Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 5, 2017	2017_646618_0020	023298-17	Resident Quality Inspection

Licensee/Titulaire de permis

SLOVENIAN LINDEN FOUNDATION
52 NEILSON DRIVE ETOBICOKE ON M9C 1V7

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

DOM LIPA
52 NEILSON DRIVE ETOBICOKE ON M9C 1V7

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

CECILIA FULTON (618), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 4, 5, 6 ,10,11 and 12, 2017.

During this inspection the following complaint intakes were inspected: 018875-17 and 021703-17 - related to reporting and complaints.

During this inspection the following Critical Incident inspection was conducted: CIR #2794-000012-17, Log # 009743-17 - related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of the Board, Facilities Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Resident's family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents had a screen and cannot be opened more than 15 centimetres (cms)

On October 5, 2017, during stage one of the RQI, the inspector was conducting a resident interview with resident #007, when the resident asked the inspector to open the window for him/her. When opening this window, the inspector discovered that the window was able to open greater than 15 centimeters.

Interview and observation with the Facilities Coordinator on October 10, 2017, confirmed that the window in an identified room was able to open greater than 15 centimeters. The inspector and Facilities Coordinator also observed that the window screen in the identified room was damaged with a large hole in the bottom of the screen. Additional observations in three other identified resident rooms revealed that the windows were able to open greater than 15 centimeters. The Facilities Coordinator informed the inspector that the resident rooms in an identified resident home area were in the process of redevelopment, and that many windows do not have any restriction on the distance they are able to be opened.

Interview with the Executive Director confirmed that the windows in the identified resident rooms were able to open greater than 15 centimeters, and confirmed that all windows in the identified resident home area have no restriction on the distance they can be opened.

The Executive Director revealed that the Board of Directors are aware of the redevelopment requirements to the identified resident home area, however, there is no scheduled date for the commencement of the redevelopment project. The total windows identified that opened greater than 15 cms. were 23.

The severity of the non-compliance and the severity of the harm were potential. The scope of the noncompliance was widespread. There was no past history of non compliance in this area. [s. 16.]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

In May 2017, the home submitted a Critical Incident System Report (CIS) reporting an allegation of staff to resident abuse. The CIS report stated that in May 2017, resident #001 reported to RN #100, that PSW# 109, yelled at the resident when the resident asked for assistance.

Interview with PSW #109 revealed that on the identified date, he/she was providing care to resident #001. PSW #109 reported that resident #001 demonstrated identified behaviours which PSW responded to by raising his/her voice and asked why the resident was doing what he/she was doing. PSW #109 confirmed that the manner in which he/she spoke to the resident did not treat the resident with respect and dignity.

Interview with the DOC revealed that an investigation into the alleged abuse incident was conducted. The DOC confirmed that PSW #109 did not treat resident #001 with respect and dignity [s. 3. (1) 1.]

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 right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality are fully promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review of all medication incidents had occurred in the home since the time of the last review in order to reduce and prevent medication incidents.

Interview with the Director of Care (DOC) revealed that quarterly reviews of medication incidents has not been conducted.

The DOC revealed that this review is supposed to take place at the quarterly Program Advisory Committee (PAC) meetings. The DOC further revealed that the last PAC meeting was held on March 15, 2017 and that at the time of this interview, a future meeting has not been scheduled. The DOC confirmed that he/she was not able to provide evidence, either in the form of minutes of previous PAC meetings or by recollection of the discussion points of past meetings that would demonstrate that quarterly reviews of medication incidents had taken place.

Review of the PAC meeting binder revealed that prior to the March 15, 2017 meeting, the last meeting for which minutes were available was conducted on January 12, 2016. The minutes did not include documentation of discussions/review of the medication incidents for that quarter.

The DOC revealed that they thought there had been meetings during this time period, but they could not confirm this or produce minutes to confirm that any meetings had occurred.

The DOC confirmed that quarterly reviews of medication errors had not occurred. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred, that any changes and improvements identified in the review are implemented and that a written record is kept of contents of the review and the plan,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written procedures comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Review of the homes policy, titled: Dom Lipa Slovenian Linden Foundation - Complaint/Concern/Issue Policy. Created on January 1, 2011 and revised on January 12, 2017, reveals that it does not comply with the regulations as it does not contain any timelines for responding, or any requirements regarding the documentation of complaints and concerns.

Interview and review of this policy with the Executive Director confirmed that this is the current policy and that it is not compliant with the regulations. [s. 21.]

WN #5: 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 any written complaints that have been received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

Interview with the DOC, ED and the Director of the Board of Directors confirmed that when they have received written complaints from residents and others that they have not forwarded them to the Director.

Interview with the DOC revealed that they had received an e-mail in October 2017, which they identified as a complaint. The DOC confirmed that they had not forwarded this to the Director as required.

Interview with the Director of the Board confirmed that they had received an e-mail of the above mentioned October 2017, complaint from family members and that they had not forwarded that written complaint to the director.

Interview with ED confirmed that they had received several e-mails from family members concerned about an ongoing issue and that they had not forwarded them to the Director. The ED revealed that they were not aware of the requirement to forward written complaints to the Director and had not necessarily identified these correspondence as complaints, but rather as requests. [s. 22. (1)]

WN #6: 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 :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

In May 2017, the home submitted a Critical Incident System Report (CIS) reporting an allegation of staff to resident abuse. The CIR report stated that in May 2017, resident #001 reported to RN #100, that PSW# 109, yelled at the resident when the resident asked for assistance.

Record review of resident #001's progress notes dated May 2017, and interview with RN #100 revealed that resident #001 reported to the RN that he/she was unhappy with the care he/she had received on the previous shift. RN #100 reported that he/she spoke with the resident and his/her Power of Attorney (POA) regarding the issues and documented the concern. RN #100 reported that he/she was not aware of the requirements to report to the Ministry, however, he/she reported the resident's allegations to the DOC on his/her following shift in May 2017.

Interview with the DOC revealed that he/she was informed by RN #100 about the allegation of abuse in May 2017, however did not call the Ministry nor initiate a CIS until a later date in May 2017, after he/she had spoken with PSW #109 regarding the allegation of abuse. The DOC confirmed that the allegation of abuse of resident #001 was not immediately reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee had written complaint procedures in place that incorporate the requirements set out in section 101 for dealing with complaints.

Review of the home's policy - Titled - Dom Lipa Slovenian Linden Foundation - Complaint/Concern/Issue Policy. Created on January 1, 2011 and revised on January 12, 2017, reveals that there is no procedure outlined for dealing with complaints as set out in section 101 of the Regulations, including timelines for investigation, responses and resolution of the complaints.

Review of this policy with the Executive Director confirmed that the complaint procedures, identified in O. Reg. 79/10, s. 100, are not included as part of this policy. [s. 100.]

WN #8: 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 is kept in the home which included the requirements as identified in regulation 101. (2).

Those requirements would include: an explanation of the nature of each verbal or written complaint, the date the complaint was received, 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, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

Interview with the DOC and the Executive Director revealed that there is no formal policy in place or record kept which captures or documents the steps taken to deal with complaints. [s. 101. (2)]

Issued on this 16th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CECILIA FULTON (618), NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2017_646618_0020
Log No. / No de registre :	023298-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 5, 2017
Licensee / Titulaire de permis :	SLOVENIAN LINDEN FOUNDATION 52 NEILSON DRIVE, ETOBICOKE, ON, M9C-1V7
LTC Home / Foyer de SLD :	DOM LIPA 52 NEILSON DRIVE, ETOBICOKE, ON, M9C-1V7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Theresa MacDermid

To SLOVENIAN LINDEN FOUNDATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The Licensee shall:
1) identify all windows in the home accessible to residents that can be opened more than 15 centimetres.
2) schedule remedial action to ensure all identified windows cannot be opened more than 15 centimetres
3) create and maintain a record of the remedial action taken.
4) develop and implement an auditing process to ensure all windows accessible to residents cannot be opened more than 15 centimetres.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents had a screen and cannot be opened more than 15 centimetres (cms)

On October 5, 2017, during stage one of the RQI, the inspector was conducting a resident interview with resident #007, when the resident asked the inspector to open the window for him/her. When opening this window, the inspector discovered that the window was able to open greater than 15 centimeters.

Interview and observation with the Facilities Coordinator on October 10, 2017, confirmed that the window in an identified room was able to open greater than 15 centimeters. The inspector and Facilities Coordinator also observed that the window screen in the identified room was damaged with a large hole in the bottom of the screen. Additional observations in three other identified resident rooms revealed that the windows were able to open greater than 15 centimeters. The Facilities Coordinator informed the inspector that the resident rooms in an identified resident home area were in the process of redevelopment, and that many windows do not have any restriction on the distance they are able to be opened.

Interview with the Executive Director confirmed that the windows in the identified resident rooms were able to open greater than 15 centimeters, and confirmed that all windows in the identified resident home area have no restriction on the distance they can be opened.

The Executive Director revealed that the Board of Directors are aware of the redevelopment requirements to the identified resident home area, however, there is no scheduled date for the commencement of the redevelopment project. The total windows identified that opened greater than 15 cms. were 23.

The severity of the non-compliance and the severity of the harm were potential. The scope of the noncompliance was widespread. There was no past history of non compliance in this area. [s. 16.] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 5th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Cecilia Fulton

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