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 le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2018;	2018_630589_0009 (A1)	016340-18, 016514-18	Complaint

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Craiglee Nursing Home
102 Craiglee Drive SCARBOROUGH ON M1N 2M7

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

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 le Loi de 2007 les foyers de soins de longue durée

Amended by JOANNE ZAHUR (589) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Staff number correction completed: changed staff #108 to #103 for Order report.

Issued on this 21 day of September 2018 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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Craiglee Nursing Home
102 Craiglee Drive SCARBOROUGH ON M1N 2M7

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

Amended by JOANNE ZAHUR (589) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 26, 27, 31, August 1, 2, 3, 7 and 29, 2018, onsite and August 20, 24, 29, 31, and September 5, 2018, off-site.

Log #106514-18 was inspected concurrently with complaint log #016340-18 during the resident quality inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Social Worker (SW).

During the course of the inspection, the inspector(s) observed staff to resident interactions, the provision of care, reviewed health records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Hospitalization and Change in Condition

Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **1 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	Legendé 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. 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 :

The licensee failed to ensure resident #031 had been free from neglect by the licensee or staff in the home.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to resident #031 being neglected by staff related to underlying health conditions. The MOHLTC received a Critical Incident System (CIS) report related to staff to resident neglect in care received for an underlying health condition, plan of care related to hot weather protocols and continence care.

A review of resident #031's health record indicated they had been admitted to the home on an identified date in September 2015, with underlying health conditions.

In an interview, the complainant stated resident #031 was prone to an identified health condition as they had lived with them prior to entering long-term care and they were able to detect the identified health condition as they would exhibit responsive behaviours. The complainant further stated the resident had been exhibiting these responsive behaviours during an identified time of day.

A review of the home's 24 hour report book on an identified shift, indicated an entry that a family member suspected resident #031 may have had an underlying health condition due to their exhibiting responsive behaviours and had requested an identified test be done. A review of resident #031's most recent written care plan indicated when the resident exhibited responsive behaviours they may have an underlying health condition. A further review of the 24 hour report book indicated entries for two identified dates related to the test for resident #031 however after that, there were no further entries noted.

A review of the progress notes during an identified period of time indicated resident #031 had been exhibiting responsive behaviours identified to indicate an underlying health condition.

On an identified shift, staff #121 had been scheduled to work and they stated they had not been informed of the need for an identified test for resident #031 therefore, no attempts were made by them.

In an interview, staff #105 stated they were not aware of the need for this test for resident #031. Staff #105 further stated when they did rounds on three identified dates in June 2018, the need for the identified test for resident #031 had not been communicated to them by staff #111, 103 and 109. Staff #105 stated they conduct daily rounds to each resident home area (RHA) to collect any pertinent resident information that may need to be endorsed shift to shift and require their follow-up.

A review of staff 105's 24 hour daily report for three identified dates did not indicate any entries related to the need for an identified test for resident #031. A further review of this report only indicated resident #031 was being monitored and had no responsive behaviours.

In an interview, staff #106 stated the first time they and staff #112 became aware of the family member’s request for an identified test was during the interdisciplinary team meeting (IDTC) held with identified staff, management and family members. As a result of this meeting staff #106 initiated an internal complaint investigation form and registered staff were directed by staff #112 to complete the medical procedure for resident #031, 20 days after the initial request by a family member had been made. The results of the identified test were received by the home and endorsed to resident #031’s attending physician who did not endorse any new orders.

A review of the progress notes for resident #031 from an identified period indicated on several shifts no documentation related to the identified test having been completed, one entry that indicated an attempt had been made but was unsuccessful and an entry that indicated the identified test had been completed.

A further review of the progress notes indicated on an identified date resident #031 exhibited signs and symptoms of a medical condition and was transferred to hospital. On an identified date a staff member called the hospital for an update on resident #031 and was informed that they were deceased.

A review of the home's death registry binder indicated resident #031's cause of death was from identified underlying health conditions.

In an interview, staff #111 stated they recalled the family member requesting an identified test be completed and acknowledged their mistake in not documenting the interaction with resident #031’s family member in the progress notes.

In interviews, staff #103 and #109 stated they had not documented their actions in resident #031’s progress notes only endorsing verbally to oncoming shifts.

In an interview, staff #121 stated they first became aware of the need for the identified test for resident #031 when informed by staff #108.

A review of meeting notes taken by staff #106 during a meeting with family, staff,

management and resident #031's attending physician present indicated the attending physician denied receiving a referral from the charge nurse (staff #111). The notes further indicated if the physician had received a request they would have written an order for the identified test.

In an interview, staff #111 verified they had not communicated the family member's request to the attending physician.

A review of the home's investigation notes indicated staff #103, #109 and #111 received disciplines for their inaction in not completing the identified test and not documenting in the progress notes.

In an interview, staff #111 denied a pattern of inaction in completing the identified test but did verify their inaction of not documenting in resident #031's progress notes was neglect on their part.

In an interview, staff #108 verified that the pattern of inaction by staff #111, #108 and #109 had not protected resident #031 from neglect. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee had failed to ensure resident #031's SDM was notified of the results of the alleged neglect investigation immediately upon the completion.

The MOHLTC received a complaint related to resident #031 being neglected by staff. The MOHLTC also received a CIS report related to staff to resident neglect in care received for an underlying health condition, plan of care related to hot weather protocols and continence care.

A review of resident #031's health record and documentation notes indicated on an identified date their family member spoke to staff #111 and requested a test be completed as they suspected an underlying health condition. The family member stated resident #031 had been exhibiting responsive behaviours which usually indicated an underlying health condition. Further review indicated that the test had not been completed until 20 days after their initial request. Resident #031's attending physician was notified of the results and did not provide any new orders. On an identified date one day later resident #031 was transferred to hospital and admitted with identified health conditions. On an identified date after resident #031's admission to hospital the Long-Term Care Home (LTCH) held a meeting with resident #031's Power of Attorney (POA) and family members to discuss their concerns and allegations of neglect. The next day resident #031 died in hospital with the cause of death identified as the admitting diagnosis health conditions. As a result, the home initiated an investigation into this incident which resulted in staff disciplines.

The complainant verified in a conversation that neither themselves nor the POA had been notified of the results of the home's investigation related to their complaint.

In an interview staff #106 could not verify if resident #031's POA had been notified

of the results of the home's investigation related to neglect.

During a conversation, staff #120 stated that a package had been prepared for the POA but it had not been picked up from the home in the past three weeks. Staff #120 further stated the home had completed their investigation on an identified date in July 2018, and they were not sure if the above mentioned package contained any notes related to the outcome of the home's investigation. On an identified date in August 2018, the inspector received notification from the LTCH that the POA had been notified of the outcome of the home's investigation via email on the same day, 52 days after the home's internal investigation had been completed. [s. 97. (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 to ensure the resident and resident's SDM are notified of the results of the alleged neglect investigation immediately upon the completion, to be implemented voluntarily.

Issued on this 21 day of September 2018 (A1)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JOANNE ZAHUR (589) - (A1)

Inspection No. / No de l'inspection : 2018_630589_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 016340-18, 016514-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 21, 2018;(A1)

Licensee / Titulaire de permis :
CVH (No. 1) LP
766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD :
Craiglee Nursing Home
102 Craiglee Drive, SCARBOROUGH, ON, M1N-2M7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patrick Brown

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 CVH (No. 1) LP, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee must be complaint with LTCHA, 2007, c. 8, s .19 (1).

Specifically, the licensee must prepare, submit and implement a plan to ensure residents are protected from neglect. The plan must include, but is not limited, to the following:
a. Provide education specifically to RPNs #111, #103 and #109 on the licensee's prevention of abuse and neglect policy identifying the definition of neglect and staff patterns of inaction that constitute neglect,
b. Provide education specifically to RPNs #111, #103 and #109 on the home's documentation policy requirements that includes what is expected to be documented and timelines for this documentation,
c. Develop and implement a communication process to ensure there is collaboration between physicians, nurse managers and charge nurses to mitigate resident risk,
d. Develop an auditing process to ensure registered staff are following documentation policy requirements and the communication process, and
e. The home is required to maintain a documentation record of the education and training material content provided including the dates of when the education was provided, who provided the education, and signed staff attendance records.

Please submit the written plan for achieving compliance quoting inspection #2018_630589_0009, to Joanne Zahur LTC Homes Inspector, MOHLTC, by email to:
TorontoSAO.MOH@ontario.ca by September 26, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI

Grounds / Motifs :

1. The licensee failed to ensure resident #031 had been free from neglect by the licensee or staff in the home.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to resident #031 being neglected by staff related to underlying health conditions. The MOHLTC received a Critical Incident System (CIS) report related to staff to resident neglect in care received for an underlying health condition, plan of care related to hot

weather protocols and continence care.

A review of resident #031's health record indicated they had been admitted to the home on an identified date in September 2015, with underlying health conditions.

In an interview, the complainant stated resident #031 was prone to an identified health condition as they had lived with them prior to entering long-term care and they were able to detect the identified health condition as they would exhibit responsive behaviours. The complainant further stated the resident had been exhibiting these responsive behaviours during an identified time of day.

A review of the home's 24 hour report book on an identified shift, indicated an entry that a family member suspected resident #031 may have had an underlying health condition due to their exhibiting responsive behaviours and had requested an identified test be done. A review of resident #031's most recent written care plan indicated when the resident exhibited responsive behaviours they may have an underlying health condition. A further review of the 24 hour report book indicated entries for two identified dates related to the test for resident #031 however after that, there were no further entries noted.

A review of the progress notes during an identified period of time indicated resident #031 had been exhibiting responsive behaviours identified to indicate an underlying health condition.

On an identified shift, staff #121 had been scheduled to work and they stated they had not been informed of the need for an identified test for resident #031 therefore, no attempts were made by them.

In an interview, staff #105 stated they were not aware of the need for this test for resident #031. Staff #105 further stated when they did rounds on three identified dates in June 2018, the need for the identified test for resident #031 had not been communicated to them by staff #111, 103 and 109. Staff #105 stated they conduct daily rounds to each resident home area (RHA) to collect any pertinent resident information that may need to be endorsed shift to shift and require their follow-up.

A review of staff 105's 24 hour daily report for three identified dates did not indicate any entries related to the need for an identified test for resident #031. A further review of this report only indicated resident #031 was being monitored and had no

responsive behaviours.

In an interview, staff #106 stated the first time they and staff #112 became aware of the family member's request for an identified test was during the interdisciplinary team meeting (IDTC) held with identified staff, management and family members. As a result of this meeting staff #106 initiated an internal complaint investigation form and registered staff were directed by staff #112 to complete the medical procedure for resident #031, 20 days after the initial request by a family member had been made. The results of the identified test were received by the home and endorsed to resident #031's attending physician who did not endorse any new orders.

A review of the progress notes for resident #031 from an identified period indicated on several shifts no documentation related to the identified test having been completed, one entry that indicated an attempt had been made but was unsuccessful and an entry that indicated the identified test had been completed.

A further review of the progress notes indicated on an identified date resident #031 exhibited signs and symptoms of a medical condition and was transferred to hospital. On an identified date a staff member called the hospital for an update on resident #031 and was informed that they were deceased.

A review of the home's death registry binder indicated resident #031's cause of death was from identified underlying health conditions.

In an interview, staff #111 stated they recalled the family member requesting an identified test be completed and acknowledged their mistake in not documenting the interaction with resident #031's family member in the progress notes.

In interviews, staff #103 and #109 stated they had not documented their actions in resident #031's progress notes only endorsing verbally to oncoming shifts.

In an interview, staff #121 stated they first became aware of the need for the identified test for resident #031 when informed by staff #108.

A review of meeting notes taken by staff #106 during a meeting with family, staff, management and resident #031's attending physician present indicated the attending physician denied receiving a referral from the charge nurse (staff #111). The notes further indicated if the physician had received a request they would have written an

order for the identified test.

In an interview, staff #111 verified they had not communicated the family member's request to the attending physician.

A review of the home's investigation notes indicated staff #103, #109 and #111 received disciplines for their inaction in not completing the identified test and not documenting in the progress notes.

In an interview, staff #111 denied a pattern of inaction in completing the identified test but did verify their inaction of not documenting in resident #031's progress notes was neglect on their part.

In an interview, staff #108 verified that the pattern of inaction by staff #111, #108 and #109 had not protected resident #031 from neglect. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk to resident #031 evidenced as neglect. The scope of the issue was a level 1 as it was isolated to one resident. The home has a level 1 compliance history as there were no previous non-compliance with LTCH Act, s. 19 (1). Due to actual harm/risk to resident #031, a compliance order is warranted.

(589)

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

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

Dec 12, 2018

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 21 day of September 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JOANNE ZAHUR - (A1)

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

Service Area Office / Bureau régional de services : Toronto