Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2020	2019_659189_0020	007713-19, 018703-19, 019931-19	Critical Incident System

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

NICOLE RANGER (189)

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): December 11, 13, 16, 17, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
Log #019931-19 related to falls prevention,
Log #018703-19, #007713-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM) , Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Physiotherapist (PT), registered nurse (RN), registered practical nurse (RPN), personal support workers (PSW), and residents.

During the course of the inspection the inspector observed staff to resident interactions, the provision of care, reviewed residents' health records, staff training records, home's investigation notes, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from abuse.

The home submitted a Critical Incident System report (CIS) to the Ministry of Long Term Care (MLTC) related to an incident of staff to resident abuse. According to the CIS report, resident #001 reported that PSW#102 was inappropriate with the resident.

A review of resident #001's clinical record indicated their Cognitive Performance Score (CPS) was zero out of six which meant intact cognition. According to interview with staff, resident #001 can make themselves understood and can understand others.

In an interview resident #001 reported to the inspector that on an identified date, they felt that PSW #102 was inappropriate towards them when providing care. Resident #001 became emotional when describing the incident to the inspector.

An interview with PSW #102, confirmed they had assisted resident #001 on the identified date and acknowledged that the resident stated they were uncomfortable with the care.

Interviews with the Director of Nursing Care (DNC) and the General Manager(GM), identified that the home had conducted an investigation of the incident and they had concluded that nothing inappropriate occurred between PSW #102 and resident #001. They did identify that because of the response resident #001 had to this incident, that PSW #102 would no longer provide care to resident #001.

Given the evidence provided by resident #001 and the acknowledgement from PSW #102 that they were aware that the resident was uncomfortable with how the care was being provided, the inspector concluded that the home had failed to take appropriate actions to protect resident #001 from abuse . [s. 19. (1)]

2. The licensee has failed to ensure that resident #002 was not neglected by staff.

The home submitted a CIS report to the MLTC related to an incident of staff to resident neglect.

According to the CIS report, resident #002 called for assistance to be transferred back into the bed. It was reported to the management that PSW #104 who was assigned to provide care to resident #002, did not provide assistance to the resident with care when requested. The home conducted an internal investigation into the incident and concluded that PSW #104 had failed to respond to resident #002's call for assistance.

Interview with PSW #104 identified that they were assigned to resident #002 on the identified date. PSW #104 identified they were aware of the residents usual care need to be returned to bed after meal service, but as the resident had visitors on this occasion, and did not call to request the care, PSW #104 went on their break, leaving PSW #105 on the unit.

Interview with PSW #105 identified that they were serving snacks to co-residents, when resident #002's family member informed them that resident would like to return to bed. PSW #105 reported that they went into the resident's room, and resident #002 was upset that they had not returned to bed at their usual time. PSW #105 reported that they told the resident and family that they were unable to perform the transfer without the assistance of another staff, and that there was no one available at that time.

When PSW #104 returned to the unit, PSW #105 informed them that the resident #002 needed care. According to PSW #104 another staff member assisted them with the resident transfer back to bed. Once back in bed, the resident requested further assistance with care. PSW #104 told the resident that their shift was ending, and they did not provide the requested care.

PSW #104 did report to the staff on the oncoming shift that resident # 002 required care. PSW #104 confirmed that they were aware that resident #002 required assistance with care, but they had not provide the care as it was the end of their shift.

Interview with the DNC and the GM, confirmed that the resident did not receive assistance when they requested it, and that the failure to provide the requested assistance constituted neglect of resident #002. [s. 19. (1)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an incident of abuse involving resident #001.

The home submitted a CIS report to the MLTC related to an incident of staff to resident abuse. According to the CIS report, resident #001 reported that PSW#102 was inappropriate with the resident.

The home's policy titled "Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor", undated, directed the charge nurse or designate in any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal office to report to the police immediately.

A review of the home's internal investigation records and progress notes reviewed in Point Click Care (PCC), showed there was no documented evidence that the police were notified of the alleged abuse of resident #001. Interview with the DNC and GM confirmed that the police were not notified of the incident.

The home's policy titled " Prevention of Abuse and Neglect", undated, indicated the following resources/supports are available to the resident post incident: Support in the form of regular visits from the village chaplain, support in the form of visits from internal and/or external social worker, support through external counselling services.

During interview with resident #001 and the inspector, the resident was emotional when describing the incident. A review of the home's internal investigation records and resident's progress notes showed there was no documented evidence that emotional support or counseling was provided to the resident post incident. Interview with the DNC and GM confirmed that social work counseling services was not provided to the resident. By failing to notify the police of the alleged incident, and by not providing counseling services to resident #001 post incident, the home had failed to ensure that that their written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The home submitted an CIS report to the MLTC related to a fall with injury for resident #003.

A review of resident #003's written care plan indicated that the resident was at risk for falls and required identified fall prevention interventions.

On an identified date the inspector observed a fall prevention intervention in the resident's room.

During interviews with Assistant Director of Nursing Care (ADNC) and the Physiotherapist (PT), they indicated that resident #003 did not require the identified fall prevention intervention that was observed by the inspector. The ADNC reviewed the current written plan of care and confirmed that the plan of care was not revised as the identified fall prevention intervention was no longer necessary. Interview and observation with the ADNC they confirmed that the resident did not require the fall prevention intervention.

Interview with the DNC and the GM confirmed the home’s expectation is that the plan of care must be reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary; and the home had failed to ensure that resident #003's plan of care was revised. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

On an identified date, while conducting observations of resident #003’s room, the inspector identified that the resident’s call bell was not accessible due to a missing string.

A review of resident #003's written plan of care indicated that the call bell should be within reach for the resident. A review of the falls risk assessment indicated that resident #003 was at risk for falls.

Interview and observation by the DNC confirmed that the call bell for resident #003 was not accessible to the resident and that the resident is at risk for falls.

Interview with the DNC and the GM confirmed the home’s expectation that resident's call bells must be within reach, accessible and on at all times. [s. 17. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (3.1): an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The home submitted a CIS report to the MLTC related to resident #003 who incurred an injury which resulted in hospitalization and a significant change in their health status.

The home failed to report this to the Director for 21 days.

Interview with the ADNC, DNC and the GM, identified the reason for the delay as uncertainty about the resident’s change in status. The DNC and GM confirmed that the resident did incur a significant change in their health status and that they had not met their reporting requirements regarding this significant change. [s. 107. (3)]

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2019_659189_0020
Log No. / No de registre :	007713-19, 018703-19, 019931-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 8, 2020
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 :	Julie Music

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

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee shall ensure that all resident are protected from abuse by anyone.

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will protect residents from abuse and neglect.

The compliance plan shall include but is not limited to the following elements:

1. Ensure additional training is provided to PSW #102 and all PSW staff on:
 - Abuse recognition.
 - Home's policy on zero tolerance of resident abuse with examples.
 - Consequences for those who abuse or neglect residents.
2. Retrain direct care staff to recognize that not providing assistance with care constitutes abuse and neglect.
3. Conduct post-training evaluation for the staff to ensure comprehension of the training materials.
4. Maintain records of re-training, including who received the training, when it occurred, who provided the training, and the content of the training.

The plan shall be submitted to the Long Term Care Home Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from abuse.

The home submitted a Critical Incident System report (CIS) to the Ministry of Long Term Care (MLTC) related to an incident of staff to resident abuse. According to the CIS report, resident #001 reported that PSW#102 was inappropriate with the resident.

A review of resident #001's clinical record indicated their Cognitive Performance Score (CPS) was zero out of six which meant intact cognition. According to interview with staff, resident #001 can make themselves understood and can understand others.

In an interview resident #001 reported to the inspector that on an identified date, they felt that PSW #102 was inappropriate towards them when providing care. Resident #001 became emotional when describing the incident to the inspector.

An interview with PSW #102, confirmed they had assisted resident #001 on the identified date and acknowledged that the resident stated they were uncomfortable with the care.

Interviews with the Director of Nursing Care (DNC) and the General Manager (GM), identified that the home had conducted an investigation of the incident and they had concluded that nothing inappropriate occurred between PSW #102 and resident #001. They did identify that because of the response resident #001 had to this incident, that PSW #102 would no longer provide care to resident #001.

Given the evidence provided by resident #001 and the acknowledgement from PSW #102 that they were aware that the resident was uncomfortable with how the care was being provided, the inspector concluded that the home had failed to take appropriate actions to protect resident #001 from abuse . [s. 19. (1)] (189)

2. The licensee has failed to ensure that resident #002 was not neglected by staff.

The home submitted a CIS report to the MLTC related to an incident of staff to resident neglect.

According to the CIS report, resident #002 called for assistance to be transferred back into the bed. It was reported to the management that PSW #104 who was assigned to provide care to resident #002, did not provide assistance to the resident with care when requested. The home conducted an internal investigation into the incident and concluded that PSW #104 had failed to respond to resident #002's call for assistance.

Interview with PSW #104 identified that they were assigned to resident #002 on the identified date. PSW #104 identified they were aware of the residents usual care need to be returned to bed after meal service, but as the resident had visitors on this occasion, and did not call to request the care, PSW #104 went on their break, leaving PSW #105 on the unit.

Interview with PSW #105 identified that they were serving snacks to co-residents, when resident #002's family member informed them that resident would like to return to bed. PSW #105 reported that they went into the resident's room, and resident #002 was upset that they had not returned to bed at their usual time. PSW #105 reported that they told the resident and family that they were unable to perform the transfer without the assistance of another staff, and that there was no one available at that time.

When PSW #104 returned to the unit, PSW #105 informed them that the resident #002 needed care. According to PSW #104 another staff member assisted them with the resident transfer back to bed. Once back in bed, the resident requested further assistance with care. PSW #104 told the resident that their shift was ending, and they did not provide the requested care.

PSW #104 did report to the staff on the oncoming shift that resident # 002 required care. PSW #104 confirmed that they were aware that resident #002 required assistance with care, but they had not provide the care as it was the end of their shift.

Interview with the DNC and the GM, confirmed that the resident did not receive assistance when they requested it, and that the failure to provide the requested assistance constituted neglect of resident #002. [s. 19. (1)]

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as level 2 pattern as it related to 2 out of 3 residents reviewed. Compliance history was level 3 due to previous non compliance, a voluntary plan of correction (VPC) issued February 7, 2019, for s. 19 (1) under report 2019_641665_0002. Due to the scope being patterned and severity as potential for actual harm, a compliance order is warranted. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 03, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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 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 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 8th day of January, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : NICOLE RANGER

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