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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém 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
Dec 20, 2019	2019_549107_0015	017125-19, 017126-19	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

The Village of Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

MICHELLE WARRENER (107)

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): November 26, 27, 28, December 4, 5, 6, 9, 12, 2019

The following intakes were completed during this Critical Incident System inspection:
Log #017125-19, CIS #AH IL-69918-AH/CI 2854-000017-19 related to a fall with injury
Log #017126-19, CIS #AH IL-69861-AH CI 2854-000016-19 related to staff to resident neglect resulting in injury

This inspection was completed concurrently with Complaint Inspection 2019_549107_0016.

PLEASE NOTE: A Written Notification related to O.Reg. 79/10, s. 30 (2), and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (4)(b), identified in concurrent inspection #2019_549107_0016 (Log # 019632-19 IL-71024-HA), were issued in this report.

During the course of the inspection, the inspector(s) spoke with The Acting Assistant General Manager, Director of Nursing Care, Assistant Director of Nursing Care, Physiotherapist, Exercise Therapist, Registered and front line nursing staff (RN, RPN, PSW), and residents, and family members.

The Inspector made observations of care provided to residents, and reviewed clinical records, the licensee's policies, investigative notes made by staff, and other documents maintained by the home.

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

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

4 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 :

The licensee failed to ensure that resident #002 was not neglected by the licensee or staff.

The Ontario Regulation 79/10, section 5 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Critical Incident System (CIS) Report AH IL-69861-AH CI 2854-000016-19 was submitted to the Ministry of Long-Term Care for alleged abuse/neglect of resident #002 that caused injury to the resident.

During interview with Inspector #107 and in the home's investigative notes of the incident, PSWs #103 and PSW #104 confirmed they both transferred resident #002 to a device as per directions in the resident's plan of care. Both PSWs then left the resident and attended to another resident's care and left the resident for an extended period of time.

The home's policy identified specific criteria to determine if a resident was able to be left alone on a device. During interview with Inspector #107, the Acting Assistant General Manager #100 stated that based on the home's policy criteria, staff should not have left the resident unattended on the device. The Acting Assistant General Manager also confirmed that PSW #103 and #104 left resident #002 unattended on the device for an extended period.

The resident required the assistance of staff to use the device. The resident had been left on the device unattended by staff for an extended period and the resident had an incident that resulted in injury.

The Director of Nursing Care (DNC) confirmed that staff had received disciplinary action as a result of the failure to ensure the safety of resident #002. Staff did not provide resident #002 with the care, services, and assistance required, and that inaction jeopardized the health, safety and well-being of the resident.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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 :

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of resident #001 so that their assessments were integrated and were consistent with and complemented each other.

A specific admission assessment identified resident #001 as a high risk for falls based on the resident's history of falls, prior to admission. A different risk assessment, completed by registered nursing staff, identified the resident as moderate risk for falls. The two assessments were not consistent and did not complement each other.

During interview with Exercise Therapist #107, they indicated that the nursing falls risk assessment used CCAC admission information for the coding. The other assessment

indicated that the falls risk history came from discussion with family.

The two assessments were not consistent with each other and the falls risk level differed between the two assessments that were completed on the same day. [s. 6. (4) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care of residents collaborated with each other in the development and implementation of the plan of care for residents #001, #002, and #003 so that the different aspects of care were integrated and were consistent with and complemented each other. .

A. Resident #001 had a fall that resulted in an injury to the resident.

During interview with Inspector #107, RPN #115, who was working at the time of the resident's fall and had assessed the resident, stated that the resident had an injury, and that staff were to use a mechanical lift to transfer the resident. The resident had previously been independent with mobility and after the fall had a change in mobility. Documentation in resident #001's clinical progress notes directed staff to use a mechanical lift for transfers.

During interview with Inspector #107, and in the home's investigative notes, PSW #117, who transferred the resident, stated they were unaware of the need to use a mechanical lift for the resident and transferred the resident without using a mechanical lift.

During interview with Inspector #107, RPN #115 stated that PSW staff had transferred the resident prior to communication from registered staff about the need for a mechanical lift for transferring the resident.

Staff did not collaborate in the implementation of the resident's plan of care related to using a mechanical lift for transferring the resident after a fall.

B. Resident #002 had a fall that resulted in injury to the resident.

The plan of care related to an activity of daily living for resident #002 at the time of a fall, identified the resident required staff assistance with the activity of daily living but did not include a mechanical lift.

A different section of the resident's plan of care was updated six months prior to the fall to include a mechanical lift for transfers with staff assistance.

According to all staff interviewed by Inspector #107, the resident required staff assistance using a mechanical lift at the time of the incident. Staff providing care to the resident were aware of the requirement and used staff assistance with a mechanical lift when they transferred the resident prior to the fall, however, the resident's written plan of care related to the activity of daily living was not revised to include the mechanical lift until after the fall. Different sections of the resident's plan of care, written by different staff, were not consistent in the requirement for a mechanical lift for an activity of daily living.

C. Resident #003 had a Physician order for a medical directive and the order was in place after re-admission to the long-term care home. The Medication Administration Record (MAR) in place during the same time frame, was not consistent with the orders from the Physician.

During interview with Inspector #107, the Director of Nursing Care confirmed the direction on the Physician order and the direction on the resident's MAR were not consistent.

Staff did not collaborate in the development and implementation of the plan of care so that the direction related to the administration of a medical directive was consistent and provided clear direction for staff. [s. 6. (4) (b)]

3. The licensee failed to ensure that residents had their plan of care reviewed and revised when the resident’s care needs changed in relation to falls risk and assistance required for transferring.

A. Resident #001 had a fall that resulted in an injury to the resident. A quarterly falls risk assessment identified the resident was at high risk for falls. Previously, the resident was identified at moderate risk for falls. The resident’s written plan of care was not updated to include the revised risk level until 12 days later.

B. Resident #002 had a fall with injury on a specified date. Registered nursing staff completed a falls risk assessment and identified the resident was at high risk for falls. The resident's plan of care on that date indicated the resident was at a moderate risk of falls. The resident's plan of care was not updated until 13 days later, to include the change to high risk for falls. The resident's plan of care was not revised when there was a change in the resident's risk of falling from moderate risk to high risk.

During interview with Inspector #107, Registered Practical Nurse #114 stated that registered staff were to update residents' plans of care at the time a change was identified.

Documentation in the Annual Program Evaluation for the falls prevention and management program also identified that falls risk assessment scores were not up to date in resident plans of care.

During interview with Inspector #107, the Director of Nursing Care (DNC) confirmed that resident plans of care were not always updated at the time a change was identified. [s. 6. (10) (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 with s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and

LTCHA, 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,
(b) the resident's care needs change, to be implemented voluntarily.

WN #3: 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 :

A. The licensee failed to ensure that any actions taken with respect to resident #002 under the falls program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #002 had an unwitnessed fall that resulted in injury to the resident. The licensee's policy, "Head Injury Routine" required staff to complete a head injury routine for residents with actual or suspected head injury, including unwitnessed falls. The policy required staff to follow the time frames for monitoring indicated on the electronic form in Point Click Care (PCC). The monitoring form in PCC required staff to monitor the resident's vital signs and 11 indicators at 11 time intervals.

The Head Injury Routine, documented in the Assessment tab of Point Click Care for resident #002, was incomplete for one of the time intervals.

During interview with Inspector #107, the Director of Nursing Care (DNC) confirmed that the Head Injury Routine form on PCC completed for one of the time intervals was blank and had not been completed as per the home's Head Injury Routine policy requirement.

During interview with Inspector #107, Registered Nurse #106 who completed the Head Injury Routine, stated that they had assessed the resident and recorded the resident's vitals at all of the required timeframes but the information had not been captured on the assessment in the computerized system. The RN was unable to identify why the information appeared incomplete when the assessment had been completed.

B. The licensee failed to ensure that actions taken with respect to resident #003, under the dietary services and hydration program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Documentation in the resident's clinical health record reflected the resident's diet texture

was changed on a specified date, as reflected in the Physician's orders. Documentation did not reflect an assessment of the resident related to the diet texture change. A Registered Dietitian referral form had not been completed by nursing staff requesting an assessment by the Registered Dietitian and it was unclear from the documentation if an assessment had been completed for the diet texture change.

During interview with Inspector #107, Registered Dietitian #108 confirmed that they had assessed the resident on the specified date, however, had not documented the assessment that was completed. [s. 30. (2)]

WN #4: 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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed no later than one business day after an incident that caused an injury to resident #001 for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

Resident #001 had a fall and was taken to hospital with an injury. During interview with Inspector #107, RPN #115, who was working at the time of the resident's fall and had assessed the resident, stated that the resident had a change in functional abilities.

During interview with the Director of Nursing Care #101 they confirmed that the fall resulted in a significant change in condition for the resident.

The Director was notified of the injury and transfer to hospital through the INFOLINE after hours system three days after the resident had a confirmed injury and was transferred to hospital.

The Director was not notified within one day when the resident had an injury that resulted in a significant change in condition and was transferred to hospital. [s. 107. (3) 4.]

Issued on this 13th 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

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

Ordre(s) de l'inspecteur

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

Long-Term Care 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) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2019_549107_0015
Log No. / No de registre :	017125-19, 017126-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 20, 2019
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Tansley Woods 4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ken Johnstone

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / 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.

Specifically the licensee must:
a) Review the plans of care for all residents that require assistance with an identified activity of daily living, including resident #002, to determine if an assessment was completed on the residents' abilities, assess any residents that have not had an assessment, and clearly indicate in the resident(s) plans of care if the resident is unsafe to complete the activity, and
b) Re-educate PSW #103, and #104, on which residents were assessed as unsafe, and provide education on factors that would indicate residents were unsafe, and
c) Maintain a record of the education provided to PSW #103 and #104, and for review by an Inspector at a later date, and
d) Review and revise the identified policy to ensure that there is clear direction provided to staff.

Grounds / Motifs :

1. The licensee failed to ensure that resident #002 was not neglected by the licensee or staff.

The Ontario Regulation 79/10, section 5 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Critical Incident System (CIS) Report AH IL-69861-AH CI 2854-000016-19 was submitted to the Ministry of Long-Term Care for alleged abuse/neglect of

resident #002 that caused injury to the resident.

During interview with Inspector #107 and in the home's investigative notes of the incident, PSWs #103 and PSW #104 confirmed they both transferred resident #002 to a device as per directions in the resident's plan of care. Both PSWs then left the resident and attended to another resident's care and left the resident for an extended period of time.

The home's policy identified specific criteria to determine if a resident was able to be left alone on a device. During interview with Inspector #107, the Acting Assistant General Manager #100 stated that based on the home's policy criteria, staff should not have left the resident unattended on the device. The Acting Assistant General Manager also confirmed that PSW #103 and #104 left resident #002 unattended on the device for an extended period.

The resident required the assistance of staff to use the device. The resident had been left on the device unattended by staff for an extended period and the resident had an incident that resulted in injury.

The Director of Nursing Care (DNC) confirmed that staff had received disciplinary action as a result of the failure to ensure the safety of resident #002. Staff did not provide resident #002 with the care, services, and assistance required, and that inaction jeopardized the health, safety and well-being of the resident.

The severity of this issue was determined to be a level 3 as there was actual risk/harm to the resident. The scope of the issue was a level 1 as it involved one of three residents. The home had a level 3 history on non-compliance with this section of the Act that included:
Voluntary plan of correction (VPC) issued June 20, 2017 (2017_570528_0018)
Compliance Order (CO) issued November 16, 2017 (2017_587129_0012), May 7, 2019 (2019_543561_0003) (107)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 14, 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 20th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

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