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
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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
Nov 16, 2020	2020_643111_0017	015319-20, 016169-20, 016270-20, 017380-20, 018508-20, 020955-20	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Lindsay Nursing Home
240 Mary Street West LINDSAY ON K9V 5K5

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

LYNDA BROWN (111)

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): October 7 to 9, 13 to 16, 2020 and October 27, 2020 (off-site).

There were six critical incident reports (CIR) inspected concurrently during this inspection as follows:
-Two CIR's related to resident to resident abuse.
-CIR related to alleged improper care of residents.
-CIR related to alleged staff to resident neglect.
-Two CIR's related to falls with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Behavioural Support Ontario (BSO) lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinator and residents.

During the course of the inspection, the inspector: observed residents, observed BSO white board, observed resident rooms, reviewed resident health care records, reviewed home's investigations, and the following policies-Responsive Behaviour Management, Abuse & Neglect-Staff to Resident, Family to Resident, Resident to Resident and Bowel and Bladder management.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

7 WN(s)
4 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. 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 :

The licensee has failed to protect resident #001 and #004 from abuse by resident #003.

Resident #003 had a prior history of responsive behaviours towards residents. Resident #003 had abused resident #001 on a number of occasions and #004 on one occasion. There was no direction in the home's abuse prevention or responsive behaviour policy on how to determine the resident's ability to provide consent. The Inspector also observed resident #001 demonstrating a responsive behaviour towards resident #003. The Inspector also observed the BSO board on the unit (which was to identify residents with responsive behaviours, triggers and interventions to manage the behaviours). Resident #003 was identified on the BSO board, but specified responsive behaviours, triggers or interventions were not indicated and resident #001 was also not identified.The Interventions for the specified responsive behaviours in the care plan for resident #003's were inconsistently applied and did not prevent the behaviours from reoccurring towards resident #001 or resident #004.

Sources: three CIR's. Progress notes, care plan and responsive behaviours documentation for resident #003, progress notes and care plan for resident #001, progress notes for resident #004, BSO board, Responsive Behaviour Management and Prevention of Abuse policies and staff interviews.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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 :

The licensee failed to ensure that the plan of care for resident #001, set out clear directions to staff and others who provide direct care to the resident related to falls prevention interventions.

Resident #001 sustained a number of falls over a three month period. One of the falls resulted in an injury for which the resident was taken to hospital.for which resulted in a significant change in condition. Most of the falls occurred in a specified area and were related to toileting needs. RPN #112 indicated the resident had a specified intervention in a specified area, for falls prevention and included the frequency of toileting that was indicated in the resident's written care plan. PSW #111 also indicated the resident had the specified intervention in the specific area and was toileted at specified times or whenever the resident called for assistance. Resident #001's written care plan had no clear direction related to how frequently the resident was to be toileted or when the other specified intervention was to be implemented.

Sources: CIR, resident #001’s progress notes, post-fall assessments, care plan and staff interviews.

2. The licensee has failed to ensure that the care set out in the plan of care for resident #005 related to toileting, was provided to the resident as specified in the plan.

Resident #005 had been provided assistance with specified toileting by a PSW, was not discovered until a numbers of hours later, with their toileting incomplete and resulted in a change in skin condition. The care plan for resident #005 did not include the specified toileting method that the resident was provided.

Sources: CIR, resident #005’s care plan, progress notes and staff interviews.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #001 by resident #003 had occurred, immediately reported the suspicion and the information to the Director.

On two separate incidents, resident #003 was found, suspected of abuse towards resident #001.There was no documented evidence the Director was notified of either incident. Staff confirmed the Director had not been informed of the two incidents.

Sources: three CIR's, progress notes of resident #001 and #003 and staff interviews.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions between resident #003 towards resident #001 and #004, and other residents.

Resident #001 and #003 began demonstrating responsive behaviours towards each other on a specified date. Resident #001 and #003 continued to demonstrate ongoing responsive behaviours towards one another. Both residents were also involved in a number of witnessed or suspected, resident to resident abuse incidents. Resident #001 was also witnessed by the Inspector demonstrating responsive behaviours towards resident #003 in a specified area. Resident #003 had also demonstrated responsive behaviours towards resident #004, in a specified area and had one incident of resident to resident abuse towards the same resident. The Inspector also observed the BSO board on the unit which identified residents with responsive behaviours and identified resident #003, but did not identify specified responsive behaviours towards resident #001 or #004 or interventions to manage those behaviours.

Prior to the first incident, involving resident #003 towards resident #001, resident #003 had an intervention that had been put in place at a specified time, due to a previous history of the same responsive behaviour towards a former resident. There were a number of interventions that were put in place inconsistently for resident #001 and #003 or that were determined to be ineffective. An external behavioural assessment was completed and the staff reported the specified responsive behaviour was resolved, despite the behaviour continuing. After a number of resident to resident abuse incidents by resident #003 towards resident #001 and #004, additional interventions were considered.

Sources: three CIR's. Progress notes, care plan, responsive behaviours documentation, psychogeriatric assessments, and monitoring records for resident #003. Progress notes and care plan for resident #001. BSO white board and staff interviews.

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #006's SDM was notified within 12 hours, upon becoming aware of an alleged incident of staff to resident abuse.

A written complaint was received by the Executive Director (ED) from a former staff member who alleged witnessing an incident of staff to resident abuse towards resident #006. The home conducted an investigation and concluded the allegation was unfounded. The ED confirmed the SDM of resident #006 was never informed of the allegation.

Sources: CIR, home's investigation, progress notes of resident #006 and a staff interview.

2. The licensee has failed to ensure that resident #001 and #003's SDM, and any other person specified by the resident, were notified within 12 hours, upon becoming aware of two suspected incidents of resident to resident abuse.

On two separate incidents, resident #003 was found, suspected of abuse towards resident #001.There was no documented evidence the SDMs of either resident were notified of either incident. Staff confirmed the SDMs of each resident had not been informed of the two incidents.

Sources: two CIR's, progress notes of resident #001 and #003 and staff interviews.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

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 :

The licensee has failed to ensure that the results of the abuse investigation involving resident #006, were reported to the Director.

A written complaint was received by the Executive Director (ED) from a former staff member who alleged witnessing an incident of staff to resident abuse towards resident #006. The home conducted an investigation and concluded the allegation was unfounded.. The ED confirmed the investigation was concluded and the Director was not provided with the outcome of the investigation.

Sources: CIR, progress notes of resident #006, home's investigation and interviews of staff.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any suspected or witnessed incident of abuse of resident #001 by resident #003, that the licensee suspects may constitute a criminal offence.

On two separate incidents, resident #003 was witnessed and/or suspected of abuse towards resident #001. There was no documented evidence the police were notified of either incident. Interview with staff confirmed the police had not been notified of either incident.

Sources: two CIR's, progress notes of resident #001 and #003 and staff interviews.

Issued on this 23rd day of November, 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) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2020_643111_0017
Log No. / No de registre :	015319-20, 016169-20, 016270-20, 017380-20, 018508-20, 020955-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 16, 2020
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Lindsay Nursing Home 240 Mary Street West, LINDSAY, ON, K9V-5K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Butch Ashcroft

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 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. 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 LTCHA, 2007.

Specifically, the licensee must prepare, submit and implement a plan to ensure residents are protected from abuse by resident #003.

The licensee shall develop and implement a process to ensure that the capacity of residents with cognitive impairment who demonstrate responsive behaviours are being assessed; and to ensure that interventions put in place to manage responsive behaviours, such monitoring, are being consistently implemented

Please submit the written plan for achieving compliance for inspection 2020_643111_0017 to Lynda Brown, LTC Homes Inspector, MLTC, by email to CentralEastSAOMOH@ontario.ca by December 1, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to protect resident #001 and #004 from abuse by resident #003.

Resident #003 had a prior history of responsive behaviours towards residents. Resident #003 had abused resident #001 on a number of occasions and #004 on one occasion. There was no direction in the home's abuse prevention or responsive behaviour policy on how to determine the resident's ability to provide consent. The Inspector also observed resident #001 demonstrating a responsive behaviour towards resident #003. The Inspector also observed the BSO board on the unit (which was to identify residents with responsive behaviours, triggers and interventions to manage the behaviours). Resident #003 was identified on the BSO board, but specified responsive behaviours, triggers or interventions were not indicated and resident #001 was also not identified.The Interventions for the specified responsive behaviours in the care plan for resident #003's were inconsistently applied and did not prevent the behaviours from reoccurring towards resident #001 or resident #004.

Sources: three CIR's. Progress notes, care plan and responsive behaviours documentation for resident #003, progress notes and care plan for resident #001, progress notes for resident #004, BSO board, Responsive Behaviour Management and Prevention of Abuse policies and staff interviews.

An order was made by taking the following factors into account:
Severity: Resident #003 abused resident #001 on more than one occasion and on one occasion towards resident #004, causing risk of harm.
Scope: There was a pattern as there were ongoing incidents involving resident #003 towards more than one resident.
Compliance History: The licensee continues to be in non-compliance with s. 19 (1) of the LTCHA, resulting in a compliance order (CO) being issued. CO #002 was issued on January 22, 2019 (inspection 2018_598570_0013) with a compliance due date of June 30, 2019. In the past 36 months, seven other COs were issued to different sections of the legislation, all of which have been complied. (111)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 12, 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 16th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

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

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