Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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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
Aug 19, 2020	2020_821640_0013	003471-20, 011930-20, 013075-20	Complaint

Licensee/Titulaire de permis

Parkwood Mennonite Home Inc.
726 New Hampshire Street WATERLOO ON N2K 4M1

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

Parkwood Mennonite Home
726 New Hampshire Street WATERLOO ON N2K 4M1

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 6, 7, 8, 9, 10, 13, 14, 15, 16, 20, 21 and 22, 2020.

During the course of the inspection, the Long Term Care Homes (LTCH) Inspector toured the home, observed the provision of care, conducted interviews, review clinical records investigative notes and policy and procedure.

The following complaints were reviewed:

Log #003471-20 related to concerns about care and safety of a resident
Log #011930-20 related to concerns about care and safety of a resident
Log #013075-20 related to an allegation of potential abuse of a resident

NOTE: THIS INSPECTION WAS CONDUCTED CONCURRENTLY WITH CRITICAL INCIDENT INSPECTION #2020_821640_0012.

During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision makers (SDM), personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behaviour Support Ontario (BSO) staff, agency staff, Assistant Director of Care (ADOC), Clinical Coordinator, the Director of Care (DOC) and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
4 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 failed to protect residents of the home from abuse by anyone.

The MLTC received a complaint from the family of resident #002 regarding alleged physical abuse by another resident on two separate occasions.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2),
(c) the use of physical force by a resident that causes physical injury to another resident.

i) Resident #002 was struck twice by resident #006, causing injury.

On an identified date in January 2020 RN #110 assessed resident #002 to have an injury that required interventions, following the incident.

On an identified date in February 2020 the strike caused an injury. Following the incident, the nurse documented the resident required interventions as a result.

The plan of care did not identify that resident #006 would harm others and therefore there were no specific interventions to address this.

ii) On an identified date in January 2020 resident #004 pushed resident #005 resulting in an injury.

The plan of care did not provide staff with interventions to prevent or mitigate resident #004 harming other residents.

RPNs #105 and #111 said the aggressive actions of residents #004 and #006, was random without any identified triggers.

RN #110 said that the home area was for residents with specific needs so it would be expected that incidents between residents occur.

The licensee failed to ensure that residents were protected from abuse by anyone. [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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that abuse of a resident by anyone, and the information upon which it was based, that resulted in harm or a risk of harm to a resident, was immediately reported to the Director.

a) Resident #002's SDM reported concerns to the MLTC regarding resident #002 being hit on two occasions by a resident, that resulted in harm or risk of harm. The licensee had notified the SDM of both incidents following their occurrence.

On an identified date in January 2020 RN #110 assessed resident #002 to have an injury. They noted the injury needed to be monitored.

RN #110 said they had not notified the DOC of this incident until the following day.

On an identified date in February 2020 the strike cased an injury. Following the incident, the nurse documented the resident required interventions as a result.

RN #100 said they did not report either incident to the Director.

The LTCH Inspector reviewed the reporting website for all homes, and there were no submitted reports regarding these incidents.

b) Resident #004 was pushed by resident #005, resulting in resident #004 sustaining an injury.

The Critical Incident (CI) report identified the date of the incident as a specific date in January 2020 however, the incident occurred the previous day. The report was submitted one day after the actual incident of alleged physical abuse.

The Director of Care (DOC) documented on the CI report that the incident was not reported to them until the following day and the licensee did not call the after-hours reporting line prior to the submission of the report to the Director.

The licensee failed to ensure that physical abuse of residents #002 and #005, that resulted in harm or risk of harm, were reported immediately to the Director. [s. 24. (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 the licensee must ensure that abuse of a resident by anyone, and the information upon which it was based, that resulted in harm or a risk of harm to a resident, is immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006's plan of care included their identified, specific responsive behaviours related to harming other residents.

The resident was reviewed related to a concern expressed from another resident's family regarding this resident harming resident #002 twice resulting in injury.

The licensee's Responsive Behaviour policy with a revised date of August 15, 2017, directed staff that when a behaviour was seen/reported a progress note was to be written specifying the behaviour exhibited. All staff were directed to look for causes of the behaviour. The resident was to have a Dementia Observation System (DOS) initiated and staff were to document the cause and action to be taken in a "Responsive Behaviour" focus on the care plan, clearly stating what the behaviour was, when it started, the goal, and actions to be taken to mitigate or manage the behaviour. All behaviours were to be listed.

PSW #108 did not identify the responsive behaviour of harming others for this resident as being included in the resident's plan of care.

RPN #105 said that all specific responsive behaviours were expected to be included in the plan of care. They said that harming other residents should be listed as a behaviour problem and there should be an intervention to prevent it from occurring.

RPN #105 reviewed the plan of care and said the responsive behaviour of harming others, had not been included in the plan of care.

There were five documented incidents of harming other residents between January and April 2020. Two incidents were identified with an injury of the recipient of the responsive behaviour.

The plan of care was reviewed by the LTCH Inspector and the responsive behaviour of harming others had not been identified.

The licensee failed to ensure that the identified responsive behaviours were included in resident #006's plan of care. [s. 26. (3) 5.]

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 the licensee must ensure that all identified responsive behaviours are included in a resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the strategies developed for resident #006, to respond to their responsive behaviour of harming other residents, were implemented.

The resident was reviewed related to a concern expressed by another resident's family regarding this resident harming resident #002 twice.

Resident #006 had five documented incidents of harming other residents including two incidents that resulted in an injury to the other resident between January and April 2020.

PSW #108 said that one intervention in resident #006's plan of care was to keep them away from others.

The plan of care directed staff to keep resident #006 at a distance from other residents.

Resident #006 was in a common area and another PSW brought resident #002 to the same area. The PSW was a new staff member and did not know to keep others away from resident #006.

RPN #105 said the staff member that placed the resident close to resident #006 was a new staff person and may not have known to keep them apart.

The licensee failed to ensure that the strategy for resident #006 to address their responsive behaviour was implemented. [s. 53. (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 the licensee must ensure that strategies developed for a resident to respond to their responsive behaviour are implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when they received a written complaint with respect to section s.24 of the Act, it was submitted to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

The SDM of resident #002, submitted complaints to the MLTC related to the provision of care, the safety of the resident and that resident #002 had been physically hurt by another resident that resulted in injury.

Resident #002 was struck by resident #006 on a specific date in January 2020 that resulted in an injury that required nursing intervention. On a specific date in February 2020 the resident was struck again by the same resident that resulted in an injury. Resident #002 required interventions by the nurse following the incident.

On a specific date in February 2020 an SDM for this resident sent a written email message to the home wanting to know in detail what was being done to address the physical abuser to ensure resident #002’s safety.

On a later date in February 2020 an SDM sent a written email to the home following up on the previous email wanting to know what action was being taken to protect resident #002 from further abuse by resident #006.

The LTCH Inspector reviewed the reporting website for all homes, and there were no submitted reports regarding these complaints about physical abuse of resident #002.

The licensee's policy "Complaints Process and Procedure with an effective date of January 2012, directed staff to forward written complaints to senior management and immediately forward them to CIATT. Written complaints relating to s.24 of the LTCHA

must be immediately reported to the MLTC and a copy of the complaint forwarded to CIATT, along with a written report documenting the response the licensee made to the complainant and a final report must be submitted documenting the response made to the complainant upon the completion of the investigation.

RN #100 said they were not required to report the written complaints to the Director unless the complainant used the word “complaint”.

The licensee failed to ensure that written complaints regarding abuse of resident #002, were reported to the Director. [s. 103. (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 the licensee must ensure that when a written complaint is received in respect to s. 24 of the Act, that it is submitted to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written complaints concerning the care of a resident were immediately forwarded to the Director.

The SDM of resident #002, submitted complaints to the MLTC related to the provision of care to the resident.

On a specific date in October 2019 the SDM emailed the licensee, after viewing video recordings of the care provided to resident #002, with concerns about treatment of resident #002 during the provision of care.

On a specific date in March 2020 an SDM emailed the licensee stating that resident #002 had been neglected in the dining room. The resident required assistance at meal time. The SDM alleged there was no assistance provided to the resident to ensure they ate their meal.

On a specific date in June 2020 an SDM sent an email message to the licensee asking how the home would provide safety for resident #002 regarding wandering residents that had been coming into the resident's room. They recounted a specific incident with another resident that had sat on the bed of resident #002.

The licensee's policy "Complaints Process and Procedure with an effective date of January 2012, directed staff to forward all written complaints to senior management and immediately forward them to Central Intake and Assessment Triage Team (CIATT).

The LTCH Inspector reviewed the reporting website for all homes, and there were no submitted reports regarding these complaints regarding the provision of care for resident #002.

RN #100 said they were not required to report the written complaints to the Director unless the complainant used the word "complaint".

The licensee failed to ensure that all written complaints concerning the care of a resident, were immediately forwarded to the Director. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the Continence Care and Bowel Management program, including interventions and the resident's responses to interventions were documented.

The MLTC received a complaint for resident #001 regarding certain aspects of their care.

On a specific date in February 2020 the resident's primary care provider ordered a monthly procedure.

The TAR for February and March 2020 included the signatures of the nurse's that completed the intervention. On a specific date in March 2020, RN #113 signed the TAR as completed but did not complete a progress note related to the intervention.

RN #113 said they had completed the intervention on a specific date in March 2020 but had not documented the intervention and details of the procedure. They said the intervention was uneventful and the resident tolerated the procedure well.

The licensee's policy "Catheterization - Insertion, Change, Irrigation and Care" with a revised date of July 20, 2017, directed staff to document in the progress notes the date and time of insertion or change, the type and size of the catheter inserted, the amount and character of the urine obtained, if a specimen was taken and how the resident tolerated the procedure.

The Director of Care (DOC) said it was an expectation that all details of any intervention were to be documented in the progress notes as directed in the licensee's policy.

The licensee failed to ensure that resident #001's intervention and their response to the intervention were documented. [s. 30. (2)]

Issued on this 26th day of August, 2020

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l’inspection :	2020_821640_0013
Log No. / No de registre :	003471-20, 011930-20, 013075-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 19, 2020
Licensee / Titulaire de permis :	Parkwood Mennonite Home Inc. 726 New Hampshire Street, WATERLOO, ON, N2K-4M1
LTC Home / Foyer de SLD :	Parkwood Mennonite Home 726 New Hampshire Street, WATERLOO, ON, N2K-4M1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Christine Normandeau

To Parkwood Mennonite Home 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 must;

a) Protect all residents from abuse by residents #004.
b) Ensure that the plan of care for residents #004, who exhibit physically aggressive responsive behaviours, identifies the specific behaviour and the interventions and strategies are developed to address that behaviour,
c) Ensure that the strategies and interventions are implemented for residents #004.

Grounds / Motifs :

1. 1. The licensee failed to protect residents of the home from abuse by anyone.

The MLTC received a complaint from the family of resident #002 regarding alleged physical abuse by another resident on two separate occasions.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means, subject to subsection (2),
(c) the use of physical force by a resident that causes physical injury to another resident.

i) Resident #002 was struck twice by resident #006, causing injury.

On an identified date in January 2020 RN #110 assessed resident #002 to have an injury that required interventions, following the incident.

On an identified date in February 2020 the strike caused an injury. Following the incident, the nurse documented the resident required interventions as a result.

The plan of care did not identify that resident #006 would harm others and therefore there were no specific interventions to address this.

ii) On an identified date in January 2020 resident #004 pushed resident #005 resulting in an injury.

The plan of care did not provide staff with interventions to prevent or mitigate resident #004 harming other residents.

RPNs #105 and #111 said the aggressive actions of residents #004 and #006, was random without any identified triggers.

RN #110 said that the home area was for residents with specific needs so it would be expected that incidents between residents occur.

The licensee failed to ensure that residents were protected from abuse by anyone.

This issue was determined to have a severity level of 3, actual harm/actual risk. The scope of the issue was determined to be level 2, a pattern. The compliance history was determined to be level 2, previous non-compliance under other sections of the LTCHA. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 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 19th day of August, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Heather Preston

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