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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 18, 2018	2018_370649_0005	004477-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Maynard Nursing Home
28 Halton Street TORONTO ON M6J 1R3

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

JULIEANN HING (649), ARIEL JONES (566), NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, and 28, 2018.

The following intakes were also inspected:
Log #023547-17/ CIS #2211-000017-17 related to allegation of staff to resident abuse
Log #012895-17/ CIS #2211-000012-17 related to improper treatment
Log #009964-17 related to allegation of abuse, Residents' Bill of Rights and plan of care
Log #008975-17 related to a follow up order on safe transfers and positioning

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DNC), Director of Food Services (DFS), Registered Dietitian (RD), Activity Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Administration Coordinator, Volunteers, Residents and Family members.

During the course of the inspection, the inspectors conducted a tour of the home, observed staff to resident interactions and provision of care, reviewed relevant policies and procedures, staff training records, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **5 WN(s)**
- **2 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. 36.	CO #001	2017_518645_0007	566

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.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 order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

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

On April 19, 2017, the following compliance order (CO #001) from inspection number 2017_518645_0007 was made under O. Reg. 79/10, s. 36:

The licensee was ordered to prepare and submit a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan will include, but is not limited to the following:
1. Direct care staff receive training/re-training on safe use of mechanical lifts used at the home and safe transferring/positioning of residents while in bed.
2. A schedule to test and monitor staff knowledge and compliance on safe transferring/positioning technique.

The compliance plan was due on June 11, 2017, and the compliance due date was August 11, 2017.

Record review of the home's training records revealed that not all staff members received training on bed mobility, mechanical lift, positioning and transfers during an in-service held in May 2017, (following receipt of order #001).

An interview with the General Manager (GM) of the home revealed that the home was taken over by new management in June 2017 and that they had been GM of the home since August 2017. The GM confirmed that based on available records, not all the direct care staff actively working in the home at the time received the identified training/re-training.

The GM acknowledged the home did not comply with step one of compliance order #001 in relation to providing training/re-training on safe use of mechanical lifts and safe transferring/positioning of residents while in bed to all direct care staff by the compliance due date. [s. 101. (3)]

2. The licensee did not comply with the conditions to which the license was subject. The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health

Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system.

Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HCSP) residents RAI-MDS Data.

The RAI-MDS 2.0 User's Manual Canadian Version September 2010 indicates to review the resident's record and consult with the nurse assistant about the presence of an identified type of altered skin integrity, examine the resident, and determine the severity and number of any present.

A review of resident #008's December 2017 RAI-MDS assessment indicated the resident had many areas of altered skin integrity.

Further review of the resident's clinical record including the resident's care plan did not indicate any documentation of resident #008 having any areas of altered skin integrity at the time of this assessment or at any time before.

Interviews with Registered Practical Nurse (RPN) #115 and Director of Nursing Care (DNC) confirmed resident #008 did not have areas of altered skin integrity prior to or at the time of the RAI –MDS assessment and confirmed this was a coding error.

The licensee did not comply with the conditions to which the licensee was subject. [s. 101. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and are consistent with and complement each other.

Resident #007 triggered during stage one for choices lacking.

Interview with resident #007 revealed they are only being offered a modified texture diet and have been refusing their meals and wait for a family member to bring in regular textured food from outside of the home.

Review of resident #007's current care plan and kardex indicates a regular diet, regular texture and regular fluids. A review of the dietary serving sheet in the dining room indicates regular fluid and modified texture diet.

Interviews with PSWs #101, 102, and 113 revealed that they had offered resident #007 only modified textured foods over the last several months and the resident had refused. According to these staff, they were unaware that the resident is allowed to have all texture foods and stated that the resident's family member would bring in regular foods from outside for the resident. The staff further revealed they were following the dietary serving sheet in the dining room which indicated a modified texture diet and were not aware that the resident can have all textured foods as stated in the resident's care plan and kardex.

Interview with Registered Dietitian (RD) #110 revealed that resident #007 had been ordered all texture foods. The RD further indicated they were not aware that the resident

was only being offered a modified texture diet by the home and stated the dietary serving sheet should indicate all diet textures.

Interview with the Director of Food Services (DFS) #131 who started employment with the home in January 2018, and is responsible for updating the dietary serving sheet revealed that they had never received any communication from the RD of a diet change for resident #007. According to the DFS the staff had been following the dietary serving sheet which indicated a modified textured diet and giving the resident regular texture foods only when requested by the resident's family member. The DFS further revealed that the discrepancy between the kardex and the dietary serving sheet had not been identified by the staff as the residents' family member had been bringing in regular textured foods for the resident when they refused the modified texture diet offered in the home.

The above interviews demonstrated that staff failed to collaborate with each other in the development and implementation of the plan of care as it related to the diet order for resident #007. [s. 6. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A review of the home's medication incident reports for the last quarter in 2017, indicated there was one medication error involving a resident based on the Pharmacy MedeReport Record. The home was unable to provide any additional records to indicate the resident involved, or what action was taken as a result of this medication incident in October 2017. According to this report the resident's medication should have been held if the resident's vital signs exceeded an identified value. The resident's vital signs were not being checked prior to administering this medication.

Interview with the DNC #111 who worked in the home since December 2017 revealed that the home was unable to provide any further information related to this medication incident or who was the resident involved. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #023.

Critical Incident System (CIS) submitted to the Ministry of Health and Long Term Care (MOHLTC) in June 2017, indicated resident #023 sustained an altered skin integrity during a transfer with a mechanical lift conducted by one staff member. According to resident #023's statement following the incident, PSW #108 acted alone while transferring the resident from their wheelchair to bed using the lift, and the resident sustained an injury to an identified area during the transfer.

A record review of the home's investigation notes into the incident revealed that PSW #108 stated PSW #128 helped with the transfer of resident #023 using the Hoyer lift, and that PSW #108 did not know how the resident sustained the altered skin integrity. PSW #128 denied assisting PSW #108 with the transfer of resident #023. The outcome of the home's investigation confirmed that PSW #108 acted against the home's policy by conducting a two-person transfer alone, that resident #023 sustained an altered skin integrity to an identified body area during the transfer.

An interview with PSW #108 revealed that they were assigned to resident #023 on the day of the incident and felt rushed to transfer the resident following a meeting that

evening and pressure from the resident. PSW #108 stated that they conducted part of the mechanical lift transfer alone, and that a second PSW #128 came to assist after they had already applied the sling to resident #023 and pressed the button to lift the resident up from their wheelchair. PSW #108 stated further that they did not know how resident #023 got the altered skin integrity. An interview with PSW #128 revealed that they did not conduct a transfer for resident #023 at all on that day. PSW #128 stated that they did not see resident #023 until the resident was already in bed and the resident called the PSW over to show them the altered skin integrity. When PSW #128 asked resident #023 what happened, the resident indicated it had happened during a transfer with PSW #108.

An interview with the Activity Director #126, to whom the resident reported the incident the following day, revealed that resident #023 complained of pain and was fearful of being transferred using the mechanical lift following the incident. During an interview with resident #023 in March 2018, the resident could no longer recall the incident and stated that two staff members always transfer them using the lift.

An interview with the GM confirmed that, as per the home's policy, two staff are required for all transfers using mechanical lifts. Further, the GM confirmed that the outcome of the home's investigation into the incident determined that PSW #108 conducted an unsafe transfer.

Review of the home's Compliance History revealed a history of non-compliance related to O. Reg. 79/10 s. 36. An order was issued under s. 36 during RQI report #2017_518645_0007 dated April 19, 2017, with a compliance due date of August 11, 2017. As per LQIP policy, a written notice (WN) is being issued under s. 36 as additional evidence for the existing order which was not past-due at the time of this critical incident. [s. 36.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review revealed and interview with the Residents' Council assistant confirmed that the identified concerns raised during the Residents' Council meeting in November 2017, were not addressed until the following Council meeting in December 2017. The assistant stated that due to time constraints, the concerns from both the November and December 2017 meetings were combined and addressed at the same time.

An interview with the GM confirmed that the home's response letter to Residents' Council concerns for both November and December 2017 was undated, and that the Residents' Council should have received a written response to their concerns raised during the November 2017 meeting within ten days. [s. 57. (2)]

Issued on this 2nd day of May, 2018

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649), ARIEL JONES (566), NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2018_370649_0005
Log No. / No de registre :	004477-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 18, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	Maynard Nursing Home 28 Halton Street, TORONTO, ON, M6J-1R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leann Bowman

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s.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 order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Order / Ordre :

The licensee must be compliant with s.101. (3) of the LTCHA.
Specifically the licensee must:
a) Provide education and training to all direct care staff on safe use of mechanical lifts used at the home and safe transferring/positioning of residents while in bed.
b) Keep a documented record of who received the training, the format of the training and the dates the training occurred.

Grounds / Motifs :

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

On April 19, 2017, the following compliance order (CO #001) from inspection number 2017_518645_0007 was made under O. Reg. 79/10, s. 36:

The licensee was ordered to prepare and submit a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan will include, but is not limited to the following:
1. Direct care staff receive training/re-training on safe use of mechanical lifts used at the home and safe transferring/positioning of residents while in bed.
2. A schedule to test and monitor staff knowledge and compliance on safe transferring/positioning technique.

The compliance plan was due on June 11, 2017, and the compliance due date was August 11, 2017.

Record review of the home's training records revealed that not all staff members received training on bed mobility, mechanical lift, positioning and transfers during an in-service held in May 2017, (following receipt of order #001).

An interview with the General Manager (GM) of the home revealed that the home was taken over by new management in June 2017 and that they had been GM of the home since August 2017. The GM confirmed that based on available records, not all the direct care staff actively working in the home at the time received the identified training/re-training.

The GM acknowledged the home did not comply with step one of compliance order #001 in relation to providing training/re-training on safe use of mechanical lifts and safe transferring/positioning of residents while in bed to all direct care staff by the compliance due date.

The severity of this non-compliance is minimal harm or potential for actual harm. The scope is pattern as 51 per cent of direct care staff did not receive the training. A review of the home's compliance history revealed a compliance order had been issued under inspection report 2017_518645_0007 on April 19, 2017 with a compliance date of August 11, 2017. As a result of ongoing non-compliance, a compliance order is warranted. (566)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 20, 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

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

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 18th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : JulieAnn Hing

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