies & Procedures: Patient Care - Medication Reconciliation", updated June 2020). This process should be documented to include; the dates of the review, and the names and classifications of the staff who completed the review.

2) Ensure that the admission process related to Medication Reconciliation shall include, but not limited to the following:
- two best possible sources of medication information, and
- two nurses check signatures who will review and verify the medication information on new admissions and readmissions in the home.

3) Conduct a medication reconciliation audit on the next three (3) admissions or readmission in the home to ensure that the resident's Medication Reconciliation form is completed accurately, and to maintain a record of the conducted audits.

Grounds / Motifs :

1. The licensee has failed to ensure the Medication Reconciliation policies and procedures included in the Medication Management Program were complied

with, specifically for three residents.

O. Reg. 79/10, s. 114 (2) required the licensee to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the home's policy and procedure "Medication Reconciliation – Long Term care Homes", revised dated December 2016, which indicated that "The nurse would document all relevant sources used to create the best possible medication history from the list provided in the upper right-hand corner of the form as this process was crucial to compare the orders in monitoring for any discrepancies. The policy further indicated that the medication orders were first and second checked by two different nurses and available source documents were to be reviewed".

a) A Critical Incident System (CIS) report was submitted to the Director regarding a resident's incorrect transcription of their admission medication by a Registered Practical Nurse (RPN) which resulted in a change in health status.

The Director of Care (DOC) verified that when the resident was admitted, the RPN incorrectly transcribed their medications, which resulted in them receiving 16 incorrect medications for seven days. The DOC acknowledged that the two registered staff were required to verify the accuracy of the resident's medication, and this did not occur.

b) Another resident was identified as a new admission. A review of the resident's Medication Reconciliation and Admission Order Form, identified that the registered staff who prepared the form did not complete the resident specific information and did not sign the form.

The DOC, acknowledged that the registered staff who prepared the resident's admission medication reconciliation were required to sign it and complete the resident-specific information as stated in the home's policy for Medication Reconciliation.

c) Another resident was identified as a new admission. A review of the resident's

Medication Reconciliation and Admission Order Form, identified that the form was partially completed and that the first nurses check was completed six days after the resident's admission. There was no second nurses check identified.

The DOC, acknowledged that the resident's first check by a nurse on their admission medication reconciliation was completed six days later and did not receive a second check.

The Compliance order was made by taking the following factors into account:

Severity: There was actual risk specifically to two residents and actual harm to another resident as the registered staff had not followed the home's policy related to medication reconciliation.

Scope: The scope of these non-compliances were widespread as they affected 100 per cent of the residents inspected.

Compliance History: Two written notifications (WN), seven voluntary plans of correction (VPCs), and four COs were issued to the home. The four COs have previously been complied, and all were related to different sections of the legislation in the past 36 months.

Sources: CIS report, one resident's electronic Medication Administration Records (MAR), internal investigation notes, review of two residents Medication Reconciliation and Admission Order Form and medication source from Parry Sound Health Centre, review of the home's policy and procedure "Medication Reconciliation – Long Term care Homes", revised dated December 2016, and interviews with the DOC, Assistant Director of Care (ADOC), and other staff members. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2020

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The Licensee must be compliant with s. 131 (2) of O. Reg 79/10.

Specifically, the licensee must ensure that medications for all residents in a home area, including the three identified residents, are administered their medications on time in accordance with the directions specified by the prescriber.

Grounds / Motifs :

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

1. The licensee has failed to ensure that drugs were administered to three residents in accordance with the directions for use specified by the prescriber.

An RPN, stated that all residents in a specific home area had medications scheduled however; did not receive their medications as specified by the prescriber.

Another RPN further stated that residents in the home area, included the three identified residents, had received their medications approximately three hours late.

During multiple observations conducted, two of the identified residents displayed agitated behaviour.

A Compliance order was made by taking the following factors into account:

Severity: There was actual risk specifically to three residents, as their scheduled medications were not provided as specified by the prescriber.

Scope: The scope of these non-compliances were widespread as they affected 100 per cent of the residents inspected.

Compliance History: Two written notifications (WN), seven voluntary plans of correction (VPCs), and four COs were issued to the home. The four COs have previously been complied, and all were related to different sections of the legislation in the past 36 months.

Sources: Multiple home area observations, interview with two RPNs, and the DOC, Medication Administration Records (MARs) for three residents, and the home's policy titled "Administering Routine Medications", revised date November 2015. (687)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 20th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

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

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