Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2019	2019_630589_0001	002788-18, 025452-18, 026829-18, 030190-18	Critical Incident System

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

JOANNE ZAHUR (589), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 10, 11, 14, 15, 16, 17, 18, 21, 22, and 23, 2019.

During this inspection the following were inspected:
Log #002788-18/CIS #2503-000003-18 and Log #030190-18/CIS #2503-00036-18 related to resident to resident abuse, and Responsive Behaviours,
Log #025452-18 related to compliance order #001 from inspection #2018_630589_0009, s. 19 (1) Prevention of Abuse and Neglect, and
Log #026829-18 related to compliance order #001 from inspection #2018_626501_0012, s. 101, Air temperatures in the home.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Acting Director of Care (A-DOC), Nurse Managers (NM), Registered Dietitian (RD), Acting-Environmental Services Manager (A-ESM), Physician, Personal Support Workers (PSW), Registered Practical Nurse (RPN), Registered Nurse (RN), Social Worker (SW), Behavioural Support Ontario Lead (BSO-L), Maintenance Worker (MW), Resident Assessment Instrument-Minimum Data Set-Coordinator (RAI-MDS-C), residents, family members, and substitute decision makers (SDM).

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

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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
LTCHA, 2007 S.O. 2007, c.8 s. 101. (3)	CO #001	2018_626501_0012	501
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_630589_0009	589

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 O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

The licensee has failed to ensure the temperature in the home was maintained at a minimum of 22 degrees Celsius.

A compliance order (CO) #001 was served in inspection report #2018_646618_0003

under O. Reg. 79/10, s. 21. A follow up inspection to CO #001 was initiated which indicated the licensee had failed to complete steps 1, 2 and 3, as well as communicate the updated protocols to all staff. Therefore, a subsequent order under s.101 was issued.

The home was again unable to demonstrate that developed protocols had been communicated to staff as specified in the order. The previous Environmental Services Manager (ESM) was not available to describe what protocols had been developed and what education had been provided. Staff #114 who is also the Acting-Environmental Services Manager (A-ESM) was unable to locate the final protocols that were developed and any evidence of what education had taken place. The current Executive Director (ED) #100 who had only been in the position a few days, was also unable to provide the inspector with details of what the home had done to ensure compliance with s.101 of the LTCHA.

The following observations of air temperatures were made with staff #137 on an identified date in January 2019:
• Five resident rooms ranged from 19.3 to 21.6 degrees Celsius,
• An identified resident washroom was 21.1 degrees Celsius, and
• An identified tub/shower room was 15.5 degrees Celsius, and

The following observations were made with staff #114 on an identified date in January 2019, 1 day later:
• An identified shower room was 21.6 degrees Celsius, and
• An identified resident washroom was 20.4 degrees Celsius.

During the above observations, it was noted that several rooms had small portable heaters placed on the floor that had been provided by the home. However, on two occasions, there were heaters provided by residents' families. In an identified resident room a tall portable heater had been placed on the resident's overbed table close to their bed. In another identified resident room a small heater was on the floor near the resident's bedside table which could have been tipped over and it did not have an automatic shut off. Staff #137 and staff #114 ensured that these heaters were taken out of service and replaced with heaters provided by the home.

The following interviews took place on two identified dates in January 2019, with four residents regarding the air temperature in the home in which they stated the following:
• Resident #012 stated they were cold,

• Resident #013 stated it was really cold at night,
• Resident #004 stated they were cold and would like an extra blanket, and
• Resident #015 stated they were cold and on the previous day they had been really cold.

During interviews, staff #114 and staff #100 acknowledged it was a challenge to maintain the home at a minimum of 22 degrees Celsius related to heating, ventilation, and air conditioning systems which may include building renovations as necessary. [s. 21.]

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system (CIS) report related to an incident of physical aggression between two residents. The CIS report indicated that during dinner time on an identified date in November 2018, resident #002 had been exhibiting a responsive behaviour towards resident #004. Resident #003 who is seated at the same dining table as resident #004, had asked that resident #002 stop, but they did not. Resident #003 got up from their dining chair with the

aid of two mobility devices and exhibited a responsive behaviour towards resident #002. Resident #002 allegedly then struck one of the mobility devices resulting in resident #003 experiencing a fall incident.

Observations by the inspector indicated the large and small dining rooms are situated beside each other with the servery between them. On the same day, at the lunch and dinner meals resident #002 was observed seated in the large dining room eating their meal calmly. Residents #003 and #004 were observed in the small dining room seated at the same table together which is located beside the table where resident #002 used to be seated.

During interviews, resident #003 recalled an incident had occurred in the small dining room but thought it had involved another resident and not resident #002. Resident #003 stated they liked resident #002. Resident #002 stated on the above mentioned date, that resident #003, out of the blue, exhibited a responsive behaviour towards them. Resident #002 further stated they did not strike resident #003's mobility device, and denied exhibiting a responsive behaviour towards resident #004.

During an interview, staff #102 stated they had been assigned to monitor and serve dinner in the small dining room on an identified date in November 2018. When they were at the servery getting dessert they heard a commotion coming from the small dining room. Upon entering the dining room they observed resident #002 was wet and resident #003 was kneeling on the floor. PSW #102 further stated the residents present informed them that residents #002 and #003 had been exhibiting responsive behaviours towards each other. Staff #102 also stated they had informed the charge nurse during the preceding week and again on the evening before the incident that resident #002 had been exhibiting responsive behaviours towards resident #004 over the past two to three days and there was building tension between residents #002 and #003 as a result. Staff #102 stated even though they had reported increasing tension between these two residents, they remained assigned to the same dining room.

During interviews with residents #005, #006 and #007 who had been present in the dining room during this altercation, they recalled the incident and that resident #003 had asked resident #002 to stop but they did not. Resident #007 further stated that resident #002 was known to speak their mind, exhibit responsive behaviours towards resident #004 and other residents and that this was not something new.

During an interview, staff #113 acknowledged they had been informed of increasing

tension between residents #002 and #003, however the residents remained assigned to the same dining room. Staff #113 stated they had not documented in the progress notes, had not completed a referral to the home's internal Behavioural Support Ontario lead (BSO), as they thought the day shift nurse had completed one, nor had they moved the resident's from their assigned dining room until reassessed by the BSO lead.

During an interview, staff #105 stated she recalled being informed of increasing tension between resident's #002 and #003 however thought they had documented this. A review of the progress notes did not indicate any entries had been completed nor a referral to the BSO. Staff #105 acknowledged when the BSO lead is not in the home, they are responsible to implement interventions and strategies when resident(s) are exhibiting responsive behaviours.

During an interview, staff #110 stated they had not been aware of the increasing tension between resident's #002 and #003 until they returned to work, at which time they conducted an investigation into the incident. They spoke to the two resident's involved, conducted a debrief with the staff and implemented interventions to ensure the two residents involved were not in the same dining room. Staff #110 further stated that the Charge Nurses (CNs) and NMs are in charge in their absence and have the authority to implement new interventions and strategies related to responsive behaviours. Staff #110 concluded that the home had failed to ensure that strategies had been implemented to minimize the risk of altercations and potentially harmful interactions between these two residents. [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The home has failed to ensure that the home was maintained in a good state of repair.

During a follow-up inspection for compliance order #001 served in report #2018_626501_0012 related to air temperatures in the home, observations were conducted by staff #137 and the inspector which indicated an identified shower/tub room was cold with an air temperature reading of 15.5 degrees Celsius.

In addition to the room being cold, the inspector observed the following:
• a radiator cover was marked, falling off and exposing pipes,
• the surface of the white floor tiles appeared worn off and dirty,
• an intake airway was covered with gray tape which was hanging off,
• wall tiles were broken and some replaced tiles were not of the same colour and roughly affixed to the wall exposing portions of grout to surrounding tiles,
• wall corners had been damaged and poorly repaired,
• a scrub brush in the shower was rusted,
• old glue marks remained on the wall where other dispensers had once been,
• a wooden cupboard that held cleaning chemicals was warped and marked with stains,
• one of the ceiling heater covers was not attached properly,
• a light fixture cover was cracked and discoloured, and
• white ceiling tiles above shower area were discoloured from what could have been a leak from above; one whole ceiling tile was almost completely brown.

During an interview, staff #100 stated the room obviously needed work to make it more appealing. Due to the cold temperature and disrepair, staff #100 took the room out of service. [s. 15. (2) (c)]

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.

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

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) :	JOANNE ZAHUR (589), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2019_630589_0001
Log No. / No de registre :	002788-18, 025452-18, 026829-18, 030190-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 4, 2019
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 :	April Beckett

To CVH (No. 1) LP, 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

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Order / Ordre :

The licensee must be complaint with O. Reg. 79/10, s. 21.

Specifically, the licensee must prepare, submit and implement a plan to ensure that the home is maintained at a minimum temperature of 22 degrees.

The plan must include, but is not limited, to the following:
a. Immediate, short and long-term plans to resolve ongoing issues with the heating, ventilation, and air conditioning systems in the home.
b. Implement a strategy to ensure there is experienced leadership for the home's maintenance services on a consistent basis.
c. Develop and implement strategies to ensure the maintenance services provided will address air temperatures in all home areas including resident rooms, common areas and shower/tub rooms.
d. Develop and implement a method of communicating to all staff and family members to ensure that all portable heaters are approved by the home's Environmental Services Manager prior to use.
e. Develop and implement an auditing system that will ensure the safe use of portable heaters in resident rooms during the cold weather months. Maintain a documented record of resident rooms with portable heaters and the safety audits completed.
f. Develop and implement a temperature auditing system to monitor temperatures during days, evenings and night shifts.

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 February 19, 2019.

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

Grounds / Motifs :

1. The licensee has failed to ensure the temperature in the home was maintained at a minimum of 22 degrees Celsius.

A compliance order (CO) #001 was served in inspection report #2018_646618_0003 under O. Reg. 79/10, s. 21. A follow up inspection to CO #001 was initiated which indicated the licensee had failed to complete steps 1, 2 and 3, as well as communicate the updated protocols to all staff. Therefore, a

subsequent order under s.101 was issued.

The home was again unable to demonstrate that developed protocols had been communicated to staff as specified in the order. The previous Environmental Services Manager (ESM) was not available to describe what protocols had been developed and what education had been provided. Staff #114 who is also the Acting-Environmental Services Manager (A-ESM) was unable to locate the final protocols that were developed and any evidence of what education had taken place. The current Executive Director (ED) #100 who had only been in the position a few days, was also unable to provide the inspector with details of what the home had done to ensure compliance with s.101 of the LTCHA.

The following observations of air temperatures were made with staff #137 on an identified date in January 2019:
• Five resident rooms ranged from 19.3 to 21.6 degrees Celsius,
• An identified resident washroom was 21.1 degrees Celsius, and
• An identified tub/shower room was 15.5 degrees Celsius, and

The following observations were made with staff #114 on an identified date in January 2019, 1 day later:
• An identified shower room was 21.6 degrees Celsius, and
• An identified resident washroom was 20.4 degrees Celsius.

During the above observations, it was noted that several rooms had small portable heaters placed on the floor that had been provided by the home. However, on two occasions, there were heaters provided by residents' families. In an identified resident room a tall portable heater had been placed on the resident's overbed table close to their bed. In another identified resident room a small heater was on the floor near the resident's bedside table which could have been tipped over and it did not have an automatic shut off. Staff #137 and staff #114 ensured that these heaters were taken out of service and replaced with heaters provided by the home.

The following interviews took place on two identified dates in January 2019, with four residents regarding the air temperature in the home in which they stated the following:
• Resident #012 stated they were cold,

• Resident #013 stated it was really cold at night,
• Resident #004 stated they were cold and would like an extra blanket, and
• Resident #015 stated they were cold and on the previous day they had been really cold.

During interviews, staff #114 and staff #100 acknowledged it was a challenge to maintain the home at a minimum of 22 degrees Celsius related to heating, ventilation, and air conditioning systems which may include building renovations as necessary. [s. 21.]

The severity of this issue was determined to be a level 2 as there was minimal/potential harm to the residents. The scope of the issue was a level 3 as it was widespread affecting all residents of the home. Compliance history was a level 3 as there was related non-compliance that included:
• Compliance order (CO) made under s.21 of the Regulations, February 28, 2018, (#2018_646618_0003) with a compliance date of March 30, 2018.
• CO made under s.101.(3) of the LTCHA, 2007, August 28, 2018, (#2018_626501_0012) with a compliance date of October 5, 2018. (501)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 17, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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