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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2020	2019_820130_0008 (A3)	014434-19, 015223-19, 019267-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Kilean Lodge
83 Main Street East GRIMSBY ON L3M 1N6

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

Amended by GILLIAN HUNTER (130) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date extended to December 31, 2020, as per request.

Issued on this 4 th day of November, 2020 (A3)

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

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

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Kilean Lodge
83 Main Street East GRIMSBY ON L3M 1N6

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

Amended by GILLIAN HUNTER (130) - (A3)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 18, 21, 22, 23, 24 and 28, 2019.

During the course of the inspection, the inspector(s) toured the facility,

observed residents and resident care, reviewed relevant resident clinical records, investigation notes, critical incident reports and relevant policies and procedures.

PLEASE NOTE: This Complaint inspection was conducted concurrently with a Critical Incident inspection # 2019_820130_0009.

This inspection was conducted related to the following intakes:

Log # 014434-19 related to: 24/hour nursing care;

Log # 015223-19 related to: Transferring and positioning technique;

Log # 019267-19 related to: Continence care and bowel management and sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Associate Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, the Office Manager/Food Services Manager (FSM), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **6 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	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that there was at least one Registered Nurse (RN) who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

Complaint logs #019267-19/L-70869-HA and 014434-19/IL-68697-HA were submitted to the Director in 2019, related to 24 hour nursing care.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals.
Kilean Lodge did not qualify for any exceptions as specified in the regulations. Kilean Lodge is a long term care home with a licensed capacity of 50 beds.

At the time of the complaint, the planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was one registered nurse (RN) per shift, as identified on work schedules provided by the home and confirmed by the ED.

In an interview, the ED identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events.

A review of the nursing schedule indicated that on twenty occasions over a four month period in 2019, there was no RN on duty.

The ED confirmed in an interview that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that when resident #001 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

A review of the clinical record, including progress notes and post fall assessments, indicated resident #001 sustained five falls over a three month period in 2019; however, although the plan of care identified the resident was at significant risk for injury due to falls, at least four identified fall prevention interventions were not considered or implemented until after the fifth fall.

This ADOC confirmed that different approaches related to fall prevention were not considered or implemented until after the fifth fall.

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 when residents are being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

The following Complaint and Critical incident received, IL-68971-HA /015223-19, CI #1866-000014-19, described an incident whereby resident #001 fell as a result of an improper transfer. According to the clinical record and incident reports, on an identified date in 2019, PSW #105 was providing specific care to resident #001, who had a specific health status. The ADOC confirmed in an interview that it was the expectation that two staff provide care to a resident with the specific health status. The plan of care indicated two staff were required for the specific care.

The ED and the incident reports confirmed, staff #105 provided care to the resident without a second person. The resident had a specific intervention in place at the time the care was rendered; staff #105's action caused the resident to fall. The resident sustained facial injuries.

The ED, incident records and staff #105 confirmed, that safe transferring and positioning devices or techniques were not used when assisting resident #001 on the identified date.

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that resident #001's right to (i) participate fully in the development, implementation, review and revision of their plan of care and right to (ii) give or refuse consent to any treatment, care or services for which their consent was required by law was fully respected and promoted.

A) Resident #001 was admitted to the home in 2019. Admission assessments indicated the resident had a specific cognitive status. The resident signed their own admission consent forms and participated in the development of their own plan of care on admission.

Two months after their admission, RN # 104 obtained a telephone order from the physician regarding a change to medications, as per the family's request. RN #106 checked the order and recorded a progress note, that the plan of care was discussed with the resident's family.

A review of the plan of care indicated there had been no reassessment of the resident's cognitive status during this time period. There was no recorded evidence found to indicate that the plan to change medications had been discussed with the resident prior to or after the medication had been changed. Progress notes indicated that the resident's condition had changed; however, indicated they were still able to communicate their needs to staff.

Interview with RN #106 confirmed that they checked the telephone order, discussed the plan with the substitute decision maker (SDM), but at no time consulted with the resident about the plan to change their medications.

Resident #001's right to (i) participate fully in the development, implementation, review and revision of their plan of care and right to (ii) give or refuse consent to any treatment, care or services for which their consent was required by law was not fully respected and promoted, when their medication was changed without their consultation.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that when resident #001 had fallen, that they were assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's policy titled: Fall Prevention and Injury Reduction, Care5-O10.05, revised March 31, 2019, stated a "Post-Fall Assessment is completed by the nurse immediately following the fall, including vital signs every shift for a minimum of 72 hours".

According to the clinical record review, resident #001 sustained a fall in July 2019. The resident was found on the floor next to their bed, which resulted in reddened areas to both knees. A review of the Point Click Care (PCC) Assessment history and the ADOC confirmed, there was no post fall assessment completed after this fall. This was the second fall within a 30 day period.

In July 2019, resident #001 did not have a post fall assessment completed using a clinically appropriate assessment instrument that was specifically designed for falls.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and any significant change in resident's condition, either decline or improvement, to be reassessed along with RAPs by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.

The licensee did not comply with the conditions to which the licensee was subject for the following identified resident:

A) Resident #001 was admitted to the home in 2019. Admission assessments indicated the resident had a specific cognitive status. The resident signed their own admission consent forms and participated in the development of their own plan. They were independent with at least six activities of daily living (ADL's).

Approximately two months after admission, the resident experienced a change in condition; was sent to hospital and returned with a specific health status. The plan of care, including assessments by the RD and the PT, identified a change in at least five ADL's.

In an interview, the RAI Coordinator #101 confirmed a Significant Change in Condition Assessment was not completed and that the next MDS assessment initiated was a Quarterly Assessment completed weeks after the change was noted. The same assessment identified a decline in five ADLS and showed a warning that indicated: "significant change in resident status".

The ADOC confirmed there was a significant change in the resident's condition after the resident's return from hospital and that the changes in condition warranted a Significant Change in Condition Assessment.

Issued on this 4 th day of November, 2020 (A3)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by GILLIAN HUNTER (130) - (A3)
Inspection No. / No de l'inspection :	2019_820130_0008 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014434-19, 015223-19, 019267-19 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 29, 2020(A3)
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Kilean Lodge 83 Main Street East, GRIMSBY, ON, L3M-1N6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Burton

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Revera Long Term Care Inc., 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically, the licensee must:

1. Ensure at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN) who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

Complaint logs #019267-19/L-70869-HA and 014434-19/IL-68697-HA were submitted to the Director in 2019, related to 24 hour nursing care.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals.
Kilean Lodge did not qualify for any exceptions as specified in the regulations.
Kilean Lodge is a long term care home with a licensed capacity of 50 beds.

At the time of the complaint, the planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was one registered nurse (RN) per shift, as identified on work schedules provided by the home and confirmed by the ED.

In an interview, the ED identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events.

A review of the nursing schedule indicated that on twenty occasions over a four month period in 2019, there was no RN on duty.

The ED confirmed in an interview that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.
This non compliance was issued as a result of the following complaint inspections: #019267-19/L-70869-HA and 014434-19/IL-68697-HA.

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with s. 8 (3) of the LTCHA.
The severity of this issue was determined to be a level 3 as there was actual harm or actual risk of harm to the resident. The scope of the issue was a level 3 as it was widespread. The home had level 2 compliance history.

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020(A3)

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:

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

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

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

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 4 th day of November, 2020 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by GILLIAN HUNTER (130) - (A3)

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

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