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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 23, 2020	2019_595110_0012 (A1)	020625-19, 020626-19, 020627-19	Follow up

Licensee/Titulaire de permis

Southlake Residential Care Village
596 Davis Drive NEWMARKET ON L3Y 2P9

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

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 2P6

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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date changed to February 28, 2020 at the request of the licensee after review by Senior Manager.

Issued on this 23rd day of January, 2020 (A1)

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

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

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Licensee/Titulaire de permis

Southlake Residential Care Village
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Long-Term Care Home/Foyer de soins de longue durée

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 2P6

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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 25, 2019 (PM), 26, 27, 28. December 4, 2019

The purpose of this inspection was a follow up to three compliance orders from Inspection Report #2019_595110_0005.

During the course of the inspection the completed record reviews and observations of bathing equipment along with resident interviews.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Registered Nurses, Physiotherapist, Personal Support Workers.

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 34. (1)	CO #002	2019_595110_0005	110
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2019_595110_0005	110

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This Inspection Protocol (IP) was initiated in follow-up to a written Compliance Order, served October 16, 2019, in report #2019_595110_0005, with a compliance due date of November 15, 2019.

A record review of resident #008's written plan of care identified the resident's bathing preference and scheduled days and times.

A record review of the 'Follow up Question' report over an identified time period in point click care (POC) revealed the following:
Bath Day 1 -Bathing-bath/shower, or sponge bath
Bath Day 2 -Bathing-bath/shower, or sponge bath. Documented by PSW #101
Bath Day 3 -Bathing- bath/shower, or sponge bath. Documented by PSW #101.

An interview with PSW #101 shared that they were able to bath resident #008 on bath day 2 but not on bath day 3. The PSW shared that the resident was looking very weak and lethargic and reported that they were not going to bath the resident as scheduled. The PSW shared they reported the resident's condition to charge nurse RN #108. The staff shared that on the unit they do not do "make up" baths or reschedule a missed a bath or shower.

An interview with RN #108 stated that they did not recall PSW #101 sharing their observations and the resident's missed bath. The RN further stated that they do

not schedule "make up" baths when a bath or shower was missed.

A review of the progress notes between an identified weeks period failed to identify any documentation of the resident's missed bath or scheduled make-up bath to provide for at a minimum two baths per week.

The licensee failed to provide resident #008 with two baths per week, by their bathing preference. [s. 33. (1)]

2. An interview with resident #002 identified that they did not receive their scheduled bath on their identified bathing day and that they were informed the unit was short staffed. When asked if a "make up" bath was offered, the resident responded "no, it doesn't work that way, no one said anything."

An interview with PSW #101 revealed that resident #002 had spoken to them about missing their scheduled bath on the identified day.

A record review of the resident's written plan of care identified the resident's bathing preference and the scheduled days and times.

A review of the 'Follow Up Question' report related to bathing over an identified period revealed the following:
Bath Day 1 - Bathing-bath/shower, or sponge bath
Bath Day 2 - Resident refused
Bath Day 3 - Resident refused. Documented by PSW #103.

An interview with PSW #103 shared that resident #002 was not bathed on the identified day as the resident preferred assistance by regular staff and an agency staff was providing them care. The PSW also shared that there was not a "make-up" shower if a shower was missed and the resident only preferred showers on this identified date.

An interview with RN #105 shared that they had no awareness that resident #002's bathing preference was missed on the identified date as no information had been passed along.

The licensee failed to provide resident #002 with two baths per week, by their bathing preference. [s. 33. (1)]

3. An interview with resident #003 revealed that they did not receive their scheduled bath on an identified day of the week. When asked if a "make up bath" was offered, the resident responded with "no".

An interview with PSW #101 revealed that resident #003 had spoken to them about missing their scheduled bath on the identified date.

A record review of the resident's written plan of care identified the resident's bathing preference and the scheduled days and times.

A review of the 'Follow Up Question' report related to bathing over an identified period revealed the following:
Day 1 - No documentation.
Day 2 - Bathing -Not applicable. The documentation was completed by PSW #103.
Day 3 - Full-body bath/shower, sponge bath.

An interview with PSW #103 shared that bathing resident #003 was a "big production" and on the identified date there was a lot of miscommunication and confirmed the resident was not bathed.

An interview with RN #105 shared that they missed communicating to PSW #103 to go ahead and bath resident #003 and confirmed the resident was not bathed nor was a "make-up" bath offered.

The licensee failed to provide resident #003 with two baths per week, by their bathing preference. [s. 33. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence Specifically failed to comply with the following: s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23. 1.

The licensee has failed to comply with the following requirement of the LTCHA:

It is a condition of every licence that the licensee shall comply with every order made under this Act.

On October 16, 2019, Compliance Order (CO) #001 from inspection #2019_595110_0005, was made under O. Reg. 79/10, s. 33 (1). and stated:

The licensee must be compliant with O. Reg. 79/10, s. 33 (1).

The licensee was ordered to:

1. Ensure that resident's #008, #009 and #012 are bathed, at a minimum, twice a week by the method of his or her choice.
2. Ensure that all resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to comply with step 1 and 2 whereby the licensee failed to provide resident #008 with two baths per week, by their bathing preference. Further, the licensee did not comply with step 2 as they failed to provide resident #003 with two baths per week, by their bathing preference, in an identified week or resident #002 with two baths per week in another identified weeks period.

The licensee did not comply with the order made under this Act. [s. 101. (3)] [s. 101. (3)]

Issued on this 23rd day of January, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JACK SHI (760) - (A1)
Inspection No. / No de l'inspection :	2019_595110_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020625-19, 020626-19, 020627-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 23, 2020(A1)
Licensee / Titulaire de permis :	Southlake Residential Care Village 596 Davis Drive, NEWMARKET, ON, L3Y-2P9
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, NEWMARKET, ON, L3Y-2P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra-McNamara

To Southlake Residential Care Village, 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)

Linked to Existing Order / Lien vers ordre existant: 2019_595110_0005, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 33 (1).

Specifically, the licensee shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Grounds / Motifs :

1. Compliance Order #001 was issued the the licensee on October 16, 2019, under inspection #2019_595110_0005, with a compliance due date of November 15, 2019.

The compliance order was issued to O. Reg. 79/10, s. 33 (1). and asked that the licensee do the following:
1. Ensure that resident's #008, #009 and #012 are bathed, at a minimum, twice a week by the method of his or her choice.
2. Ensure that all resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Upon inspection, the licensee did not comply with step #1 as the licensee failed to

provide resident #008 with two baths per week, by their bathing preference, in an identified weeks period. Further, the licensee did not comply with step #2 as they failed to provide resident #002 and #003 with two baths per week, by their bathing preference over an identified weeks period.

The grounds are presented as follows:

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This Inspection Protocol (IP) was initiated in follow-up to a written Compliance Order, served October 16, 2019, in report #2019_595110_0005, with a compliance due date of November 15, 2019.

A record review of resident #008's written plan of care identified the resident's bathing preference and scheduled days and times.

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An interview with PSW #101 shared that they were able to bath resident #008 on bath day 2 but not on bath day 3. The PSW shared that the resident was looking very weak and lethargic and reported that they were not going to bath the resident as scheduled. The PSW shared they reported the resident's condition to charge nurse RN #108. The staff shared that on the unit they do not do "make up" baths or reschedule a missed a bath or shower.

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A review of the progress notes between an identified weeks period failed to identify

any documentation of the resident's missed bath or scheduled make-up bath to provide for at a minimum two baths per week.

The licensee failed to provide resident #008 with two baths per week, by their bathing preference. [s. 33. (1)]

(110)

2. An interview with resident #002 identified that they did not receive their scheduled bath on their identified bathing day and that they were informed the unit was short staffed. When asked if a "make up" bath was offered, the resident responded "no, it doesn't work that way, no one said anything."

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An interview with RN #105 shared that they had no awareness that resident #002's bathing preference was missed on the identified date as no information had been passed along.

The licensee failed to provide resident #002 with two baths per week, by their bathing preference. [s. 33. (1)] (110)

3. An interview with resident #003 revealed that they did not receive their scheduled bath on an identified day of the week. When asked if a "make up bath" was offered, the resident responded with "no".

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An interview with RN #105 shared that they missed communicating to PSW #103 to go ahead and bath resident #003 and confirmed the resident was not bathed nor was a "make-up" bath offered.

The licensee failed to provide resident #003 with two baths per week, by their bathing preference. . [s. 33. (1)]

The severity of this issue was determined to be a level 1 as there was minimum risk to resident's #001, #003 and #008. The scope of the non compliance was widespread as it related to three out of three resident's reviewed.
The home had a level 3 compliance history to the same section as follows:
-Inspection #2019_595110_0005-Compliance Order (CO) issued October 16, 2019.

(110)

Feb 28, 2020(A1)

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

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

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

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:

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

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

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

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 23rd day of January, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JACK SHI (760) - (A1)

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