Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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419 rue King Ouest bureau 303
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 7, 2019	2019_414110_0007	012421-18, 001553-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

Bendale Acres
2920 Lawrence Avenue East SCARBOROUGH ON M1P 2T8

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

DIANE BROWN (110)

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): April 11, 12, 16, 17, 18, 23, 25, 26, 29, 30. May 1, 2, 10, 2019.

During the course of the inspection, two Critical Incident Reports were inspected related to a resident fall that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the residents health status.

A Compliance Order related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent complaint inspection report #2019_414110_0005 (Log #s 017992-18 and 023885-18) will be issued in this report.

During the course of the inspection, the inspector reviewed staff schedules, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, the Nurse Managers, Physiotherapist (PT), Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Falls Prevention

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)**

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The home submitted a Critical Incident Report (CIR) on an identified date related to resident #003's fall that caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

A record review of progress notes on the morning of the resident's fall identified the writer was informed by the unit nurse that resident #003 fell and was found lying on the floor with a mobility aide on top of them. The assessment noted a laceration and the resident was transferred to the hospital. A further note documented a call to the Hospital whereby resident #003 was admitted with a change in health status.

A record review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) full annual assessment pre and post fall revealed that the resident's overall level of self-sufficiency had changed significantly.

A record review of the resident's written plan of care identified the resident at high risk for falls as evidenced by a history of falls. The resident's written plan of care in place at the time of the resident's fall included interventions for staff to monitor the resident Q (every) 30 minutes for safety; toilet the resident at beginning of each shift for comfort and toilet the resident around 11- 12 pm.

The written plan of care did not provide direction as to who was to complete the interventions.

An interview with PSW #109 shared that resident #003 knew when they needed to go the washroom. The staff stated the resident was a total two staff assist for toileting and that they had moments when they spontaneously got up thinking they were going home or to the washroom.

A review of the staffing schedule identified two staff who worked the identified shift of the identified date, full time PSW #111 and full time RPN #110. An interview with PSW #111 revealed that the RPN was assigned to resident #003 on that shift. The PSW shared that staff would only toilet the resident if they were awake and when they arrived on shift on the identified date, they checked on everyone including resident #003 who was asleep. The interview with the PSW revealed that the RPN is the one who provided the care and the last time the PSW had checked on the resident was at the start of their shift around 2300hrs (11:00 pm).

An interview with RPN #110 shared that they had discovered the resident on the floor in the early morning of an identified date. When asked the RPN stated that when they had completed their rounds at the start of their shift 2300hrs (11:00pm) the resident was asleep and it was risky to wake the resident up. The RPN, who had worked full time on nights shared that only a couple of times they have toileted the resident between 11:00-12:00 at night because the resident would be sleeping. When asked about the frequency of monitoring resident #003, the RPN shared they monitored hourly.

An interview with Nurse Manager (NM) #107 they shared that the interventions related to toileting were to toilet the resident at the beginning of each shift for comfort and toilet resident around 11:00- 12:00 pm and did not provide clear direction as to whether staff are to wake up the resident or not. The NM also shared that the intention of 30 minute monitoring should have been a short term intervention to identify the resident needs and what the resident was doing and this intervention did not provide clear direction of who

should be monitoring the resident and if also on nights. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The home submitted a CIR on an identified date related to a resident #003's fall that caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

A record review of progress notes on the morning of the resident's fall identified the writer was informed by the unit nurse that resident #003 fell and was found lying on the floor with a mobility aide on top of them. The assessment noted a laceration and the resident was transferred to the hospital. A further note documented a call to the Hospital whereby resident #003 was admitted with a change in health status.

A record review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) full annual assessment pre and post fall revealed that the resident's overall level of self-sufficiency had changed significantly.

A record review of the resident's written plan of care identified the resident at high risk for falls as evidenced by a history of falls. The resident's plan of care identified two more recent falls one on an identified date, another eight days following then the resident fall two months later which resulted in a transfer to hospital and significant change in health status.

A record review of the post fall huddles of the two most previous falls identified a physiotherapy (PT) referral for assessment as a post fall strategy. A record review of the progress notes included a PT post fall assessment for both falls. The recommendations documented after the first fall were for staff to toilet the resident around 0600hrs, before and after every meal, before going to bed at night. The recommendations documented after the second fall were to toilet the resident around 1600hrs daily.

A review of the written plan of care in place prior to the resident's fall with transfer to hospital did not include the PT recommendations related to toileting.
An interview with the PT revealed that they had received the referrals and completed assessments related to the resident's two falls as documented. The PT stated that the

process in place was to share the assessment recommendations with the registered staff on duty and that it was the registered staff's responsibility to enter the recommendations into the resident's written plan of care.

An interview with RN #113 shared that any registered staff including those who work part time who are provided a report from the PT have the responsibility to update the care plan and put the updated care plan into the communication binder for sharing at report. The RN confirmed the resident's plan of care had not been updated with a 0600hr and 1600hr toileting plan and that toileting the resident at 0600hrs and before breakfast was not practical. The RN shared that there should have been collaboration between the PT and nursing staff and that staff needed to be very strict with following interventions as the resident was so high risk for falls.

An interview with Nurse Manager #107 revealed that there was a gap in the that recommendations provided by PT and OT should be entered into the resident's plan of care by a registered staff and that it was not happening as required. The NM stated that going forward they have spoken with PT and OT and after their assessment and conversation with the registered staff the PT and OT will enter the recommendations into the resident's written plan of care and then highlight the area and place it in the communication binder to collaborate with staff. The NM shared that nursing and PT had not collaborated with each other in the assessment of resident #003's plan of care related to the prevention of falls. [s. 6. (4) (a)]

3. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a CIR on an identified date related to resident #004's fall that caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

A record review of an identified Hospital Patient Transfer Record identified the resident's diagnosis representing a significant change in health status.

A record review of progress notes identified that resident #004 was found lying on the floor, outside their room at an identified time and day and that prior to the fall, the assigned PSW provided care, and left the resident outside their room with their mobility aide to walk towards the dining room.

A review of the resident's written plan of care identified the resident at high risk of falls with a fall history. The interventions included staff to encourage the use of the resident's mobility aide and staff to assist the resident from their room, to and from the dining room.

The assigned PSW was identified as PSW #100. An interview with PSW #100 revealed that at shift report the RN shared that resident #004 could now get up and have their meal in the dining room related to an improved health status. The PSW shared that they had provided care to resident #004 and when assisting the resident to their mobility aide and escorted them outside of their room a co worker, PSW #101, asked for their assistance with another resident. PSW #100 stated that PSW #101 said to leave resident #004 that they had their mobility aide and that they could walk to the dining room on their own.

An interview with PSW #101 confirmed that they had asked PSW #100 to assist them the morning of resident #004's fall and that PSW #100 asked them if resident #004 could walk. The PSW shared that they responded yes they could walk and to leave them somewhere safe. PSW #101 stated they had seen the resident walk by themselves in the hallway and at other times and revealed they were unaware the resident's plan of care directed staff to assist the resident to go to and from the dining room.

An interview with RN #104 confirmed that they had worked the shift of resident #004's fall. The RN stated they directed the PSW to get the resident up and into the dining room for their meal. The RN shared that they found the resident on the floor outside in an identified area and that the resident's mobility aide was not with in the area of where the resident had fallen. The RN stated that the resident had had a fall with their mobility aide, in the dining room, a few weeks before and subsequently documented in the care plan that the resident needed to be walked to and from the dining room. The RN stated that the resident was not supposed to be left alone with walking.

Interviews with Nurse Manager #105 and Nurse Manager #106 confirmed that the resident's plan of care had not been followed with respect to walking resident #004 to and from the dining room with their mobility aide. [s. 6. (7)]

4. The following evidence was identified under inspection report #2019_414110_0005 (Log #s 017992-18 and 023885-18).

The MOHLTC received a complaint and CIR on an identified date that resident #002 had fallen in the home, was transferred to hospital and experienced a significant change in

the resident's health status.

A record review of an identified Report from an identified Hospital on an identified date, revealed the resident sustained an injury and required medical intervention. A subsequent report documented resident's significant change in health status following the medical intervention.

A record review of the home's progress notes identified that on an identified date and time a PSW reported that resident #002 was on the floor beside the resident's bed.

A record review of the resident's 'Bendale Acres – One-Page Bedside Guide' identified the resident as frequently incontinent of bladder and continent of bowel with a toileting plan to be toileted around 0800hrs, 1100hrs 1400hrs, 1630hrs, 2000hrs, 0200hrs, 0500hrs and when necessary (PRN). The guide further documented the resident had a history of falls. An interview with PSW #105 shared that part of the resident's planned care was to provide close observations of the resident. An interview with RPN #103 revealed the resident was at risk of falls and described interventions for close observation.

Staff interviews identified that PSW #100 had provided care to resident #002 prior to the resident's fall.

An interview with PSW #100 shared they provided care that morning but did not toilet the resident. The PSW further stated that when they attempted to assist the resident to their mobility aide the resident leaned back and pulled up their feet appearing resistive to getting up. The staff stated they then placed the resident back onto their bed with a pillow on their side to support them. The interview revealed that PSW #100 had provided care to the resident once before when the resident first came into the home.

An interview with PSW #105 revealed they knew the resident well and had "practically" been on the unit every day since the resident's admission. The PSW stated they toileted the resident when they first woke up in the morning and before and after meals because they would attempt to toilet on their own. The PSW stated most of the time when the resident got up it would be to go to the washroom. The PSW further shared that if the resident was already up they would seat them at the nursing station, always in view and would not leave them alone unsupervised. PSW #105 revealed that the morning of the resident's fall they had checked on the resident at the beginning of their shift around 0700hrs to observe the resident sleeping. The PSW stated they then assisted co-worker,

PSW #106 with care of another resident. Then when PSW #105 returned to resident #002's room at around 0800hrs they found the resident on the floor, fully dressed and with their shoes on. PSW #105 stated that they were unaware PSW #100 dressed resident #002 and put them back to bed as the resident appeared resistive to getting up. The PSW shared that resident #002 was not the kind of resident you would leave alone and that PSW #100 had not communicated they were planning to provide morning care, had dressed the resident and left them in their bed.

An interview with RPN #103 revealed that they worked at the time of the resident's fall. The RPN shared that they were unaware that PSW #100 had provided care to resident #002. The RPN stated that PSW #100 put the resident back to bed where the regular staff knew to bring them to the dining room. The RPN shared that because the resident was already awake they tried to get up out of bed to walk on their own.

An interview with RPN #102 shared that the resident would attempt to use the washroom on their own.

An interview with Nurse Manager #107 confirmed that the resident's plan of care had not been followed with respect to the resident's established toileting routine and that PSW #100 had not communicated with staff PSW #100 and RPN #103 prior to providing care to resident #002 in order to provide the planned care of close observation of resident #002 when awake. [s. 6. (7)]

Additional Required Actions:

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

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 10th day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2019_414110_0007
Log No. / No de registre :	012421-18, 001553-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 7, 2019
Licensee / Titulaire de permis :	City of Toronto 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Bendale Acres 2920 Lawrence Avenue East, SCARBOROUGH, ON, M1P-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bahar Karimi

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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 City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

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.
Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1. The grounds identified in this order shall be shared with all registered and PSWs who worked on resident #002 and #004's home area. A staff signature shall be required.
2. Care is provided to resident #004 as specified in their plan of care.
3. At shift report registered staff shall identify all residents at risk for falls and remind PSWs to refer to the 'Bendale Acres – One-Page Bedside Guide' for fall prevention interventions.
4. At shift report registered staff shall remind PSWs to refer to the 'Bendale Acres – One-Page Bedside Guide' and follow resident's established toileting plans.
5. The above mentioned documentation shall be available to the inspector upon request.
The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report # 2019_414110_0007 to Diane Brown, LTC Homes Inspector, MOHLTC, by June 25, 2019.

Grounds / Motifs :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a CIR on an identified date related to resident #004's fall that caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

A record review of an identified Hospital Patient Transfer Record identified the resident's diagnosis representing a significant change in health status.

A record review of progress notes identified that resident #004 was found lying on the floor, outside their room at an identified time and day and that prior to the fall, the assigned PSW provided care, and left the resident outside their room with their mobility aide to walk towards the dining room.

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before and subsequently documented in the care plan that the resident needed to be walked to and from the dining room. The RN stated that the resident was not supposed to be left alone with walking.

Interviews with Nurse Manager #105 and Nurse Manager #106 confirmed that the resident's plan of care had not been followed with respect to walking resident #004 to and from the dining room with their mobility aide. [s. 6. (7)]

(110)

2. The following evidence was identified under inspection report #2019_414110_0005 (Log #s 017992-18 and 023885-18).

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An interview with RPN #102 shared that the resident would attempt to use the washroom on their own.

An interview with Nurse Manager #107 confirmed that the resident's plan of care had not been followed with respect to the resident's established toileting routine and that PSW #100 had not communicated with staff PSW #100 and RPN #103 prior to providing care to resident #002 in order to provide the planned care of close observation of resident #002 when awake.

The severity of this issue was determined to be a level 3 as there was actual harm to residents #004 and #002.
The scope was a level 2, patterned as it related to 2 residents.
The home had a level 4 compliance history as they had on-going non-compliance with s. 6 (7) of the
LTCHA that included:
-Voluntary Plan of Correction issued September 13, 2017 (#2017_420643_0013);
-Voluntary Plan of Correction issued May 14, 2018 (2018_594624_0006).
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
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Toronto ON M5S 2B1
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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 7th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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