Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2019	2019_486653_0010	001494-18, 003700-18, 008725-18, 011609-18, 012212-18, 017711-18, 018146-18, 019172-18, 019918-18, 025264-18, 025996-18, 027445-18, 027748-18	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Rockcliffe Care Community
3015 Lawrence Avenue East SCARBOROUGH ON M1P 2V7

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

ROMELA VILLASPIR (653)

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): April 3, 4, and 5, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intakes related to falls had been inspected:

-Log #(s): 001494-18, 003700-18, 008725-18, 011609-18, 012212-18, 017711-18, 018146-18, 019172-18, 019918-18, 025264-18, 025996-18, 027445-18, and 027748-18.

During the course of the inspection, the inspector reviewed the home's staffing schedule, the home's investigation notes, complaints and CIS binders, residents' clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Assistant Director of Care (ADOC), and the Executive Director (ED).

A Compliance Order related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent complaint inspection report(s) #2019_486653_0009 (Log #s 008535-17, 029445-17, 028666-17, 001996-19) and #2019_684604_0007 (Log #019628 -18) will be issued in this report.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home had submitted a Critical Incident Report (CIR) to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated on an identified date and time, the Personal Support Worker (PSW) informed the registered staff that an identified incident occurred to resident #006 during care. The resident was sent to the hospital for further treatment and evaluation.

A review of resident #006's written plan of care indicated they required an identified number of staff for assistance with bed mobility.

A review of resident #006's progress note indicated the PSW informed the Registered Practical Nurse (RPN) that resident #006 had an identified incident, which resulted in an injury and further assessment at the hospital.

During an interview, RPN #134 acknowledged they had worked during the identified shift, and at an identified time, PSW #135 reported to them that resident #006 had an incident during care. RPN #134 went to the resident's bedroom and found them with an identified injury. RPN #134 sent them to the hospital for further assessment. The RPN further indicated the resident required an identified number of staff for assistance with bed mobility, and confirmed the required assistance was not provided at the time of the incident.

At the time of the inspection, the PSW was no longer employed with the home and was unavailable for an interview.

During an interview, Assistant Director of Care (ADOC) #116 indicated they reviewed the home's video surveillance following the incident and noted that care was not provided to resident #006 as specified in the plan, which resulted in an injury. [s. 6. (7)]

2. The following evidence was identified under inspection report #2019_486653_0009 (Log #s 028666-17,001996-19):

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline received complaint related to resident #002 losing their personal item, not getting physiotherapy services, and sustaining multiple falls in the home.

A telephone interview with the complainant conducted by Inspector #746 indicated resident #002 recently had a fall in the home and got hurt.

The home had submitted a CIR to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated on an identified date and time, a PSW reported that resident #002 was found lying in an identified area of the home. Resident #002 sustained an identified injury and was sent to the hospital for further assessment and treatment.

A review of resident #002's written plan of care indicated they required an identified number of staff for assistance with care.

An interview with PSW #119 indicated they had worked during the identified shift and was assigned to resident #002's care. PSW #119 indicated they had asked PSW #121 to assist them in transferring resident #002 from their assistive device using a transfer equipment. After the transfer, the transfer equipment was returned and PSW #121 left and went to the dining room. PSW #119 stated they transported the resident to an identified area and did not remain with the resident. PSW #119 indicated they went to another resident to help with transfer, and when they returned to resident #002, that was when PSW #119 had found them lying on the floor. The PSW further stated they would normally stay with the resident, however, on that particular day the PSW left resident #002 alone, to help another resident.

An interview with PSW #121 acknowledged they assisted PSW #119 with resident #002's transfer from their assistive device using the transfer equipment, and they had left and went to the dining room right after the transfer.

An interview with Registered Nurse (RN) #120 indicated PSW #119 reported to them that resident #002 had a fall in an identified area. The RN attended to the resident and noted an injury. RN #120 further indicated the resident did not complain of pain, and they had treated the injury. The RN stated resident #002 was not supposed to be left alone at an identified time.

During an interview, ADOC #116 acknowledged that care was not provided to resident #002 as specified in the plan when they had been left alone at an identified time. The ADOC further acknowledged that the incident resulted in actual harm as resident #002

sustained an identified injury. [s. 6. (7)]

3. The following evidence was identified by Inspector #746 under inspection report #2019_486653_0009 (Log #s 008535-17, 029445-17):

The MOHLTC received a complaint related to weight changes of resident #011.

A telephone interview with the complainant indicated that the staff at the home were over feeding resident #011. The complainant stated that the staff would offer the resident additional snacks during nourishment pass which were not part of the resident's plan of care. The complainant stated they had observed the staff providing resident #011 with additional snacks which resulted in nutrition concerns.

A review of resident #011's admission written plan of care indicated that staff were to provide the resident with identified snacks during the afternoon and evening nourishment pass.

An interview with PSW #107 indicated they would give the resident extra snacks as staff felt the resident was always hungry and was a good eater. PSW #107 indicated that the staff provided resident #011 with extra snacks since their admission and it was not until two to three months ago when staff were informed to provide labelled healthy snacks to resident #011.

An interview with PSW #111 indicated that resident #011's family member had spoken to them regarding concerns related to staff providing the resident with additional snacks during nourishment. PSW #111 indicated that the resident was receiving extra snacks from staff. PSW #111 stated that resident #011 was not able to retrieve snacks on their own, and snacks were provided to the resident by staff. PSW #111 further indicated that for the last two to three months was the first time the snack cart had been coming up with labelled snacks.

An interview with Registered Dietitian (RD) #114 indicated that the home was aware of the family's concerns related to staff providing extra snacks to resident #011 and that the nourishment cart was provided to staff with the resident's prescribed snacks to discourage staff from giving extra snacks. RD #114 indicated education was provided to staff to discourage them from providing resident #011 with extra snacks and the written plan of care was reviewed as well.

An interview with ADOC #116 acknowledged the home did not provide care to resident #011 as specified in the plan of care. [s. 6. (7)]

4. The following evidence was identified by Inspector #604 under complaint inspection report #2019_684604_0007 (Log #019628-18):

The MOHLTC ACTIONline received a complaint related to resident #022 not receiving appropriate care in the home.

During a telephone interview, the complainant indicated that resident #022 was not receiving an identified care service. A review of the written plan of care indicated resident #022 required staff to provide the identified care service on their bath/shower day.

Observations were conducted by Inspector #604 on resident's bath/shower days and with each observation made, the Inspector noted that the identified care service was not provided to resident #022.

During an interview, PSW #140 stated that on bath/shower days if agreeable by the resident, the identified care service would be provided. The PSW confirmed they provided resident #022 with the bath/shower that day, but did not provide the identified care service to the resident.

During an interview, RN #120 indicated on bath/shower days the staff would provide the identified care service to resident #022, as it was the home's policy. The RN indicated that the identified care service should have been provided. The RN and Inspector #604 observed resident #022 and the RN acknowledged that the identified care service had not been provided to resident #022 as specified in the plan.

The licensee had failed to ensure that the care set out in the plan of care was provided to residents #006, #002, #011, and #022 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 13th day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ROMELA VILLASPIR (653)

Inspection No. / No de l'inspection : 2019_486653_0010

Log No. / No de registre : 001494-18, 003700-18, 008725-18, 011609-18, 012212-18, 017711-18, 018146-18, 019172-18, 019918-18, 025264-18, 025996-18, 027445-18, 027748-18

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : May 10, 2019

Licensee / Titulaire de permis : Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD : Rockcliffe Care Community
3015 Lawrence Avenue East, SCARBOROUGH, ON, M1P-2V7

Shelley Fazackerley

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

1. Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure that care is provided to residents #006, #002, #011 and #022 as specified in their plan of care, including but not limited to the identified areas of concern.

2. The above mentioned documentation shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2019_486653_0010 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by May 24, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home had submitted a Critical Incident Report (CIR) to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated on an identified date and time, the Personal Support Worker (PSW) informed the registered staff that an identified incident occurred to resident #006 during care. The resident was sent to the hospital for further treatment and evaluation.

A review of resident #006's written plan of care indicated they required an

identified number of staff for assistance with bed mobility.

A review of resident #006's progress note indicated the PSW informed the Registered Practical Nurse (RPN) that resident #006 had an identified incident, which resulted in an injury and further assessment at the hospital.

During an interview, RPN #134 acknowledged they had worked during the identified shift, and at an identified time, PSW #135 reported to them that resident #006 had an incident during care. RPN #134 went to the resident's bedroom and found them with an identified injury. RPN #134 sent them to the hospital for further assessment. The RPN further indicated the resident required an identified number of staff for assistance with bed mobility, and confirmed the required assistance was not provided at the time of the incident.

At the time of the inspection, the PSW was no longer employed with the home and was unavailable for an interview.

During an interview, Assistant Director of Care (ADOC) #116 indicated they reviewed the home's video surveillance following the incident and noted that care was not provided to resident #006 as specified in the plan, which resulted in an injury. (653)

2. The following evidence was identified under inspection report #2019_486653_0009 (Log #s 028666-17,001996-19):

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline received complaint related to resident #002 losing their personal item, not getting physiotherapy services, and sustaining multiple falls in the home.

A telephone interview with the complainant conducted by Inspector #746 indicated resident #002 recently had a fall in the home and got hurt.

The home had submitted a CIR to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated on an identified date and time, a PSW reported that resident #002 was found lying in an identified area of the home. Resident #002 sustained an identified

injury and was sent to the hospital for further assessment and treatment.

A review of resident #002's written plan of care indicated they required an identified number of staff for assistance with care.

An interview with PSW #119 indicated they had worked during the identified shift and was assigned to resident #002's care. PSW #119 indicated they had asked PSW #121 to assist them in transferring resident #002 from their assistive device using a transfer equipment. After the transfer, the transfer equipment was returned and PSW #121 left and went to the dining room. PSW #119 stated they transported the resident to an identified area and did not remain with the resident. PSW #119 indicated they went to another resident to help with transfer, and when they returned to resident #002, that was when PSW #119 had found them lying on the floor. The PSW further stated they would normally stay with the resident, however, on that particular day the PSW left resident #002 alone, to help another resident.

An interview with PSW #121 acknowledged they assisted PSW #119 with resident #002's transfer from their assistive device using the transfer equipment, and they had left and went to the dining room right after the transfer.

An interview with Registered Nurse (RN) #120 indicated PSW #119 reported to them that resident #002 had a fall in an identified area. The RN attended to the resident and noted an injury. RN #120 further indicated the resident did not complain of pain, and they had treated the injury. The RN stated resident #002 was not supposed to be left alone at an identified time.

During an interview, ADOC #116 acknowledged that care was not provided to resident #002 as specified in the plan when they had been left alone at an identified time. The ADOC further acknowledged that the incident resulted in actual harm as resident #002 sustained an identified injury. (653)

3. The following evidence was identified by Inspector #746 under inspection report #2019_486653_0009 (Log #s 008535-17, 029445-17):

The MOHLTC received a complaint related to weight changes of resident #011.

A telephone interview with the complainant indicated that the staff at the home were over feeding resident #011. The complainant stated that the staff would offer the resident additional snacks during nourishment pass which were not part of the resident's plan of care. The complainant stated they had observed the staff providing resident #011 with additional snacks which resulted in nutrition concerns.

A review of resident #011's admission written plan of care indicated that staff were to provide the resident with identified snacks during the afternoon and evening nourishment pass.

An interview with PSW #107 indicated they would give the resident extra snacks as staff felt the resident was always hungry and was a good eater. PSW #107 indicated that the staff provided resident #011 with extra snacks since their admission and it was not until two to three months ago when staff were informed to provide labelled healthy snacks to resident #011.

An interview with PSW #111 indicated that resident #011's family member had spoken to them regarding concerns related to staff providing the resident with additional snacks during nourishment. PSW #111 indicated that the resident was receiving extra snacks from staff. PSW #111 stated that resident #011 was not able to retrieve snacks on their own, and snacks were provided to the resident by staff. PSW #111 further indicated that for the last two to three months was the first time the snack cart had been coming up with labelled snacks.

An interview with Registered Dietitian (RD) #114 indicated that the home was aware of the family's concerns related to staff providing extra snacks to resident #011 and that the nourishment cart was provided to staff with the resident's prescribed snacks to discourage staff from giving extra snacks. RD #114 indicated education was provided to staff to discourage them from providing resident #011 with extra snacks and the written plan of care was reviewed as well.

An interview with ADOC #116 acknowledged the home did not provide care to resident #011 as specified in the plan of care. (653)

4. The following evidence was identified by Inspector #604 under complaint

inspection report #2019_684604_0007 (Log #019628-18):

The MOHLTC ACTIONline received a complaint related to resident #022 not receiving appropriate care in the home.

During a telephone interview, the complainant indicated that resident #022 was not receiving an identified care service. A review of the written plan of care indicated resident #022 required staff to provide the identified care service on their bath/shower day.

Observations were conducted by Inspector #604 on resident's bath/shower days and with each observation made, the Inspector noted that the identified care service was not provided to resident #022.

During an interview, PSW #140 stated that on bath/shower days if agreeable by the resident, the identified care service would be provided. The PSW confirmed they provided resident #022 with the bath/shower that day, but did not provide the identified care service to the resident.

During an interview, RN #120 indicated on bath/shower days the staff would provide the identified care service to resident #022, as it was the home's policy. The RN indicated that the identified care service should have been provided. The RN and Inspector #604 observed resident #022 and the RN acknowledged that the identified care service had not been provided to resident #022 as specified in the plan.

The licensee had failed to ensure that the care set out in the plan of care was provided to residents #006, #002, #011, and #022 as specified in the plan.

The severity of this issue was determined to be:
-a level 3 as there was actual harm to residents #006 and #002;
-a level 2 as there was actual risk to resident #011 and;
-a level 1 as there was no harm to resident #022.
The scope was a level 3 as it related to four residents. The home had a level 4 compliance history as they had on-going non-compliance with s. 6 (7) of the LTCHA that included:
-Voluntary Plan of Correction issued June 30, 2016 (#2016_302600_0006);

-Voluntary Plan of Correction issued July 12, 2018 (#2018_523461_0008). (653)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 26, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 10th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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