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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 15, 2020	2020_722630_0022	017822-20, 019775-20	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Glendale Crossing
3030 Singleton Avenue LONDON ON N6L 0B6

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

AMIE GIBBS-WARD (630), CHRISTINA LEGOUFFE (730), SAMANTHA PERRY (740)

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): September 28, 29, 30, October 1 and 2, 2020.

The following Complaint intakes were completed within this inspection:
Log #017822-20 related to sufficient staffing, responsive behaviours, reporting and complaints and personal support services.
Log #019775-20 related to sufficient staffing, prevention of abuse and neglect and residents' rights.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the acting Director of Care (DOC), an Assistant Director of Care (ADOC), a Neighbourhood Coordinator, the Administrative Assistant/Scheduling Co-orindator, the Personal Expressions Response Team (PERT) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspectors also observed resident rooms and common areas, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the home's written staffing plan and reviewed written records of complaints received by the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

4 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. A) The licensee has failed to ensure that the care set out in the plan of care was based on an assessment and the needs of the resident related to responsive behaviours.

Staff and family reported the resident had responsive behaviours which required specific interventions to be provided by staff. There was a lack of documented assessments and plan of care direction regarding this resident's specific needs for these interventions. This placed the resident at risk for not receiving the care they required for safety and well-being.

Sources: Observations on September 28, 29, 30 and October 2, 2020; the resident's clinical record including responsive behaviour assessments by the home's Personal Expressions Response Team (PERT); a Critical Incident System (CIS) report; interview with a family member; and interviews with staff including the PERT Lead Registered Practical Nurse (RPN).

B) The licensee has failed to ensure that the care set out in the plan of care for a resident was based on an assessment of the resident and the needs and preferences of that resident related to skin and wound care.

The resident had specific areas of altered skin integrity. A skin and wound care assessment showed the resident required a specific intervention to help protect their skin. The plan of care did not provide direction for staff regarding the use of this intervention.

Sources: Observations on September 28, 29 and 30, 2020; the resident's clinical record including care plan and skin and wound care evaluations; interview with a family member; and interviews with staff including a Registered Nurse (RN).

C) The licensee has failed to ensure that the care set out in the plan of care for a resident was based on an assessment of the resident and the needs and preferences related to mouth care.

A resident's family expressed concerns about the provision of mouth care based on the resident's needs and requested specific interventions to be in place for the resident's mouth care. The resident's plan of care indicated they needed staff assistance with mouth care but provided no further direction to staff. There was no documented assessment of the resident's specific mouth care requirements completed by staff in the home. This placed the resident at risk for not receiving the mouth care they needed.

Sources: the resident's clinical record including care plan; interview with a family member; and interviews with staff including a Personal Support Worker (PSW).

D) The licensee has failed to ensure that the care set out in the plan of care for a resident was based on the needs and preferences related to dressing care.

The resident's family brought forward concerns to the management regarding the clothing a resident was wearing. They said it was the resident's preference to be dressed in a specific clothing item during the day.

The resident's most recently completed Activities of Daily Living (ADL) assessment showed they required assistance with dressing, but did not indicate any specific preferences related to clothing. The resident's plan of care showed they required assistance with dressing, but listed no clothing preferences. This placed the resident at risk for not receiving dressing care based on their needs and preferences.

Sources: Observations September 28, 29 and 30, 2020; the resident's clinical record including care plan; interview with a family member; and interviews with staff including a PSW.

E) The licensee has failed to ensure that the care set out in the plan of care for three residents was based on their needs and preferences related to positioning in a specific type of chair.

Observations during the inspection found three residents were using a specific type of chair in their rooms. Each resident had a history of either sliding out of and/or falling near this type of chair. Each resident had a different ability to manipulate the controllers for their chair. There was no documented assessment for these residents regarding their safety with the use of the chair. The plan of care for these residents did not include direction for staff regarding the resident's care needs when in their chair.

Sources: Observations September on 28, 29 and 30, 2020; clinical records including progress notes; interview with a family member; and interviews with staff including acting Director of Care (DOC). [s. 6. (2)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to five residents on October 2, 2020, related to their call bells.

On October 2, 2020, five residents were observed in their separate rooms with their call bells not within reach and no staff in the area. The plan of care for these five residents each indicated they were at risk for falls and the call bell was to be within reach of chair. The cord on three of the resident's call bells were not long enough to extend across the room from the wall to where the resident was sitting. Staff reported those call bells needed an extension added to ensure it would reach the resident as they required it to call for assistance from staff when in the chair.

Sources: Observations on October 2, 2020; interview with residents; interviews with staff including a Registered Practical Nurse (RPN). [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's staffing plan for nursing and personal support services provided for a staffing mix that was consistent with residents' assessed care and safety needs on a specific neighbourhood during the night shifts in August 2020.

The family for a resident expressed concern that the staffing levels in the home were not meeting the resident's care needs on night shifts in August. There were 32 residents who lived on this neighbourhood when at full occupancy. The home's staffing plan for night shift allotted one Personal Support Worker (PSW) assigned to the neighbourhood plus a float PSW and a Registered Practical Nurse (RPN) who both covered two neighbourhoods. As part of the staffing plan one to one staffing would be provided for specific residents based on their assessed needs. There were at least three night shifts in August 2020 when this neighbourhood did not have their full complement of PSW staff.

Based on interviews and record reviews staff were unable to provide the care a specific resident required as they had to leave them to respond to the care needs of other residents. At times other residents did not receive the care they required on nights shifts due to the time staff spent with this resident. The resident did not receive one to one staffing on specific night shifts in August due to staff not being available.

Sources: the resident's clinical record including Dementia Observation System (DOS) charting; interview with a family member; review of the home's written staffing plan; and interviews with staff including acting DOC. [s. 31. (3) (a)]

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 the home's staffing plan for nursing and personal support services provides for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two written complaints concerning the care of residents were forwarded to the Director.

The home received a written complaint related to care concerns for two different residents. The General Manager (GM) said that the two complaints should have been forwarded to the Director. There was no negative impact on the residents in the home as both complaints were resolved.

Sources: “Resident/Family Complaint Response Forms” for two residents; the home’s “Resident/Family Complaint” policy effective June 12, 2018, interview with the GM. [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home related to the written letter of complaint submitted to the management of the home.

A family member for a resident reported they did not receive a response from the home regarding a written complaint. The General Manager (GM) said they received a complaint letter on a specific date and forwarded it to the Ministry of Long-Term Care (MLTC). Various staff members, the home's physician and management in the home responded to the complainant through phone conversations.

The home's "Resident/Family Complaints" policy required all written complaints to be documented on the "Resident/ Family Complaints Response Form." This form directed the staff to document the complaint details and the home's response. There was no documented "Resident/ Family Complaints Response Form" or other form of documentation that met all the legislative requirements for this written complaint.

Sources: Written letter of complaint August 29, 2020; "Resident/Family Complaints" policy last review July 22, 2019; interview with a family member; and interviews with staff including the GM. [s. 101. (2)]

Issued on this 15th day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), CHRISTINA LEGOUFFE (730), SAMANTHA PERRY (740)
Inspection No. / No de l'inspection :	2020_722630_0022
Log No. / No de registre :	017822-20, 019775-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 15, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Glendale Crossing 3030 Singleton Avenue, LONDON, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Awde

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee must be compliant with s. 6 (2) of the LTCHA.

Specifically, the licensee must:

Ensure the plan of care for a specific resident is based on a documented assessment of the resident and their needs related to staff monitoring and one to one care for responsive behaviours.

Ensure the plan of care for three specific residents, and any other resident who uses a specific type of chair, is based on a documented assessment of the resident and their safety needs when using this type of chair.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment and the needs of the resident related to responsive behaviours.

Staff and family reported the resident had responsive behaviours which required specific interventions to be provided by staff. There was a lack of documented assessments and plan of care direction regarding this resident's specific needs for these interventions. This placed the resident at risk for not receiving the care they required for safety and well-being.

Sources: Observations on September 28, 29, 30 and October 2, 2020; the resident's clinical record including responsive behaviour assessments by the home's Personal Expressions Response Team (PERT); a Critical Incident System (CIS) report; interview with a family member; and interviews with staff

including the PERT Lead Registered Practical Nurse (RPN).

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

Severity: There was risk of actual harm because the resident's needs for a specific type of care related to their responsive behaviours was not assessed and included in the plan of care.

Scope: This was an isolated case as no other residents were identified with this issue during the inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (2) and two Voluntary Plan of Correction (VPCs) were issued to the home. (630)

2. The licensee has failed to ensure that the care set out in the plan of care for three residents was based on their needs and preferences related to positioning in a specific type of chair.

Observations during the inspection found three residents were using a specific type of chair in their rooms. Each resident had a history of either sliding out of and/or falling near this type of chair. Each resident had a different ability to manipulate the controllers for their chair. There was no documented assessment for these residents regarding their safety with the use of the chair. The plan of care for these residents did not include direction for staff regarding the resident's care needs when in their chair.

Sources: Observations September on 28, 29 and 30, 2020; clinical records including progress notes; interview with a family member; and interviews with staff including acting Director of Care (DOC). [s. 6. (2)]

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

Severity: There was risk of harm related to falls as the plan of care for three residents was not based on an assessment of the resident and their safety needs when using this type of chair.

Scope: This was widespread as three of the three residents reviewed did not have an assessment or a plan of care to provide direction for staff related to the use of their electric recliner chair.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (2) and two Voluntary Plan of Correction (VPCs) were issued to the home. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2020

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

Ensure the care set out in the plan of care is provided to five specific residents related to their call bells.

Conduct a one time audit of the call bells, including the length of the cords, in all resident rooms to ensure the call bell can be used by the resident in accordance with their plan of care. The home must keep a documented record of the audit including the dates the audit was completed, the name of the people completing the audit and any corrective action taken in response to the audit.

Grounds / Motifs :

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

1. The licensee has failed to ensure the care set out in the plan of care was provided to five residents on October 2, 2020, related to their call bells.

On October 2, 2020, five residents were observed in their separate rooms with their call bells not within reach and no staff in the area. The plan of care for these five residents each indicated they were at risk for falls and the call bell was to be within reach of chair. The cord on three of the resident's call bells were not long enough to extend across the room from the wall to where the resident was sitting. Staff reported those call bells needed an extension added to ensure it would reach the resident as they required it to call for assistance from staff when in the chair.

Sources: Observations on October 2, 2020; interview with residents; interviews with staff including a Registered Practical Nurse (RPN). [s. 6. (7)]

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

Severity: There was risk of harm related to falls as the call bells for five residents were not within reach in accordance with their plan of care.

Scope: This was widespread as three of the three resident neigbourhoods reviewed had one or more residents with their call bells not within reach.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) and three Voluntary Plan of Correction (VPCs) were issued to the home. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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