Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
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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
Nov 12, 2019	2019_800532_0013	013928-19, 013929-19, 013934-19, 017609-19, 017875-19, 018094-19	Follow up

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

NUZHAT UDDIN (532), AMANDA OWEN (738), MARIA MCGILL (728)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 7-11, 2019.

The following intakes were completed in this Follow-up (FU) inspection:

Log #017609-19, Critical Incident (CI) #M507-000046-19 related to prevention of abuse.

Log #018094-19, CI #M507-000047-19 related to falls prevention.

Log #018430-19, CI #M507-000049-19 related to unexpected death.

Log #013928-19, Follow-up (FU) to CO #010 from inspection #2019_610633_0005 related to bathing.

Log #013929-19, FU to CO #011 from inspection #2019_610633_0005 related to oral care.

Log # 013934-19, FU to CO #014 from inspection #2019_610633_0005 related to dining and snack services.

Log # 017875-19, FU to CO #001 from inspection #2019_755728_0016 related to prevention of abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer (CEO), Acting Administrator, the Director of Care, the Consultant, the Administrative Supervisor (AS), Receptionist, Physician, Pharmacy Consultant, Minimum Data Set (MDS)-Resident Assessment Instrument (RAI) Coordinator Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.
The inspectors also toured resident home areas, observed resident care provision, observed meal service, resident staff interaction, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 33. (1)	CO #010	2019_610633_0005	532
O.Reg 79/10 s. 34. (1)	CO #011	2019_610633_0005	532
O.Reg 79/10 s. 73. (2)	CO #014	2019_610633_0005	728

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. 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 the identified resident was protected from neglect.

This inspection was completed as a follow up to Compliance Order (CO) #001 from inspection #2019_755728_0016 issued on September 17, 2019, related to prevention of abuse.

Ontario Regulation 79/10 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 or more residents.

A critical incident (CI) was submitted to the Ministry of Long-term Care (MLTC) related to the unexpected death of an identified resident. The CI documented that the resident had a change in health status. The physician was not notified when there was a change in the health status.

A)The identified resident's plan of care identified several comorbidities and there was no documentation to indicate that the physician was contacted to report the change in the resident's health status despite presenting with new concerns.

An RN and the RAI/RN said that an assessment of someone presenting with a new concern and a past medical history of specified diagnoses would include a thorough evaluation and a call to the physician.

B) The Medication Administration Record (MAR) for the resident documented that they received a medication which required an assessment but a review of the resident's plan of care indicated that the assessment was not done prior to each administration of their medication as the order would suggest.

C) There was no documentation in the plan of care to support that the resident's substitute decision maker (SDM) was contacted when the resident had the change in status.

The licensee failed to ensure that the resident who had multiple co-morbidities and presented with a change in health status was assessed by a registered staff and the physician and treatment was provided. In addition, the directions were not followed when a medication prescribed for the resident was given. The SDM was not provided an update in relation to the recent change in condition, and thus, did not have an opportunity to participate in the plan of care. The resident died within a few days.

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance, was implemented.

During several dining observations, an identified resident was observed to be in an unsafe position while being assisted with eating.

The plan of care documented that the resident required total assistance with their eating.

A PSW said that the resident was positioned safely, and it was easier to provide the assistance to the resident when they were positioned in that posture.

An RPN said that the residents were to be positioned safely for the activities of daily living and directed staff to safely position the resident.

The licensee has failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance was implemented. [s. 73. (1) 10.]

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 proper techniques to assist residents with eating, including safe positioning of residents who require assistance is implemented., to be implemented voluntarily.

WN #3: 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 the identified resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

The following is further evidence to support compliance order #004 issued on October 3, 2019, during inspection #2019_800532_0011 to be complied December 16, 2019.

The plan of care for the identified resident stated that the resident had specified assistive device and the staff were to ensure that the assistive device was clean and in place every morning and removed every evening.

The MDS/RAI Quarterly assessment and the MDS/RAI annual assessment both documented that the resident had the assistive device and daily cleaning was done by the resident or staff.

Multiple resident observations showed that the assistive device was not in place.

A PSW stated that the resident had not had the assistive device for the past couple of weeks or months.

An RPN acknowledged that the resident had not had the assistive device for a while and the plan of care was not reviewed and revised when the resident's care needs had changed.

The licensee has failed to ensure that an identified resident was reassessed, and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with every order made under this Act.

On June 11, 2019, the following compliance order (CO #014) from inspection number 2019_610633_0005 was made under O. Reg. 79/10, s. 73 (2), LTCHA, 2007:

Specifically, the licensee must ensure that:
A) No person simultaneously assists more than two residents who need total assistance with eating or drinking.
B) An identified number of residents and any resident who requires assistance with eating or drinking, are not served a meal until staff are available to assist.
C) That all PSW staff review the home's Pleasurable Dining Experience protocol. A written record is kept of the review that includes the date of staff sign off.

The compliance due date was August 2, 2019.

The licensee completed part A) and part B) of compliance order #014. The licensee did not complete part C) of the compliance order.

A PSW said that they had not yet reviewed the Pleasurable Dining Protocol because it was not required to be completed by the home until October 15, 2019.

A letter from the home to PSW staff titled Mandatory PSW training, dated September 30, 2019, said that PSW's were required to complete the education by October 15, 2019. The package included information on dining services and the pleasurable dining protocol.

The Clinical Consultant from PrimaCare, said that the PSW's were currently completing the education and that it was required to be completed by October 15, 2019, after the compliance due date.

The licensee failed to ensure that all PSW staff in the home reviewed the Pleasurable Dining Protocol by the compliance due date of August 2, 2019. [s. 101. (3)]

WN #5: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The following is further evidence to support compliance order #016 issued on June 11, 2019, during inspection #2019_610633_0005 to be complied October 25, 2019.

The DOC, RN/RAI and an RPN said that if an order for a medication gave specific direction then the direction should be followed. They said that the assessment should be triggered in the Point of Care (POC) system and automatically documented in PointClickCare (PCC).

The RN/RAI and the Pharmacist Consultant said that medication orders were input by pharmacy and if a specific assessment was required in the order, supplemental documentation should be selected.

The RN/RAI and the Pharmacist Consultant said that the orders were input by pharmacy and the supplemental documentation of the assessment should have been indicated on each of the orders.

A) A critical incident (CI) was submitted to the Ministry of LTC (MLTC) related to an unexpected death of an identified resident.

The Medication Administration Record (MAR) for the resident documented that they received the medication, but the directions were not followed.

The RN/RAI, RPN, and the DOC said that the order implied that an assessment was required prior to administering the medication. They said that there was a risk of

providing the medication to the resident without an assessment. The RN/RAI said that the physician should have been notified by staff in the home to review the order given and that a number of the documented assessments were not meeting the threshold.

Two registered staff said that the resident's assessment was not done prior to administering the medication because the order was not automatically reminding registered staff in POC to complete the assessment.

B) Another identified resident's Medication Administration Record (MAR) documented that an assessment was to be completed before administering the medication.

The medication was documented as given on identified dates, however, the assessment was not done each time the medication was administered.

The RN/RAI and an RPN said that the pop-up to do the assessment was not checked in POC, so staff were not reminded to complete that part of the order.

C) A third resident's MAR documented that an assessment was to be completed before administering the medication.

The medication was documented as given for an identified time. The assessment was not documented prior to administering the medication.

The licensee failed to ensure that drugs were administered to the residents in accordance with the directions for use specified by the prescriber for three of the identified residents. [s. 131. (2)]

Issued on this 21st day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 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) :	NUZHAT UDDIN (532), AMANDA OWEN (738), MARIA MCGILL (728)
Inspection No. / No de l'inspection :	2019_800532_0013
Log No. / No de registre :	013928-19, 013929-19, 013934-19, 017609-19, 017875-19, 018094-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 12, 2019
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Brucelea Haven Long Term Care Home - Corporation of the County of Bruce 41 McGivern Street West, P.O. Box 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Griffin Allen

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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 # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0016, CO #001;

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 be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:
a) ensure an assessment is completed and documented when a resident experiences a change in their health status;
a) ensure a physician is contacted, as appropriate, when any resident exhibits a change in their health status;
b) ensure that any resident who requires an assessment prior to administering a medication, that they are assessed and the assessment is documented;
c) ensure that any resident's substitute decision maker is contacted when a resident exhibits a change in condition and that this interaction is documented in the resident's plan of care.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2019_755728_0016 issued on September 17, 2019, with a compliance date of September 20, 2019, the CO stated:

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:

a) ensure that all residents are protected from neglect;
b) ensure that any resident's substitute decision maker is given the opportunity to participate fully in the development and implementation of the resident's plan

of care; and,
c) provide and maintain documentation of education to all registered staff related to the home's process when a resident experience a change in status including but not limited
to:
i) when a physician is required to be notified;
ii) what the level of care means; and,
iii) the process for involving substitute decision makers in care decisions.

The compliance due date was September 20, 2019.

The licensee completed step c) and failed to complete step a) and b) of CO #001.

This inspection was completed as a follow up to Compliance Order (CO) #001 from inspection #2019_755728_0016 issued on September 17, 2019, related to prevention of abuse.

1. The licensee failed to ensure that the identified resident was protected from neglect.

This inspection was completed as a follow up to Compliance Order (CO) #001 from inspection #2019_755728_0016 issued on September 17, 2019, related to prevention of abuse.

Ontario Regulation 79/10 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 or more residents.

A critical incident (CI) was submitted to the Ministry of Long-term Care (MLTC) related to the unexpected death of an identified resident. The CI documented that the resident had a change in health status. The physician was not notified when there was a change in the health status.

A)The identified resident's plan of care identified several comorbidities and there was no documentation to indicate that the physician was contacted to report the

change in the resident's health status despite presenting with new concerns.

An RN and the RAI/RN said that an assessment of someone presenting with a new concern and a past medical history of specified diagnoses would include a thorough evaluation and a call to the physician.

B) The Medication Administration Record (MAR) for the resident documented that they received a medication which required an assessment but a review of the resident's plan of care indicated that the assessment was not done prior to each administration of their medication as the order would suggest.

C) There was no documentation in the plan of care to support that the resident's substitute decision maker (SDM) was contacted when the resident had the change in status.

The licensee failed to ensure that the resident who had multiple co-morbidities and presented with a change in health status was assessed by a registered staff and the physician and treatment was provided. In addition, the directions were not followed when a medication prescribed for the resident was given. The SDM was not provided an update in relation to the recent change in condition, and thus, did not have an opportunity to participate in the plan of care. The resident died within a few days.

The severity of the issue was a level 3, actual risk and the scope of the issue was a level 1, Isolated. The home had a level 5 compliance history that included:
Compliance order (CO) issued September 17, 2019 (2019_755728_0016)
CO issued June 11, 2019 (2019_610633_0005)
CO issued January 18, 2018 (2017_610633_0023)
CO issued October 26, 2018 (2018_580568_0014) (728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 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 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 12th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : Central West Service Area Office