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 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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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 29, 2018	2018_560632_0004	026268-17, 026269-17, 026270-17, 026271-17, 026272-17	Follow up

Licensee/Titulaire de permis

Haldimand War Memorial Hospital
206 John Street DUNNVILLE ON N1A 2P7

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

Edgewater Gardens Long Term Care Centre
428 Broad Street West DUNNVILLE ON N1A 1T3

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

YULIYA FEDOTOVA (632), ROBIN MACKIE (511)

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): February 8, 12, 14, 15, 21, 2018.

The following intakes were completed in this Follow up (FU) inspection:

Log #026268-17 was related to training
Log #026269-17 was related to bedrails
Log #026270-17 was related to medication, nutrition and hydration
Log #026271-17 was related to staffing
Log #026272-17 was related to nutrition and hydration.

The following Critical Incident System (CIS) inspection was completed concurrently with this Follow-up inpsection:
Log #009170-17, CIS #2963-000010-17 was related to fall prevention. Non-compliance related to O. Reg. 79/10, s. 8(1)(b) was identified during the Critical Incident inspection and was issued as a compliance order (CO) on this Follow-up Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Assessment Instrument (RAI) Co-ordinator, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), with residents and their families.

During the course of the inspection, the inspector(s) reviewed inspection related documentation, clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, staff education and audit records, investigation notes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Sufficient Staffing
Training and Orientation

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)**

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. 15. (1)	CO #002	2017_556168_0030	632
O.Reg 79/10 s. 26. (4)	CO #003	2017_556168_0030	632
LTCHA, 2007 S.O. 2007, c.8 s. 76. (7)	CO #001	2017_556168_0030	632
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #004	2017_556168_0030	511

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	Legendé 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system it was in compliance with and was implemented in accordance with applicable requirements under the Act.
O. Reg. 79/10, s. 68, which required an organized program of nutrition care and dietary services, including the development and implementation of policies and procedures.

A. The home's Policy Nutrition and Hydration Monitoring Form for Meals & Snacks NC-03-230 (revision in 2017) directed staff to complete the Food and Fluid section of Point of Care (POC) for all residents during snack and meal services. An additional Clinical Records Policy N-4-10 (revised on October 2017), directed staff when documenting into the clinical record on Point Click Care (PCC) or POC, to ensure it was complete, accurate, legible and permanently recorded.
Resident #003 was observed during an identified snack service on an identified date in February, 2018. They were provided an identified amount of a drink and a snack and it was observed that the resident did not consume any fluids. On the same identified day, the Inspector observed a meal service in the dining room. During meal service, the resident consumed an identified amount of their drinks provided and no water was consumed. On an identified date in February, 2018, POC records of resident #003 were reviewed for the fluid intake at the identified snack service and meal service on an identified date in February, 2018, the amount of fluids consumed were not recorded in the Documentation Survey Report v2. An interview with the Administrator on an identified date in February, 2018, confirmed that no documentation was completed by staff on an identified date in February, 2018, related to resident #003's fluids intake during identified meal and snack services.

The home did not ensure that Food and Fluid section of POC for resident #003 during identified snack and meal services was completed.

B. Resident #005 was observed during an identified meal service on an identified date in February, 2018, by Inspector #511. The resident consumed an identified amount of their soup and an identified amount of their drinks. On an identified date in February, 2018, POC records of resident #005 were reviewed for the fluid intake at meal service on an identified date in February, 2018, and the fluids consumed were not recorded in the Documentation Survey Report v2. An interview with the Administrator on an identified date in February, 2018, confirmed that no documentation was completed by staff on an

identified date in February, 2018, related to resident #005's fluids intake during meal service.

The home did not ensure that Food and Fluid section of POC for resident #005 during meal service was completed.

C. Resident #009 was observed during meal service on an identified date in February, 2018. The resident consumed an identified amount of their drinks. On an identified date in February, 2018, the resident was observed during an identified snack service and they consumed an identified amount of their drinks. On an identified date in February, 2018, POC records of resident #009 were reviewed for the fluid intake at meal service on an identified date in February, 2018, and were not recorded in Documentation Survey Report v2 and the fluids, consumed during an identified snack service on an identified date in February, 2018, were recorded not representing an identified amount of their drink consumed. The resident was observed to have consumed an identified amount of their drink. An interview with the Administrator on an identified date in February, 2018, confirmed that no documentation was completed by staff on an identified date in February, 2018, related to resident #009's fluids intake during an identified meal service and the records were incorrectly documented in relation to the fluids consumption during an identified snack services on an identified date in February, 2018.

The home did not ensure that Food and Fluid section of POC for resident #009 identified snack and meal services was completed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system it was in compliance with and was implemented.
O. Reg. 79/10, s. 48(1)(1), which required the home to have a falls prevention and management program to reduce the incidents of falls and the risk of injury. O. Reg. 79/10, s. 30 (1)(1) stated that programs required under s. 48 must have relevant policies, procedures and protocols and provided methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The home's Falls Prevention Policy N-5-65 (no date) indicated that the registered staff was to initiate a specified assessment for all unwitnessed falls and witnessed falls that had resulted in a possible specified injury or the resident was on coagulation therapy. An additional Clinical Records Policy N-4-10 (revised on October 2017), directed staff when

documenting into the clinical record on PCC or POC, to ensure it was complete, accurate, legible and permanently recorded.
On an identified date in May, 2017, the licensee submitted a mandatory report to the Ministry of Health and Long-Term Care (MOHLTC) (2963-000010-17) for resident #008's fall on an identified date in May, 2017, which resulted in an identified injury. On an identified date in February, 2018, interview with staff #113 indicated that an identified assessment was to be completed after a resident had an unwitnessed fall or hit their head. On an identified date in February, 2018, interview with staff #110 indicated that an identified assessment was on an identified form and to be initiated, when a resident hit their head or if residents were not able to confirm if they did not hit their head. Review of the resident's clinical records (dated on an identified date in May, 2017), indicated no records about resident's responses about the result of the fall or initiation of an identified assessment. Review of the medical record with the RAI Co-ordinator and the Administrator confirmed no an identified assessment had been completed at the time of resident #008's fall.

The home did not ensure that an identified assessment was initiated for resident #008's fall on an identified date in May, 2017.

Please note: this non-compliance was issued as a result of Critical Incident (CI) log #009170-17. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

Issued on this 18th day of April, 2018

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

Ministére 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) :	YULIYA FEDOTOVA (632), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2018_560632_0004
Log No. / No de registre :	026268-17, 026269-17, 026270-17, 026271-17, 026272-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 29, 2018
Licensee / Titulaire de permis :	Haldimand War Memorial Hospital 206 John Street, DUNNVILLE, ON, N1A-2P7
LTC Home / Foyer de SLD :	Edgewater Gardens Long Term Care Centre 428 Broad Street West, DUNNVILLE, ON, N1A-1T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Greg Allen

To Haldimand War Memorial Hospital, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_556168_0030, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8 (1)(b).

Specifically the licensee must:
a) Ensure the home's Nutrition and Hydration Monitoring Form for Meals & Snacks Policy is complied with by all nursing staff.
b) Ensure that all fluids consumed by residents #003, #005 and #009 and all other residents during snack and meal services are documented by staff as per the home's Nutrition and Hydration Monitoring Form for Meals & Snacks Policy and the records are complete and accurate.
c) Ensure that Head Injury Routine is completed for resident #008 and any other resident sustaining an unwitnessed fall or witnessed falls that had resulted in a possible head injury or if the resident was on coagulation therapy.
d) Quality management activities that will be implemented to monitor the initiation of the Head Injury Routine for residents according to the home's Falls Prevention Policy and there shall be documentation of these quality management activities.
e) Quality management activities that will be implemented to monitor volumes of fluids consumed by residents during snack and meal services including their complete and accurate documentation by staff. There shall be documentation of these quality management activities and actions taken to enhance documentation practices.

Grounds / Motifs :

1. The licensee failed to comply with the following compliance order #005 (section 3) from inspection #2017_556168_0030 served on November 3, 2017, with a compliance date of January 5, 2018.

The licensee was ordered to prepare, submit and implement a plan to ensure that the registered dietitian (RD), who is a member of the staff of the home, completes a nutritional assessment for all residents, including resident #004, whenever there is a significant change in the resident's health condition; and assesses the resident's hydration status, and any risks related to hydration.
The plan shall include, but not be limited to:
A. A review of the current written procedures in place related to communication between nursing and dietary staff in regards to residents' fluid intake and hydration levels, including the completion of hydration referrals to the RD and related to assessing residents' changes in condition, hydration status and risk levels for residents, and changes to be made; and
A review of the actual practices in place related to communication between nursing and dietary staff in regards to residents' fluid intake and hydration levels, including the completion of hydration referrals to the RD and related to assessing residents' changes in condition, hydration status and risk levels for residents, and changes to be made; and
A revision of the appropriate procedures to ensure that they are reflective of the expectations of the home to ensure effective communication between nursing and dietary staff in regards to residents' fluid intake and hydration levels, including the completion of hydration referrals to the RD and that there is an interdisciplinary assessment of residents' changes in condition, hydration status and risk levels for residents, and changes to be made.
B. Each registered nursing staff member, the RD and the DESM will each receive training on the revised procedures and direction to comply with the procedures.
The plan should be submitted via email by November 23, 2017, to Jessica Paladino via e-mail at HamiltonSAO.MOH@ontario.ca.

The licensee failed to insure that the procedure in "Nutrition and Hydration Monitoring Form for Meals & Snacks NC-03-230" Policy was complied with by staff.

The severity of this issue was determined to be a level (1) as there was

minimum risk to the residents. The scope of this issue was a level (3) as it related to widespread non-compliance with the Nutrition and Hydration Monitoring Form for Meals and Snacks Policy. The home had a level (4) compliance history as they had on-going non-compliance with this section of O. Reg. 79/10, s. 8(1)(b) as follows:
- voluntary plan of correction (VPC) issued November 18, 2014 (2014_306510_0021);
- written notification (WN) issued May 11, 2015 (2015_306510_0006);
- VPC issued December 16, 2016 (2016_341583_0022);
- CO#005 issued November 3, 2017 with a compliance due date of January 5, 2018 (2017_556168_0030).

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with. O. Reg. 79/10, s. 48, which required the home to have a falls prevention and management program to reduce the incidents of falls and the risk of injury. O. Reg. 79/10, s. 30(1)(1) stated that programs required under s. 48 must have relevant policies, procedures and protocols and provided methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the licensee's policy regarding "Falls Prevention Policy N-5-65" last reviewed no date, which was part of the licensee falls prevention and management program.

The home's Falls Prevention Policy N-5-65 (no date) indicated that the registered staff was to initiate a specified assessment for all unwitnessed falls and witnessed falls that had resulted in a possible specified injury or the resident was on coagulation therapy. An additional Clinical Records Policy N-4-10 (revised on October 2017), directed staff when documenting into the clinical record on PCC or POC, to ensure it was complete, accurate, legible and permanently recorded.
On an identified date in May, 2017, the licensee submitted a mandatory report to the Ministry of Health and Long-Term Care (MOHLTC) (2963-000010-17) for resident #008's fall on an identified date in May, 2017, which resulted in an identified injury. On an identified date in February, 2018, interview with staff #113 indicated that an identified assessment was to be completed after a resident had an unwitnessed fall or hit their head. On an identified date in

February, 2018, interview with staff #110 indicated that an identified assessment was on an identified form and to be initiated, when a resident hit their head or if residents were not able to confirm if they did not hit their head. Review of the resident's clinical records (dated on an identified date in May, 2017), indicated no records about resident's responses about the result of the fall or initiation of an identified assessment. Review of the medical record with the RAI Co-ordinator and the Administrator confirmed no identified assessment had been completed at the time of resident #008's fall.

The home did not ensure that an identified assessment was initiated for resident #008's fall on an identified date in May, 2017.

Please note: this non-compliance was issued as a result of Critical Incident (CI) log #009170-17. (632)

2. O. Reg. 79/10, s. 68, which required an organized program of nutrition care and dietary services, including the development and implementation of policies and procedures.

Resident #009 was observed during meal service on an identified date in February, 2018. The resident consumed an identified amount of their drinks. On an identified date in February, 2018, the resident was observed during an identified snack service and they consumed an identified amount of their drinks. On an identified date in February, 2018, POC records of resident #009 were reviewed for the fluid intake at meal service on an identified date in February, 2018, and were not recorded in Documentation Survey Report v2 and the fluids, consumed during an identified snack service on an identified date in February, 2018, were recorded not representing an identified amount of their drink consumed. The resident was observed to have consumed an identified amount of their drink. An interview with the Administrator on an identified date in February, 2018, confirmed that no documentation was completed by staff on an identified date in February, 2018, related to resident #009's fluids intake during an identified meal service and the records were incorrectly documented in relation to the fluids consumption during an identified snack services on an identified date in February, 2018.

The home did not ensure that Food and Fluid section of POC for resident #009 identified snack and meal services was completed.
(632)

3. Resident #005 was observed during an identified meal service on an identified date in February, 2018, by Inspector #511. The resident consumed an identified amount of their soup and an identified amount of their drinks. On an identified date in February, 2018, POC records of resident #005 were reviewed for the fluid intake at meal service on an identified date in February, 2018, and the fluids consumed were not recorded in the Documentation Survey Report v2. An interview with the Administrator on an identified date in February, 2018, confirmed that no documentation was completed by staff on an identified date in February, 2018, related to resident #005's fluids intake during meal service.

The home did not ensure that Food and Fluid section of POC for resident #005 during meal service was completed.
(632)

4. Resident #003 was observed during an identified snack service on an identified date in February, 2018. They were provided an identified amount of a drink and a snack and it was observed that the resident did not consume any fluids. On the same identified day, the Inspector observed a meal service in the dining room. During meal service, the resident consumed an identified amount of their drinks provided and no water was consumed. On an identified date in February, 2018, POC records of resident #003 were reviewed for the fluid intake at the identified snack service and meal service on an identified date in February, 2018, the amount of fluids consumed were not recorded in the Documentation Survey Report v2. An interview with the Administrator on an identified date in February, 2018, confirmed that no documentation was completed by staff on an identified date in February, 2018, related to resident #003's fluids intake during identified meal and snack services.

The home did not ensure that Food and Fluid section of POC for resident #003 during identified snack and meal services was completed. (632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 29th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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 Inspector / Nom de l'inspecteur : Yuliya Fedotova

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