

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de
Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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 23, 2020	2020_669642_0015	008707-20, 009046- 20, 010357-20, 011021-20	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale
Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 2A1

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

AMY GEAUVREAU (642), AMANDA BELANGER (736), HILARY ROCK (765), KEARA
CRONIN (759), SYLVIE BYRNES (627)

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 14-18, 2020, onsite, and September 21-25, 2020, was off-site.

The following intakes were completed during this complaint inspection:

- Two Logs, related to alleged improper treatment which caused an injury from an unknown cause.**
- One Log, related to nutrition and hydration.**
- One Log, related to continence care and management.**
- One Log, related to medication, dietary services and hydration.**

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 20 (1) was identified in this inspection and has been issued in a concurrent inspection, #2020_669642_0016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim ED, Director of Care (DOC), Assistant Director of Care's (ADOCs), Physician, Nurse Practitioner, Registered Dietician (RD), Behavioural Support Resource Team (BSRT), Resident and Family Experience Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Support Aids (CSAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

**Contenance Care and Bowel Management
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints**

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

5 WN(s)

3 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (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 resident #006 was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Review of resident's #006's care plan for a specific focus, in effect prior to the resident's hospitalization indicated that the resident needed to have a specific procedure completed. A review of the resident's progress notes and medication administration records (MAR) from admission to a specific date, indicated that resident #006 had not had their specific procedure completed successfully, due to staff not being able to complete the procedure.

Review of the home's Documentation-Plan policy indicated that all disciplines providing direct care and/or delivering care services to the resident would collaborate with other members of the care team and would review the plan of care as required and if the care had not been effective; consider different approaches in the revision of the plan of care.

In an interview with RNs #124, and #125, they stated that they had difficulty completing the procedure for resident #006 and therefore did not always complete it, so they informed the next shift, the ADOC and the physician. In separate interviews with ADOC #111, the Nurse Practitioner (NP) and the Physician, they stated the care plan had not been revised, when the staff were having a difficult time doing the procedure for resident #006.

Resources: Documentation-Plan policy, resident #006's progress notes, care plan, medication administration records, interviews with RN #124, and other staff.

[627] [s. 6. (10) (c)]

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care was based on their disease diagnosis.

Inspector #736 observed resident #001's door to their room closed, and it had a specific sign on it. During interviews with both PSW #103 and RPN #108, they indicated that resident #001 required specific care, due to having a specific diagnosis.

In a review of resident #001's care plan and disease diagnosis, there was no indication that the resident required any specific care. In an interview with ADOC #102, they indicated that resident #001 required specific care related to their diagnosis. The ADOC reviewed the resident's diagnosis in Point of Care (PCC), and indicated that the diagnosis was not present, but should have been. The ADOC indicated that resident #001's plan of care was not based on their disease diagnosis.

Sources: Observation; review of resident #001's diagnosis and care plan; interviews with PSW #103, RPN #108, and ADOC #102, as well as other staff. [s. 26. (3) 9.]

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 with every residents plan of care must be based on, at a minimum, interdisciplinary assessment of the residents disease diagnosis, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 and #008 received a bath twice a week.

A review of documentation, indicated that resident #003 missed a certain amount of baths, and resident #008 missed a certain amount of baths in the look back period. Inspector #765 and staff members could not identify if any of the missed baths had been re-offered or made up. As per the homes policy, residents were to be provided the required minimum of two baths per weeks and when a resident refused a bath, they were to be offered an alternative mode of bathing, and if the resident refused, they were to offer a bathing routine at an alternative time. Staff members indicated that there was no process for making up missed baths and that it was difficult to make them up. ADOC #102 confirmed resident #003 and #008 had not received their baths twice a week.

Sources: Follow up question report, documentation survey report, progress notes on Point of Care (PCC), resident care plans, interviews with ADOC #102, RPN #134 and other staff members. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**Specifically failed to comply with the following:****s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,****(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).****(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).****(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).****(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).****(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).****(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).****Findings/Faits saillants :**

1. The licensee has failed to ensure that a complaint for resident #001, had been documented and a record kept, with the date it was received, the action taken to resolve the complaint, and the final resolution.

A complaint was submitted related to an injury to resident #001. The complainant indicated that the home was also aware of the complaint. A review of the licensee's internal complaints record book, indicated that there was no documented record kept related to any complaint received by the home in relation to resident #001.

In an interview with Executive Director (ED) #130, they reviewed progress notes for resident #001, which indicated that the resident's Substitute Decision-Maker (SDM) was concerned related to resident #001 having an injury. The ED further indicated to the Inspector that they were unsure why the complaint was not documented and followed-up.

Inspector #736 reviewed the internal complaints binder with the interim ED #100, and they confirmed that there was no record of any complaints related to the injury to resident #001, therefore it was unknown of the actions taken to resolve the complaint or if any final resolutions were provided to resident #001's SDM.

Sources: Resident #001's progress notes; internal complaints binder; licensee's policy titled, "Complaints Management"; interviews with interim ED #100, ED #130, and other staff. [s. 101. (2)]

2. The licensee has failed to ensure that complaints regarding resident #008's personal care were documented and kept as a record in the home.

Inspector #765 had reviewed the complaint report that had been submitted by resident #008's SDM. The SDM had specific concerns related to resident #008's personal care. The SDM had stated that they had informed different staff about their care concerns for resident #008, and felt that staff did not follow up or had resolutions for their complaints.

The Inspector reviewed the home's complaint binder and could not identify any complaints regarding resident #008 as being documented. The home's policy stated that complaints shall be investigated, action taken for resolution, and completion of a complaint record. The ED confirmed that resident #008's family had complaints and that staff were required to track and complete follow ups on complaints. The Interim ED confirmed there was no records saved in the complaint binder where the home recorded their complaints, and no complaint forms were filled out for resident #008.

Sources: Complaints Management policy, the home's internal complaint binder, interviews with ED #130 and Interim ED #100, and other staff. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance shall ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; and the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and response made in turn by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #017, who required assistance for eating at meal service, was provided a meal only when staff were available to provide assistance for the resident.

Resident #017's care plan indicated that they required specific assistance with meals. On a specific day, during lunch meal service, Inspector #759 observed resident #017 with a meal at their table and observed that they had no one providing assistance to eat their meal. An interview with PSW #107 indicated that a staff member close by was providing assistance to resident #017, although Inspector #759 did not observe the resident receiving assistance from anyone prior to receiving assistance from PSW #107.

Sources: Observations, interview with PSW #107, resident #017's care plan. [s. 73. (2) (b)]

Issued on this 6th day of November, 2020

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : AMY GEAUVREAU (642), AMANDA BELANGER (736),
HILARY ROCK (765), KEARA CRONIN (759), SYLVIE
BYRNES (627)

Inspection No. /

No de l'inspection : 2020_669642_0015

Log No. /

No de registre : 008707-20, 009046-20, 010357-20, 011021-20

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Oct 23, 2020

Licensee /

Titulaire de permis : The Royale Development GP Corporation as general
partner of The Royale Development LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON,
L3R-0E8

LTC Home /

Foyer de SLD : Bradford Valley Care Community
2656 6th Line, Bradford, ON, L3Z-2A1

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** Cathy VanBeek

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

To The Royale Development GP Corporation as general partner of The Royale
Development LP, you are hereby required to comply with the following order(s) by the
date(s) set out below:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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 :**

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 comply with s. 6 (10) of the LTCHA.

Specifically, the licensee must:

- 1) Assess residents' who are receiving specific care and review the residents' care needs to ensure that they are receiving the care as set out in their plan, and if the resident's plan is no longer effective, then reassess the resident care needs, and update the care plan.
- 2) Keep a written record of the specific assessments; the care plan reviews; the dates of the assessments; if a reassessment of the plan of care was needed; and the date the care plan was updated. This documentation will be provided to an Inspector when requested.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Review of resident's #006's care plan for a specific focus, in effect prior to the resident's hospitalization indicated that the resident needed to have a specific procedure completed. A review of the resident's progress notes and medication

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

administration records (MAR) from admission to a specific date, indicated that resident #006 had not had their specific procedure completed successfully, due to staff not being able to complete the procedure.

Review of the home's Documentation-Plan policy indicated that all disciplines providing direct care and/or delivering care services to the resident would collaborate with other members of the care team and would review the plan of care as required and if the care had not been effective; consider different approaches in the revision of the plan of care.

In an interview with RNs #124, and #125, they stated that they had difficulty completing the procedure for resident #006 and therefore did not always complete it, so they informed the next shift, the ADOC and the physician. In separate interviews with ADOC #111, the Nurse Practitioner (NP) and the Physician, they stated the care plan had not been revised, when the staff were having a difficult time doing the procedure for resident #006.

Resources: Documentation-Plan policy, resident #006's progress notes, care plan, medication administration records, interviews with RN #124, and other staff.

[627]

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

Severity: A specific procedure had not been completed, for resident #006. There was actual harm as resident #006 had been sent to the hospital and later returned from the hospital and had to have a change in their plan of care.

Scope: This was an isolated case as there were no other residents who needed this specific procedure.

Compliance History: One written notification (WN) was issued to the home related to the same sub-section of the legislation in the past 36 months. [627] (642)

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
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2007, c. 8

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

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

Dec 11, 2020

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

Ordre(s) de l'inspecteur

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

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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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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foyers de soins de longue durée*, L.O.
2007, chap. 8

**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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
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2007, chap. 8

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 révision
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 23rd day of October, 2020

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Amy Geauvreau

Service Area Office /

Bureau régional de services : Central East Service Area Office