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

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
Jun 29, 2021	2021_875501_0012	003824-20, 020051-20, 023828-20, 002990-21, 004562-21	Critical Incident System

Licensee/Titulaire de permis

The Mennonite Home Association of York County
123 Weldon Road Stouffville ON L4A 0G8

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

Parkview Home Long-Term Care
123 Weldon Road Stouffville ON L4A 0G8

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

SUSAN SEMEREDY (501), JENNIFER BATTEN (672)

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): June 1, 2, 3, 4, 7, 8, 2021.

The following intakes were inspected during this critical incident inspection:
Log #003824-20 related to staff to resident physical abuse;
Log #020051-20 related to falls prevention;
Log #023828-20 related to falls prevention; and,
Log #002990-21 related to a follow up for CO#001 from inspection #2021_814501_0004 for s.19(1) duty to protect.
Please note:
Log #004562-21 related to a follow up for CO#001 from inspection #2021_763116_0003 for s.5 safe and secure home was complied in a previous inspection 2021_784762_0008.

Inspector #746 and #706026 were present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC, Assistant Director of Care (ADOC), Director of Property & Environmental Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), maintenance worker, housekeeper and residents.

During the course of the inspection, the inspectors observed resident and staff interactions and infection prevention and control practices. Inspectors also reviewed clinical health records, temperature logs, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **6 WN(s)**
- **2 VPC(s)**
- **2 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_814501_0004	501
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2021_763116_0003	501

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 :

1.The licensee has failed to ensure that a resident was protected from abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A resident was found distraught stating that a PSW abused them when providing care. An interview with this PSW indicated the resident was refusing some of the care but denied abuse occurred.

Documentation and interviews with several staff members indicated the resident had reddened painful areas. An interview with an RPN who assessed the areas, confirmed they were consistent with the resident's account of what had happened. Interviews with staff also indicated the resident was fearful for quite awhile following the incident. The ADOC indicated the allegation was substantiated.

Failing to protect residents from abuse causes undue emotional and physical pain.

Sources: Critical Incident System (CIS) report, LTCH's investigation notes, resident's clinical record and interviews with the ADOC and other staff members.
[s. 19. (1)]

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #005 and #008's 24-hour care plan included the risk of falling and interventions to mitigate those risks.

A CIS report was submitted to the MLTC related to a fall sustained by resident #005 which resulted in multiple injuries. When the resident was initially admitted to the LTCH they were noted to be at risk for falling. A review of the resident's 24-hour plan of care did not identify the resident was at risk for falling or provide any interventions to mitigate those risks.

Resident #008 was admitted to the home with multiple diagnoses which placed the resident at risk for falling. The resident was known to be a falls risk but did not have a falls prevention plan of care within the first 24 hours post admission to the home. During a month after the resident was admitted they sustained a number of falls in the home but did not have a plan of care related to falls prevention during that time period.

The Resource Nurse verified that residents #005 and #008 were at risk for falling and should have had 24-hour care plans which included this risk and interventions to mitigate the risk. The DOC verified the expectation in the home was for every resident to have a 24-hour care plan which included all risks the resident posed to themselves along with interventions to mitigate those risks and that staff who created 24-hour plans of care were aware of that expectation.

By not ensuring residents #005 and #008, who were both at risk for falling, had 24-hour care plans which included the risk of falling and interventions to mitigate those risks, the residents were placed at risk for sustaining falls which resulted in significant injuries.

Sources: CIS report, residents' care plans; Fall Incident/Post Fall Huddle documents, Pre-Admission Checklist and the home's fall prevention policy; Interviews with the Resource Nurse and DOC.
[s. 24. (2) 1.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1.The licensee has failed to ensure that the temperature was measured and documented in writing on every floor of the home.

The LTCH has five resident home areas (RHAs) and has three floors. A review of the home's temperature logs for a week in June 2021 indicated temperatures were being measured and documented in two RHAs including common areas, each of which were on the same floor. An interview with the Director, Property & Environmental Services indicated they were unaware of the new regulations.

Failing to measure and document temperatures on every floor puts residents at risk for heat related illness.

Sources: LTCH's temperature logs and an interview with the Director, Property & Environmental Services.
[s. 21. (2) 2.]

2. The licensee has failed to ensure that temperatures were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the home's temperature logs for a week in June 2021 indicated temperatures were being measured and documented once a day. An interview with the Director, Property & Environmental Services indicated they were unaware of the new regulations.

Failing to measure and document temperatures three times a day puts residents at risk for heat related illness.

Sources: LTCH's temperature logs and an interview with the Director, Property & Environmental Services.
[s. 21. (3)]

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 ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home: one resident common area on every floor of the home, which may include a lounge, dining area or corridor and that temperatures are measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A PSW was observed serving nourishments in the dining room and did not attempt to assist residents to perform hand hygiene. On the same day, on another unit, PSWs did not attempt to assist residents to perform hand hygiene before the lunch meal. An interview with the DOC confirmed the expectation in the home is for staff to assist residents to perform hand hygiene before and after eating.

Failing to assist residents to perform hand hygiene puts them at risk for of infectious disease.

Sources: Just Clean Your Hands Implementation Guide for LTCH from Public Health Ontario 2009, observations and an interview with the DOC. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.2) The heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1.2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the heat related illness prevention and management plan for the home was evaluated and updated annually.

A review of the home's policy related to heat related illness indicated it was last reviewed August 2016. An interview with the DOC indicated they were aware of the new regulations but had not yet updated the home's policy.

Failing to update the LTCH's heat related illness prevention and management plan annually in accordance with evidence-based practices puts residents at risk for heat related illness.

Sources: The LTCH's policy titled Prevention and Management of Hot Weather Related Illness, last reviewed August 2016 and an interview with the DOC. [s. 20. (1.2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation was reported to the Director.

A review of the CIS report regarding an allegation of physical abuse toward a resident by a PSW indicated the report was submitted the same day as the incident. A search of the on-line reporting site failed to indicate an amendment was submitted by the LTCH to report the results of their investigation. A review of the home's investigation notes indicated the allegation was substantiated. An interview with ADOC #107 confirmed this was not reported to the Director as required.

Sources: Critical Incident System (CIS) report, LTCH portal and reporting site, LTCH's investigation notes, and an interview with ADOC #107. [s. 23. (2)]

Issued on this 30th day of June, 2021

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) :	SUSAN SEMEREDY (501), JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2021_875501_0012
Log No. / No de registre :	003824-20, 020051-20, 023828-20, 002990-21, 004562-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 29, 2021
Licensee / Titulaire de permis :	The Mennonite Home Association of York County 123 Weldon Road, Stouffville, ON, L4A-0G8
LTC Home / Foyer de SLD :	Parkview Home Long-Term Care 123 Weldon Road, Stouffville, ON, L4A-0G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Gayman

To The Mennonite Home Association of York County, you are hereby required to comply with the following order(s) by the date(s) set out below:

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:

1. Ensure residents are protected from abuse.

2. Provide an identified PSW with re-instruction related to assisting residents with physical care in a gentle and safe manner. Keep a record of this retraining.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A resident was found distraught stating that a PSW abused them when providing care. An interview with this PSW indicated the resident was refusing some of the care but denied abuse occurred.

Documentation and interviews with several staff members indicated the resident had reddened painful areas. An interview with an RPN who assessed the areas, confirmed they were consistent with the resident's account of what had happened. Interviews with staff also indicated the resident was fearful for quite awhile following the incident. The ADOC indicated the allegation was substantiated.

Failing to protect residents from abuse causes undue emotional and physical pain.

Sources: Critical Incident System (CIS) report, LTCH's investigation notes, resident's clinical record and interviews with the ADOC and other staff members.

An order was made by taking the following factors into account:

Severity: There was actual harm to a resident as there were reddened areas on their skin and the resident felt pain.

Scope: This was an isolated incident.

Compliance History: Non-compliances were issued to the home related to different sub-sections of the legislation in the past 36 months.

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2021

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Order / Ordre :

The licensee must be compliant with section s. 24 (2) of O. Reg. 79/10.

Specifically, the licensee must:

1. Implement a process to ensure that every resident newly admitted to the home who is at risk for falling has a 24-hour care plan created and implemented which addresses their identified risks.
2. Educate the relevant registered staff who are involved in creating the 24-hour care plans to ensure they are aware of the requirement. Keep a documented record of the education provided and the staff signatures to indicate they received the education.

Grounds / Motifs :

1. The licensee failed to ensure that residents #005 and #008's 24-hour care plan included the risk of falling and interventions to mitigate those risks.

A CIS report was submitted to the MLTC related to a fall sustained by resident #005 which resulted in multiple injuries. When the resident was initially admitted to the LTCH they were noted to be at risk for falling. A review of the resident's 24-hour plan of care did not identify the resident was at risk for falling or provide any interventions to mitigate those risks.

Resident #008 was admitted to the home with multiple diagnoses which placed the resident at risk for falling. The resident was known to be a falls risk but did not have a falls prevention plan of care within the first 24 hours post admission to the home. During a month after the resident was admitted they sustained a number of falls in the home but did not have a plan of care related to falls prevention during that time period.

The Resource Nurse verified that residents #005 and #008 were at risk for falling and should have had 24-hour care plans which included this risk and interventions to mitigate the risk. The DOC verified the expectation in the home was for every resident to have a 24-hour care plan which included all risks the resident posed to themselves along with interventions to mitigate those risks and that staff who created 24-hour plans of care were aware of that expectation.

By not ensuring residents #005 and #008, who were both at risk for falling, had 24-hour care plans which included the risk of falling and interventions to mitigate those risks, the residents were placed at risk for sustaining falls which resulted in significant injuries.

Sources: CIS report, residents' care plans; Fall Incident/Post Fall Huddle documents, Pre-Admission Checklist and the home's fall prevention policy; Interviews with the Resource Nurse and DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents from falling and/or sustaining injuries during falls due to not having a plan of care implemented related to fall prevention interventions within the first 24 hours of admission to the home.

Scope: The scope of this non-compliance was patterned, as two of three

residents who had recently been admitted to the home and were considered to be at high risk for falling did not have a 24 hour plan of care created to address the residents' risks associated with falling.

Compliance History: One or more areas of non-compliance were issued to the home related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2021

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 29th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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