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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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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 3, 2019	2019_558123_0002	032785-18, 032957-18, 001233-19	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Creek Way Village
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

MELODY GRAY (123)

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): February 22, 28, March 1, 4, 5, 7, 13, 14, 15, 20, 22, 26, 27 and April 4, 2019.

During the course of the inspection, the inspector: observed staff-resident interactions; reviewed residents' health records and reviewed the home's records including investigation records and policies and procedures.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), registered nursing staff, the Physiotherapist, Life Enrichment (LE) staff, the Manager of Resident Care (MoRC), the Senior Nursing Manager, the Administrator and the physician.

The following complaint inspections were included in this inspection: #032785-18 related to responsive behaviours; #032957-18 related to responsive behaviours and #001233-18 related to falls.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

The health record of resident #002 was reviewed including the Personal Support Worker/Behavioural Supports Ontario/Responsive Behaviours (PSW/BSO/RB) Designate follow-up notes; the Life Enrichment (LE) notes; progress notes and plan of care. It was noted the resident had a cognitive status and a history of physical and verbal responsive behaviours towards residents and staff.
BSO had been involved in the resident's care intermittently since their admission to the home. The resident was discharged from BSO in March 2018.

According to the clinical record the resident was involved in the following incidents:
On an identified date in November 2018, the resident grabbed and squeezed the hand of a PSW tightly and would not let go.
On an identified date in December 2018, the resident slapped a PSW while the PSW was providing assistance.
The following day, the resident grabbed resident #006 which resulted in resident #006 sustaining an area of altered skin integrity.
The next day, the resident grabbed staff after an identified meal service.
Five days later, the resident grabbed the hand of the LE staff, squeezed tightly and would not let go.
Three days later, the resident displayed behaviours which were documented in Critical Incident (CI) report M623-000021-18, which identified that prior to an activity resident #002 was calm. The resident was assisted to prepare for an activity. They became restless and demonstrated responsive behaviours towards co-residents, including resident #006. Staff intervened in an effort to manage the behaviour and support the desired activity. Resident #002 responded to the actions of staff by demonstrating a behaviour and physically interacting with PSW #109. Following the interaction the resident was subsequently assessed and diagnosed with an identified injury.
Since the time of discharge from BSO there were no behaviour observation records nor referrals for BSO services found in the resident's health record.
The plan of care in effect at the time of the incident did not address resident #002's physical responsive behaviours in a specified location with resident #006. The plan in

place included an intervention related to resident #002's seating during an activity and noted that the resident was followed by the behaviour team related to their behaviours towards other specific residents.

PSW #109, registered staff #110 and the home's Administrator were interviewed and reported information as contained in the records.
The Administrator confirmed that after the incident between residents #002 and #006 on the identified date in December 2018, steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents, in a specified location including, identifying and implementing interventions.

This area of non-compliance was issued as a result of complaint inspections #032785-18 and #032957-18. [s. 54. (b)]

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. 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 ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to O. Reg. 79/10, physical abuse is, the use of physical force by a resident that causes physical injury to another resident.

The health record of resident #002, who had a history of responsive behaviours, was reviewed including the progress notes and it was noted that on an identified date in December 2018, resident #002 grabbed resident #006. Resident #006 did not want to be touched and pulled away and sustained an area of altered skin integrity as a result. The Senior Nursing Manager and Administrator reported resident #002 had a history of physical and verbal responsive behaviours. The Senior Nursing Manager confirmed the incident met the home's definition of physical abuse.
Resident #006 was not protected from abuse by resident #002.

This area of non-compliance was issued as a result of complaint inspections #032785-18 and #032957-18. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy and procedure, Prevention, Reporting and Elimination of Abuse and Neglect, #01-05-03, revised November 2018, was reviewed and it included: Any person who has reasonable grounds to suspect abuse or neglect of a resident is to immediately report the suspicion and the information on which it is based to the Director, Ministry of Health and Long-Term Care (MOHLTC).

The health record of resident #002 was reviewed and it was noted that resident #002, who had a history of physical responsive behaviours grabbed resident #006. Resident #006 pulled away and sustained an injury as a result.

The Senior Nursing Manager confirmed the incident was at least considered suspected abuse. The Senior Nursing Manager and the Administrator confirmed the home did not inform the Director of the incident as per the home's abuse policy and procedure.

The home did not ensure that it's policy that promoted zero tolerance of abuse and neglect of residents was complied with.

This area of non-compliance was issued as a result of complaint logs #032785-18 and #032957-18. [s. 20. (1)]

2. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

On an identified date in December 2018, the MOHLTC received CI report #M623-000021 -18 from the home. The MOHLTC also received a complaint from the family of resident #002 and a third party.

The CI report was reviewed and it was identified that prior to an activity resident #002 was calm. The resident was assisted to prepare for an activity. They became restless and demonstrated responsive behaviours towards co-residents, including resident #006. Staff intervened in an effort to manage the behaviour and support the desired activity. Resident #002 responded to the actions of staff by demonstrating a behaviour and

physically interacting with PSW #109. Following the interaction the resident was diagnosed with an identified injury.
The home's investigation record was also reviewed and it contained information as noted in the CI report.

The health record of resident #002 was reviewed including the progress notes and it contained information as noted above. It was also noted that on an identified date in December 2018, the resident's family requested that the home's incident report be faxed to a third party. The Manager of Resident Care (MoRC) spoke with the staff and a progress note was faxed. On an identified date in December 2018, the resident returned to the home with an identified injury.

The home's investigation records were reviewed and included, a family meeting with the home, on an identified date in December 2018, where the family made a request regarding the care of resident #002. On an identified date in January 2019, the resident's family provided the home with information related to an unnamed source who indicated, they were present at the time of the incident and heard the resident make a statement about their injury at the time of the incident. It also included an email from family of an identified date in January 2019, which noted the identified injury to resident #002 and that, a third party had an opinion regarding the nature of the injury to resident #002 and the circumstances in which it allegedly occurred. The third party reportedly indicated to the family that it was suspicious in nature. The family indicated they wanted resident #002 to return to the home but the third party denied the request as they wanted another individual to review the details and make a determination the following morning. The second individual also determined the identified injury was suspicious in nature and contacted the MOHLTC as a result.

PSW #109 and registered staff #110 and the home's reported information was consistent with the home's records and the resident's health record.

The resident's attending physician was interviewed and reported they spoke with a third party and were aware of the concerns.

The Administrator, was interviewed and reported that they were aware of the incident. They responded to the incident and submitted the CI notification to the MOHLTC related to resident's injury, hospitalization and change in status. They confirmed they received and responded to the family's concerns as expressed in the email. They met with the family; re-investigated the incident and spoke with an agency. They confirmed they did

not report to the Director an allegation of abuse or send the letter of complaint to the MOHLTC.

The home did not ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

This area of non-compliance was issued as a result of complaint inspections #032785-18 and #032957-18. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) The family member of resident #003 complained to the MOHLTC regarding the resident's fall on an identified date in January 2019, where the resident sustained an area of altered skin integrity.
The resident's health record was reviewed and it was noted that the resident had weekly assessments of the area of altered skin integrity an identified date in January 2019; on an identified date in February 2019; and on two identified dates in March 2019.
The Senior Nurse Manager confirmed resident #003's identified area of altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff.

b) The health record of resident #003 was reviewed and it noted that on an identified date in January 2019, the resident sustained an identified area of altered skin integrity. The skin was cleaned and dressing was applied. No weekly assessments of the identified area of altered skin integrity were found in the resident's health record.
The Senior Nursing Manager confirmed resident #003's identified area of altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff.

This area of non-compliance was identified in relation to complaint #001233-18 which is included in this inspection. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

The family member of resident #002 complained to the MOHLTC that the resident had to wait over one half an hour to receive continence care after asking staff to provide assistance.

The health record of resident #002 was reviewed including; assessments, progress notes and care plan. Resident #002 was noted to have an identified level of bowel continence and required the assistance of staff for toileting. Progress note documentation of an identified date in December 2018, indicated the family member of resident #002 reported to the registered staff that the resident had a bowel movement and the Personal Support Workers (PSWs) did not provide care to the resident for over half an hour. The progress notes identified that the registered staff explained to the family member that, 30 minutes prior, the PSWs informed them that the family member requested to put the resident on the toilet. The registered staff was speaking to another family member due to an emergency situation and they told the PSWs to wait for them as the resident was not able to be transferred to the toilet at that time due to the resident's identified medical diagnoses. The resident was provided continence care.

Registered staff #108 was interviewed and reported information as documented in the progress notes. They confirmed that the resident was incontinent of bowel when they provided the resident continence care over half an hour after the request for assistance was made.

The Senior Nurse Manager and the Administrator were interviewed and reported the family member brought the incident to their attention. They investigated and followed-up with the staff. They confirmed that on the identified date in December 2018, resident #002 did not have sufficient changes to remain clean, dry and comfortable.

This area of non-compliance was issued as a result of complaint inspections #032785-18 and #032957-18. [s. 51. (2) (g)]

Issued on this 16th day of May, 2019

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

Original report signed by the inspector.

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

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) :	MELODY GRAY (123)
Inspection No. / No de l'inspection :	2019_558123_0002
Log No. / No de registre :	032785-18, 032957-18, 001233-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 3, 2019
Licensee / Titulaire de permis :	The Regional Municipality of Halton 1151 Bronte Road, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	Creek Way Village 5200 Corporate Drive, BURLINGTON, ON, L7L-7G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marg Pattillo

To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10. s. 54.
Specifically the licensee must ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents #002, #006 and all other residents.
The licensee shall conduct an interdisciplinary assessment of resident #002's responsive behaviours and revise the plan of care to include factors that could potentially trigger an altercation with staff and co-residents and identify and implement interventions to manage this risk; including at meal times and when restless.

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

The health record of resident #002 was reviewed including the Personal Support Worker/Behavioural Supports Ontario/Responsive Behaviours (PSW/BSO/RB) Designate follow-up notes; the Life Enrichment (LE) notes; progress notes and plan of care. It was noted the resident had a cognitive status and a history of physical and verbal responsive behaviours towards residents and staff.
BSO had been involved in the resident's care intermittently since their admission to the home. The resident was discharged from BSO in March 2018.

According to the clinical record the resident was involved in the following incidents:
On an identified date in November 2018, the resident grabbed and squeezed the hand of a PSW tightly and would not let go.
On an identified date in December 2018, the resident slapped a PSW while the PSW was providing assistance.
The following day, the resident grabbed resident #006 which resulted in resident #006 sustaining an area of altered skin integrity.
The next day, the resident grabbed staff after an identified meal service.
Five days later, the resident grabbed the hand of the LE staff, squeezed tightly and would not let go.
Three days later, the resident displayed behaviours which were documented in Critical Incident (CI) report M623-000021-18, which identified that prior to an activity resident #002 was calm. The resident was assisted to prepare for an activity. They became restless and demonstrated responsive behaviours towards co-residents, including resident #006. Staff intervened in an effort to manage the behaviour and support the desired activity. Resident #002 responded to the actions of staff by demonstrating a behaviour and physically interacting with PSW #109. Following the interaction the resident was subsequently assessed and diagnosed with an identified injury.
Since the time of discharge from BSO there were no behaviour observation records nor referrals for BSO services found in the resident's health record.
The plan of care in effect at the time of the incident did not address resident #002's physical responsive behaviours in a specified location with resident #006. The plan in place included an intervention related to resident #002's seating during an activity and noted that the resident was followed by the behaviour team related to their behaviours towards other specific residents.

PSW #109, registered staff #110 and the home's Administrator were interviewed and reported information as contained in the records.
The Administrator confirmed that after the incident between residents #002 and #006 on the identified date in December 2018, steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents, in a specified location including, identifying and implementing interventions.

The severity of the issue was determined to be a level three as there was actual harm to the resident. The scope of the issue was determined to be a level as it was isolated and related to one resident.
The home had a level three compliance history with one or more related non-compliance issued in the last 36 months including: a VPC (r. 53) issued July 2016, as a result of RQI 2016_275536-16_0013.

This area of non-compliance was issued as a result of complaint inspections #032785-18 and #032957-18. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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 3rd day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

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