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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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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 6, 2020	2020_560632_0012	011957-20, 013978-20, 014897-20, 016901-20	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Allendale
185 Ontario Street South MILTON ON L9T 2M4

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

YULIYA FEDOTOVA (632), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 9, 10, 14, 16, 18, 22, 23, 2020.

This inspection was completed concurrently with Critical Incident System (CIS) inspection #2020_560632_0011.

The following intakes were completed in this Complaint inspection:
Log #011957-20 was related to personal support services,
Log #013978-20 and log #016901-20 were related to prevention of abuse and neglect, personal support services,
Log #014897-20 was related to skin and wound care.

NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, s. 6. (7) were identified in a concurrent CIS inspection #2020_560632_0011 (Log #003476 -20, Log #006809-20 and Log #017053-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager, Manager of Resident Care (MORC) #1, MORC #2, MORC #3, Minimum Data Set (MDS) - Residents Assessment Instrument (RAI) Co-ordinator, Clinical Resource Nurse, Physiotherapist, Behavior Support Ontario (BSO) Registered Practical Nurse (RPN), Occupational Therapist, Nutrition Service Supervisor, Life Enrichment Supervisor, Life Enrichment Therapist, Registered Nurses (RNs), Personal Support Workers (PSWs), Resident Care Clerk #1 and Resident Care Clerk #2.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

3 WN(s)
1 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 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 :

1. A. The licensee failed to ensure that care set out in the resident's plan of care related to an assistive device was provided as specified in the plan.

i. Resident #008 was left unattended and did not have access to their assistive device. A review of the care plan indicated that the assistive device was to be within the resident's reach.

An interview with the MORC confirmed that the resident did not have access to their assistive device as specified in the care plan.

Without the assistive device, resident #008 was at risk for further injury.

Sources: care plan, the home's internal investigation notes, interview with MORC #2 and resident #008. [506]

ii. Resident #002 was assessed as high risk for falls. A review of the care plan indicated the resident's assistive device was to be within reach as a fall prevention intervention.

During the inspection, the resident's assistive device was observed to not be within reach of the resident.

During the inspection, RPN confirmed that the assistive device was not within reach of resident #002. The MORC indicated that the assistive device was to be within the reach of resident #002.

Without the resident's assistive device to be within reach, resident #002 was at risk of falls.

Sources: care plan, Nurse-Falls Risk Assessment, interviews with RPN #122 and the MORC #1. [632]

B. The licensee failed to ensure that care set out in resident #008's plan of care was provided as specified in the plan.

Resident #008 was left unattended on an identified device. A review of the care plan indicated that the resident was not to be left alone on the identified device.

An interview with the MORC confirmed that the resident was left unattended on an identified device by the PSWs.

Without the staff remaining with the resident, resident #008 was at risk for further injury.

Sources: care plan, the home's internal investigation notes, interviews with MORC #2, PSW #120, PSW #113 and resident #008. [506]

C. The licensee failed to ensure that the care set out in the plan of care in relation to dressing a resident was provided to the resident as specified in the plan.

A review of the care plan and Minimum Data Set (MDS) quarterly review assessment indicated specified assessment information to physically assist with dressing the resident.

During the inspection, the PSW indicated that on identified date in February 2020, they dressed the resident not as per their plan of care intervention directions.

The resident was at risk of injury, when assistance with dressing was provided not as per their plan of care.

Sources: written care plan, MDS Quarterly review assessment, interview with PSW #134. [632]

D. The licensee failed to ensure that the care set out in the plan of care in relation to providing specified care for resident #004 was provided to the resident as specified in the plan.

Care plan review indicated that the resident had specified intervention for responsive behaviours.

During the inspection, the PSW indicated that the specified intervention was not provided to the resident as specified in the plan and, as a result, the resident had a fall.

During the inspection, the Senior Nursing Manager indicated what the home's expectations were for the specified intervention for responsive behaviours.

Resident #004 had a fall with injury as a result of the specified intervention for responsive behaviours was not provided.

Sources: care plan, interviews with PSW #110 and the Senior Nursing Manager. [632] [s. 6. (7)]

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008 was protected from neglect.

Ontario Regulation 79/10, s. 5, defines "neglect" as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one of more residents".

PSW #120 and #113 put a resident onto an specified device using an identified transfer aide that was left attached and the resident was left unattended without access to their assistive device. Staff also failed to check on the resident as outlined in the home's

safety check policy.

PSW #118 confirmed that they found the resident specifically positioned in the identified location. The resident was in specified distress.

A RN assessed the resident who was in specified physical and emotional condition.

The physician assessed the resident and completed specified assessment and confirmed that the resident had skin alteration in specified location of their body and the resident had specified symptoms. The physician ordered specified interventions.

Interview with resident #008 verified the incident and the resident's emotional reaction to the incident.

A review of the home's internal investigation notes and interview with the MORC confirmed that this incident met the definition of neglect which included: staff not following the resident's plan of care, leaving the resident unattended in an unsafe position. The MORC also confirmed that staff did not follow their policy for Shift Report Procedures and completed specified checks of all residents on the both shifts. RPN #122 and PSW #119 did not follow the home's policy on Standards for Documentation of Care and Services and documented that they completed assigned task for the resident when they did not.

The pattern of inaction by the staff jeopardized the health and well being of resident #008 and the resident was not protected from neglect by the licensee.

Sources: resident #008's care plan, physician's notes, electronic treatment record, point of care documentation, the home's internal investigation notes, the home's policy for 'Standards for Documentation of Care and Services' (July 2019), 'Shift Report Procedures', 'Safety Checks' (July 2019), interviews with MORC #2, resident #008 and resident #007. [506] [s. 19. (1)]

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques with resident #008.

PSW #120 and #113 used a specified transfer device to put resident #008 on identified toileting device. Once the resident was on the identified device, the staff left the resident unattended for a specified amount of time. The resident was discovered in a specified device in the identified location by the next shift. The resident indicated that they had used an identified device of the specified transfer device to move themselves. The resident was at risk for further injury being left unattended for specified period of time and having access to the the identified device.

Resident #008's written plan of care indicated that they were not to be left unattended, while on the specified device and the manufacturer’s instructions confirmed that the specified transfer device was not be used for any unsafe practices or by anyone who was not trained to use the equipment.

An interview with the MORC confirmed that staff did not use specified transferring and positioning techniques.

Sources: written plan of care, investigation notes, the home’s policy ‘Lift, Transfer and Repositioning Program’ (dated February 2019), and manufacturer’s instructions for the ceiling lift, interviews with MORC #2 and resident #008. [506] [s. 36.]

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 and ensuring that staff use safe transferring and positioning techniques with resident #008, to be implemented voluntarily.

Issued on this 19th day of October, 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) :	YULIYA FEDOTOVA (632), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2020_560632_0012
Log No. / No de registre :	011957-20, 013978-20, 014897-20, 016901-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 6, 2020
Licensee / Titulaire de permis :	The Regional Municipality of Halton 1151 Bronte Road, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	Allendale 185 Ontario Street South, MILTON, ON, L9T-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sean Weylie

To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

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 comply with s. 6.(7) of the LTCHA, 2007.

Specifically, the licensee must:
- provide identified care to resident #004 as per their plan of care;
- ensure assistve devices are within reach for resident #002 and resident #008 as per the residents' plans of care;
- provide identified care for resident #008 as per resident #008's plan of care.

Grounds / Motifs :

1. A. The licensee failed to ensure that care set out in the resident's plan of care related to an assistive device was provided as specified in the plan.

i. Resident #008 was left unattended and did not have access to their assistive device. A review of the care plan indicated that the assistive device was to be within the resident's reach.

An interview with the MORC confirmed that the resident did not have access to their assistive device as specified in the care plan.

Without the assistive device, resident #008 was at risk for further injury.

Sources: care plan, the home's internal investigation notes, interview with MORC #2 and resident #008. [506]

ii. Resident #002 was assessed as high risk for falls. A review of the care plan indicated the resident's assistive device was to be within reach as a fall prevention intervention.

During the inspection, the resident's assistive device was observed to not be within reach of the resident.

During the inspection, RPN confirmed that the assistive device was not within reach of resident #002. The MORC indicated that the assistive device was to be within the reach of resident #002.

Without the resident's assistive device to be within reach, resident #002 was at risk of falls.

Sources: care plan, Nurse-Falls Risk Assessment, interviews with RPN #122 and the MORC #1. [632]

B. The licensee failed to ensure that care set out in resident #008's plan of care was provided as specified in the plan.

Resident #008 was left unattended on an identified device. A review of the care plan indicated that the resident was not to be left alone on the identified device.

An interview with the MORC confirmed that the resident was left unattended on an identified device by the PSWs.

Without the staff remaining with the resident, resident #008 was at risk for further injury.

Sources: care plan, the home's internal investigation notes, interviews with MORC #2, PSW #120, PSW #113 and resident #008. [506]

C. The licensee failed to ensure that the care set out in the plan of care in relation to dressing a resident was provided to the resident as specified in the plan.

A review of the care plan and Minimum Data Set (MDS) quarterly review assessment indicated specified assessment information to physically assist with dressing the resident.

During the inspection, the PSW indicated that on identified date in February 2020, they dressed the resident not as per their plan of care intervention directions.

The resident was at risk of injury, when assistance with dressing was provided not as per their plan of care.

Sources: written care plan, MDS Quarterly review assessment, interview with PSW #134. [632]

D. The licensee failed to ensure that the care set out in the plan of care in relation to providing specified care for resident #004 was provided to the resident as specified in the plan.

Care plan review indicated that the resident had specified intervention for responsive behaviours.

During the inspection, the PSW indicated that the specified intervention was not provided to the resident as specified in the plan and, as a result, the resident had a fall.

During the inspection, the Senior Nursing Manager indicated what the home's expectations were for the specified intervention for responsive behaviours.

Resident #004 had a fall with injury as a result of the specified intervention for responsive behaviours was not provided.

Sources: care plan, interviews with PSW #110 and the Senior Nursing Manager. [632]

An order was made by taking the following factors into account:
Severity: The care not being provided to the residents as specified in their care plans resulted in actual harm.

Scope: The scope of this non-compliance was a pattern because the care was not provided to five out of total 12 residents as outlined in their plan of 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

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

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 6.(7) of the LTCHA, 2007, three Written Notifications (WN) and two Voluntary Plans of Correction (VPC) were issued to the home. This subsection was issued as a Compliance Order (CO) on July 9, 2019, during inspection #2019_560632_0011 with a compliance due date of September 20, 2019. In the past 36 months, five other COs were issued to different sections and subsections of the legislation, all of which have been complied. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 29, 2021

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with LTCHA, 2007, s. 19. (1).

Specifically, the licensee must:
- ensure that resident #008 is not neglected by PSWs #113, 118 and 120 and RPN #122.

Grounds / Motifs :

1. The licensee failed to ensure that resident #008 was protected from neglect.

Ontario Regulation 79/10, s. 5, defines "neglect" as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one of more residents".

PSW #120 and #113 put a resident onto an specified device using an identified transfer aide that was left attached and the resident was left unattended without access to their assistive device. Staff also failed to check on the resident as outlined in the home's safety check policy.

PSW #118 confirmed that they found the resident specifically positioned in the identified location. The resident was in specified distress.

A RN assessed the resident who was in specified physical and emotional condition.

The physician assessed the resident and completed specified assessment and confirmed that the resident had skin alteration in specified location of their body

and the resident had specified symptoms. The physician ordered specified interventions.

Interview with resident #008 verified the incident and the resident's emotional reaction to the incident.

A review of the home's internal investigation notes and interview with the MORC confirmed that this incident met the definition of neglect which included: staff not following the resident's plan of care, leaving the resident unattended in an unsafe position. The MORC also confirmed that staff did not follow their policy for Shift Report Procedures and completed specified checks of all residents on the both shifts. RPN #122 and PSW #119 did not follow the home's policy on Standards for Documentation of Care and Services and documented that they completed assigned task for the resident when they did not.

The pattern of inaction by the staff jeopardized the health and well being of resident #008 and the resident was not protected from neglect by the licensee.

Sources: resident #008's care plan, physician's notes, electronic treatment record, point of care documentation, the home's internal investigation notes, the home's policy for 'Standards for Documentation of Care and Services' (July 2019), 'Shift Report Procedures', 'Safety Checks' (July 2019), interviews with MORC #2, resident #008 and resident #007. [506]

An order was made by taking the following factors into account:
Severity: The care not being provided to resident #008 resulted in actual harm.

Scope: The scope of this non-compliance was isolated because the care was not provided for one of the three residents reviewed during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 19. (1) of the LTCHA, 2007, three Written Notifications (WN) were issued to the home. This subsection was issued as a CO on November 15, 2018, during inspection #2018_543561_0013 with a compliance due date of March 4, 2019 and on July 9, 2019, during inspection #2019_560632_0011 with a compliance due date September 20, 2019. In the past 36 months, four other COs were issued to different sections of the legislation, all of which have been

complied. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 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:

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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 6th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Yuliya Fedotova

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