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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2018	2018_766500_0017	026991-17, 027738-17, 004496-18, 017507-18, 020647-18	Critical Incident System

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

NITAL SHETH (500), REBECCA LEUNG (726)

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 3, 9, 10, 11, 29, 30, 31, Nov 1, 2 , 5, and 6, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Physiotherapist (PT), Unit Manager (UM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed the resident care areas, staff to residents interactions, reviewed resident health care records, staffing schedules, and home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified day, related to an unwitnessed fall incident resulting in resident #001 being sent to the hospital for a suspected injury.

Review of the patient care notes indicated that resident #001 was seen on the floor on an identified day. Resident was alert and presented no sign of pain, post-fall. When the registered staff reassessed resident #001 on the next day, they presented with a change in condition. The on-call physician and family were notified and agreed to transfer resident #001 to the hospital for assessment. Resident #001 was then diagnosed with an injury and underwent treatment.

Resident #001 was readmitted to the home on an identified day. A rehabilitation program was initiated by Physiotherapist (PT) #110. Review of physician's progress note indicated that resident #001's injury had healed well. PT#110 indicated that resident #001 had already tried to get up from the wheelchair and bed as their legs were stronger, and resident #001 did not realize that if they stood up, they would fall.

Review of resident #001's last Fall Risk Assessment completed post fall incident, indicated that the total score of their Fall Risk Assessment was higher and would be considered high risk.

Review of interventions for fall prevention indicated in resident #001's current care plan in Meditech and the visual care plan kept at the nursing station, resident #001 was to use a specific device at all times. On an identified day, the inspector observed resident #001 sitting in a wheelchair inside the dining room. The inspector asked personal support worker (PSW) #108 if they had assisted resident #001 to put on the specific device. PSW#108 stated that they had forgotten to help resident #001 put on the specific device in the morning.

In an interview, Unit Manager (UM) #115 acknowledged that the staff should have ensured the interventions for fall prevention were implemented as indicated in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

A review of CIS report indicated that resident #003 had an unwitnessed fall on an identified day. The resident was found by the PSW on the floor. The resident sustained an injury. The resident was closely monitored by the nursing staff. Next day, the resident was found with a change in condition and was transferred to the hospital and passed away in the hospital.

A review of the care plan dated prior to the incident, indicated that the resident was at risk for falls. The goals were to prevent falls and minimize injury from falls. The care plan included 10 interventions to prevent falls and minimize injury from falls.

A review of the care plan dated after the incident indicated an additional intervention was added to the care plan to prevent falls. The staff were directed to place the resident at the nursing station (high visibility area) especially in the evenings to help reduce risk of unwitnessed fall events, and to ensure that the resident is placed at this location when not with a visitor.

A review of progress notes documented by staff dated on six identified days, indicated the resident as being high risk for falls. Progress notes documented by the Medical Doctor (MD) dated prior to the incident, indicated that the MD identified a behaviour that contributed to the resident's risk of falls. A note documented by the PT, dated prior to the incident, indicated that the resident was at risk for falls.

A review of the home's investigation notes of the incident indicated that the resident had three previous falls with no injury. On an identified day, the resident had an un-witnessed fall and was found by staff in the washroom, with an ambulation device in front of them. The resident received a specific device and a different ambulation device on two identified days.

Interviews with PSW #103 indicated that it was difficult to monitor the resident having only two PSWs on the unit. On the day, when the incident occurred, PSW #103, went on break after placing the resident in the TV room, asking PSW #101 to monitor the resident. PSW #101 checked the resident and went to serve snacks and returned after five minutes and found the resident on the floor. PSW #103 confirmed that the strategy for monitoring the resident was not effective in order to minimize the risk of falls.

Interviews with PSW #106, and Registered Practical Nurse (RPN) #104 indicated that the resident was at high risk for falls. The strategy to monitor the resident was not effective in the evening shift.

Interview with UM #105 indicated that the resident did not have any falls from the wheelchair, however UM #105 acknowledged that the resident had a behaviour and also indicated that the resident was at increased risk for falls and a specific device was not explored by the home for the resident. UM #105 indicated that the home could not provide one-on- one monitoring to the resident for falls prevention, and at the time of the fall, within five minutes, the resident was found on the floor and sustained an injury.

A review of the resident's clinical record and staff interviews indicated that two specific devices were provided to the resident to prevent injuries, however the resident's behaviour was not addressed. The resident had an intervention to be placed at the nursing station or the more visible areas for monitoring, however, monitoring was not effective, especially in the evening shift and night shifts with two PSWs, and one registered staff on the unit. By identifying the resident being at risk for falls due to behaviour, no other strategies were implemented other than monitoring which was not effective enough in preventing falls for the resident.

This non-compliance is warranted because the plan of care was not reviewed and revised when it was determined to not be effective as the resident experienced falls over four consecutive months. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraining the resident was included in the resident's plan of care.

Review of home's "Physical Restraint Minimization Policy and Procedure" revised in April 2016 indicated the definition for "Physical Restraint - any appliance /device or equipment attached or adjacent to a resident's body that the individual cannot remove and which restricts movement. A device is considered a restraint based on the effect of the device on the resident, regardless of the intent in using the device. All devices and interventions must be assessed from the resident's perspective to determine how it affects function or freedom. For resident, who does have the ability to get up out of a chair, use of the reclining chair to provide a brief period of rest and postural support when the resident is fatigued is considered a physical restraint as the chair will prevent rising."

CIS report was submitted to the MOHLTC on an identified day, related to an unwitnessed fall incident resulting in resident #001 being sent to the hospital for suspected injury.

On two consecutive identified days, outside resident #001's room, the inspector observed resident #001 was sitting in an identified position. Resident #001 was attempting to move

their body up and forward, and trying to get up, but they were unable to do it.

On an identified day, inside the dining room, the inspector observed resident #001 was capable of sitting up and back down, independently.

In an interview, PSW #108 indicated that when resident #001 is placed in an identified position, it was for the purpose of repositioning and would prevent the resident from rising independently.

In an interview, RPN #109 stated that when resident #001 is placed in an identified position, it was for the purpose of repositioning and would prevent the resident from rising independently. This positioning was being used as a fall prevention intervention for resident #001.

Review of resident #001's last Fall Risk Assessment completed post fall incident on an identified day, indicated that the total score of their Fall Risk Assessment was higher and would be considered high risk.

Review of resident #001's current care plan and visual care plan indicated restraining of resident #001 was not included in their plan of care. Review of resident #001's last mobility assessment completed on an identified day, indicated no restraint used, and to ensure resident #001 was sitting at 90 degrees.

In an interview, PT #110 indicated that they had discussed with the registered staff about keeping resident #001 sitting at 90 degrees as resident #001 had the tendency and capacity to stand up and weight bear, as well as the ability to shift weight. PT#110 stated that resident #001 exhibited good body control. There was no need to put resident #001 in the identified position. PT#110 acknowledged that if the resident was placed in the identified position, it would prevent resident #001 from rising by them-self. PT #110 further indicated that if the resident was placed close to the rail on the wall, in the identified position, it would increase resident #001's risk for injury.

In an interview, UM #115 indicated that they did not use restraints in the home and the decision to restrain resident #001 should have been discussed with the team. [s. 31. (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 a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received annual training on how to minimize the restraining of residents, and where restraining is necessary, how to do so in accordance with this Act and the regulations.

During the inspection of a CIS fall incident involving resident #001, the inspector observed resident #001 being placed in an identified position on two consecutive days, outside resident #001's room. In the interviews, PSW #108, RPN #109 and PT #110 acknowledged that the identified position would prevent resident #001 from rising.

Review of resident #001's current care plan and visual care plan indicated restraining of resident #001 was not included in their plan of care.

Review of the home's staff annual training record provided by the Director of Care (DOC) #111 indicated 15 out of 318 direct care staff did not complete the required annual training for restraints and personal assistance services device (PASD) in 2017.

On an identified day, DOC #111 confirmed the above information was correct and informed that the home had developed a plan to ensure these 15 staff would complete the annual training as required. [s. 221. (2) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident was discharged from the home and a record kept under O. Reg. 79/10, s. 233 (1) must be kept at the home for at least the first year after the resident was discharged from the home.

A review of the resident's clinical record indicated that the resident had a significant change in their health condition and was transferred to the hospital and passed away in the hospital. Resident #001 was discharged from the home on an identified day.

An interview with UM #105 and a review of resident #001's clinical record, including paper chart and electronic chart, indicated that the resident's kardex was missing from the records. UM #105 confirmed that the kardex was searched and it was missing and the home could not find it. [s. 233.]

Issued on this 18th day of December, 2018

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

Original report signed by the inspector.

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

Ministère 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) :	NITAL SHETH (500), REBECCA LEUNG (726)
Inspection No. / No de l'inspection :	2018_766500_0017
Log No. / No de registre :	026991-17, 027738-17, 004496-18, 017507-18, 020647-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 3, 2018
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, TORONTO, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Derrick Bernardo

To The Jewish Home for the Aged, 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6. (10) (c) of the LTCHA. Specifically the licensee must:
1) Identify all residents who are high risk for falls on an identified unit.
2) Develop, document and implement a system for evaluating the effectiveness of each resident's falls prevention interventions, including any revision made based on the outcome of the evaluation.
3) Develop, document and implement a system that will minimize the risk of falls for residents at high risk for falls. Process will minimally involve Personal Support Workers (PSWs) and registered staff working on the identified unit. They will also identify the contributing factors for falls by residents and develop appropriate interventions.
4) Assign a staff member to conduct an audit of the above and maintain a record.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

A review of CIS report indicated that resident #003 had an unwitnessed fall on an identified day. The resident was found by the PSW on the floor. The resident sustained an injury. The resident was closely monitored by the nursing staff.

Next day, the resident was found with a change in condition and was transferred to the hospital and passed away in the hospital.

A review of the care plan dated prior to the incident, indicated that the resident was at risk for falls. The goals were to prevent falls and minimize injury from falls. The care plan included 10 interventions to prevent falls and minimize injury from falls.

A review of the care plan dated after the incident indicated an additional intervention was added to the care plan to prevent falls. The staff were directed to place the resident at the nursing station (high visibility area) especially in the evenings to help reduce risk of unwitnessed fall events, and to ensure that the resident is placed at this location when not with a visitor.

A review of progress notes documented by staff dated on six identified days, indicated the resident as being high risk for falls. Progress notes documented by the Medical Doctor (MD) dated prior to the incident, indicated that the MD identified a behaviour that contributed to the resident's risk of falls. A note documented by the PT, dated prior to the incident, indicated that the resident was at risk for falls.

A review of the home's investigation notes of the incident indicated that the resident had three previous falls with no injury. On an identified day, the resident had an un-witnessed fall and was found by staff in the washroom, with an ambulation device in front of them. The resident received a specific device and a different ambulation device on two identified days.

Interviews with PSW #103 indicated that it was difficult to monitor the resident having only two PSWs on the unit. On the day, when the incident occurred, PSW #103, went on break after placing the resident in the TV room, asking PSW #101 to monitor the resident. PSW #101 checked the resident and went to serve snacks and returned after five minutes and found the resident on the floor. PSW #103 confirmed that the strategy for monitoring the resident was not effective in order to minimize the risk of falls.

Interviews with PSW #106, and Registered Practical Nurse (RPN) #104 indicated that the resident was at high risk for falls. The strategy to monitor the

resident was not effective in the evening shift.

Interview with UM #105 indicated that the resident did not have any falls from the wheelchair, however UM #105 acknowledged that the resident had a behaviour and also indicated that the resident was at increased risk for falls and a specific device was not explored by the home for the resident. UM #105 indicated that the home could not provide one-on- one monitoring to the resident for falls prevention, and at the time of the fall, within five minutes, the resident was found on the floor and sustained an injury.

A review of the resident's clinical record and staff interviews indicated that two specific devices were provided to the resident to prevent injuries, however the resident's behaviour was not addressed. The resident had an intervention to be placed at the nursing station or the more visible areas for monitoring, however, monitoring was not effective, especially in the evening shift and night shifts with two PSWs, and one registered staff on the unit. By identifying the resident being at risk for falls due to behaviour, no other strategies were implemented other than monitoring which was not effective enough in preventing falls for the resident.

This non-compliance is warranted because the plan of care was not reviewed and revised when it was determined to not be effective as the resident experienced falls over four consecutive months.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1. The home had a level 2 history the non-compliance with this section of the Act that included:
-Voluntary plan of correction (VPC), and Written notifications (WN) issued June 27, 2017, (2017_659189_0015). (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

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
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 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)
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 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 3rd day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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