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
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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
Oct 20, 2017	2017_632502_0014	008181-17, 010356-17, 021526-17	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

JULIENNE NGONLOGA (502)

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): This inspection was conducted on the following date(s): September 11, 12, 13, 14, 15, 18, 19 and 20, 2017.

The following critical incident report (CIS) were inspected during this inspection: log #010356-17 related to responsive behaviour and complaint log # 008181-17 related to continence care, and 021526-17 related to improper care.

The following evidence related to s. 6. (1) (a), s. 6. (7) will be captured under inspection report 2017_630589_0015.

The following evidence related to s.5 will be captured under inspection report 2017_324535_0014

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), interim Executive Director (I-ED), Director of Care (DOC), interim Director of Care (I-DOC), Associate Director of Care (ADOC), former Associate Director of Care (f-ADOC), Physician, Registered Nurses (RN), Registered Practical nurse (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Nursing Rehabilitation Coordinator (NRC), Registered Dietitian (RD), Director of Food Services (DFS), Nurse Managers (NM), Ward Clerk (WC), Scheduling Clerk (SC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS-C) coordinator, Residents, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) conducted a tour of the home and of the outside garden area, observations of staff to resident interactions and the provision of care, record review of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours
Safe and Secure Home
Training and Orientation

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

- **4 WN(s)**
- **3 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 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 :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of alleged abuse. Review of the complaint revealed that on a specified date, resident #002 requested assistance with changing his/her continent care product three times for a specified period of time. Further review of the complaint revealed that staff #114 went on break after staff #100 directed him/her to assist the resident.

Review of resident assessment instrument-minimum data set (RAI-MDS) completed on an identified date, revealed that resident #002 was cognitively intact. Further review of the RAI-MDS revealed that resident #002 was incontinent of bladder and required extensive physical assistance by one staff.

Review of resident #002's written plan of care, revised on an identified date, under focus bladder and bowel function, revealed that resident #002 was incontinent of his/her bladder and remains continent of bowel, and required a continent care product. Further review of the written plan of care revealed that staff are to provide assistance with toileting one to two times in a shift.

In an interview, resident #002 stated that he/she requires assistance with toileting identified number of hours, and staff expect him/her to call for assistance as needed. Resident #002 further stated that on the day of the incident mentioned above, he/she requested assistance with toileting on three occasions, and staff #114 did not provide assistance. Resident #002 stated that he/she did not request assistance from another staff, as the home was short staffed.

Resident #002 also stated that since the incident two staff should be present for all of his/her care, which usually take an additional ten minutes before he/she is toileted. As result, resident #002 stated that he/she had been in need of assistance, and had developed a permanent an identified skin integrity issue that would not heal.

In interviews, staff #114, #135, and #138 stated that resident #002 was frequently incontinent, and whenever he/she requests for assistance with toileting, the resident is in further need.

In an interview, staff #114 stated that on the day of the above incident, he/she had assisted resident #002 with changing his/her continent care product at the beginning of the shift and had asked the resident before a specified meal, but the resident was not

ready to be toileted, and left the unit. This contradicted resident #002's statement that staff #114 gave him/her permission to leave the unit while serving a specified meal and he/she came back to the unit before the end of that meal service and was never asked to be toileted.

Staff #114 told the inspector that resident #002 came back after a specified meal and asked to be toileted, at that point the staff told the resident that he/she had not eaten since the beginning of the shift and needed a break. The staff stated that he/she left the unit without changing the resident, as staff #134 advised him/her to take his/her break due to a specified medical condition.

Staff #134 told the inspector that staff #114 was already in the elevator when he/she informed him/her and staff #100 that he/she was leaving the unit for his/her break.

In interviews, staff #100 and #133 stated that resident #002 was cognitively well and able to call for assistance as needed, but that he/she did not have an individualized toileting plan. Staff #100 further stated that staff #114 was aware that resident #002 was incontinent prior to leaving the unit and that he/she refused to return to the unit to provide assistance with toileting to resident #002 and take the break thereafter.

Staff #111 acknowledged that resident #002 had been neglected by staff #114, as he/she refused to assist resident #002 with toileting first, then take the break after. Staff further stated that staff #114's was disciplined as result of this incident.

The severity of this incident is actual harm/risk as the resident #002 had required assistance. The scope of this incident is isolated. The previous compliance history revealed ongoing non-compliance with VPC. As a result of this non-compliance with LTCHA 79/10, s.19 (1), a compliance order is warranted.

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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's special treatments and interventions.

On an identified date, a complaint was submitted to the MOHLTC related to resident #002's specified medical condition was not being noted in his/her chart. Review of the complaint revealed that on a specified date and time, resident #002 doing a specified activity in an identified location when he/she was stung by a wasp, to which he/she was allergic.

Review of resident #002's progress notes revealed that he/she was admitted in the home on an identified date. The admission progress notes revealed that resident #002 had identified medical conditions, for which he/she had a specified medication.

Review of resident #002's most recent written plan of care listed multiples allergies, but failed to reveal the specified medical conditions.

In an interview, staff #100 stated that he/she was not aware of resident #002's specified medical condition on the date of the incident mentioned above, and he/she requested a specified medication.

In an interview, staff #144 stated that if a resident had the medical condition identified above, registered nursing staff are expected to document the information into the medication reconciliation, resident chart, and written plan of care. Staff #144 further stated that he/she became aware of resident #002's allergy during the admission process, and he/she should have documented that information in the chart, and then communicated with other staff during the shift report.

Staff #111 acknowledged that resident #002's plan of care was not based on the resident's special treatments and interventions, as the nursing staff failed to document resident's identified allergy in the written plan of care. [s. 26. (3) 18.]

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 plan of care is based on an interdisciplinary assessment of the resident's special treatments and interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident who is incontinent has received an assessment that is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

On an identified date, a complaint was submitted to the MOHLTC related to continence care and bowel movement.

Review of resident's #002's continence assessment record on the home's electronic documentation system revealed that a continence assessment was completed on admission, and resident #002 was identified as being frequently incontinent of bladder and continent of bowel.

Review of resident #002's MDS-RAI assessment completed on an identified date, revealed resident #002's continence level declined from frequently incontinent to incontinent with multiple episodes daily. Review of continence assessment record on the home's documentation system Point Click Care (PCC) failed to reveal a reassessment of resident #002's continence status after the resident had a decline in continence level.

In interviews, staff #100 and #133 stated that resident #002's continence level had declined, and confirmed that they had not re-assessed the resident.

In an interview staff #165, stated that residents are to be assessed on admission, annually, and when there is a significant change in continence level, using a clinically appropriate assessment instrument available on the PCC. Staff #135 acknowledged that resident #002 should have been assessed using the above identified tool when resident #002's continence level declined. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the resident who is incontinent has received an assessment that is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (6) Every licensee of a long-term care home shall ensure that the following are done:
1. The further training needed by the persons mentioned in subsection (1) is assessed regularly in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff training needs are assessed at least annually.

On an identified date, a complaint was submitted to the MOHLTC related to the home failing to have staff that are properly trained and knowledgeable in the use and administration of a specified medication. Review of the complaint revealed that on an identified date and time, resident #002 had an identified allergic reaction. The complainant reported that resident #002 had to self-administer the medication identified above as staff #100 seemed unfamiliar with it use.

Review of the home's staff education record failed to reveal training on the use of the medication identified above use.

In an interview, staff #100 stated that the date of the incident, he/she was called to assist resident #002, as he/she was having an allergic reaction. While checking to ensure the medication was safe to use, the resident took it away and self-administered the medication. Staff #100 further stated that he/she had received training four to five years ago by the home's pharmacy provider as more residents needed the medication identified above in the home at that time.

In an interview, staff #133 stated that he/she had worked in the home for three years and there had not been any opportunity to administer that medication. Staff #133 further stated that he/she would not take a chance with administering the medication as he/she had not used it since graduating from nursing school, where he/she received training on the use the medication identified above.

In an interview, staff #134, stated that he/she had worked ten years in the home had not received training on the use of the medication identified above, even though two residents currently required it on the specified floor. Staff #134 further stated that every staff on the floor should be trained properly, especially on emergency interventions.

In an interview, staff #111 stated that the use of the medication identified above had not been assessed or identified as an education need for registered staff. Staff #111 further stated that he/she believed that each nursing staff member should know how to administer the medication identified above after graduating from nursing school. [s. 76. (6) 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 all staff training needs are assessed at least annually, to be implemented voluntarily.

Issued on this 6th 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) :	JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2017_632502_0014
Log No. / No de registre :	008181-17, 010356-17, 021526-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 20, 2017
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 MIDLAND AVENUE, SCARBOROUGH, ON, M1N-4B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kris Coventry

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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, 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 :

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 shall ensure that resident #002 is not neglected by the licensee or staff by developing and implementing a plan to provide assistance with toileting as required.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of alleged abuse. Review of the complaint revealed that on a specified date, resident #002 requested assistance with changing his/her continent care product three times for a specified period of time. Further review of the complaint revealed that staff #114 went on break after staff #100 directed him/her to assist the resident.

Review of resident assessment instrument-minimum data set (RAI-MDS) completed on an identified date, revealed that resident #002 was cognitively intact. Further review of the RAI-MDS revealed that resident #002 was incontinent of bladder and required extensive physical assistance by one staff.

Review of resident #002's written plan of care, revised on an identified date, under focus bladder and bowel function, revealed that resident #002 was incontinent of his/her bladder and remains continent of bowel, and required a continent care product. Further review of the written plan of care revealed that staff are to provide assistance with toileting one to two times in a shift.

In an interview, resident #002 stated that he/she requires assistance with

toileting identified number of hours, and staff expect him/her to call for assistance as needed. Resident #002 further stated that on the day of the incident mentioned above, he/she requested assistance with toileting on three occasions, and staff #114 did not provide assistance. Resident #002 stated that he/she did not request assistance from another staff, as the home was short staffed.

Resident #002 also stated that since the incident two staff should be present for all of his/her care, which usually take an additional ten minutes before he/she is toileted. As result, resident #002 stated that he/she had been in need of assistance, and had developed a permanent an identified skin integrity issue that would not heal.

In interviews, staff #114, #135, and #138 stated that resident #002 was frequently incontinent, and whenever he/she requests for assistance with toileting, the resident is in further need.

In an interview, staff #114 stated that on the day of the above incident, he/she had assisted resident #002 with changing his/her continent care product at the beginning of the shift and had asked the resident before a specified meal, but the resident was not ready to be toileted, and left the unit. This contradicted resident #002's statement that staff #114 gave him/her permission to leave the unit while serving a specified meal and he/she came back to the unit before the end of that meal service and was never asked to be toileted.

Staff #114 told the inspector that resident #002 came back after a specified meal and asked to be toileted, at that point the staff told the resident that he/she had not eaten since the beginning of the shift and needed a break. The staff stated that he/she left the unit without changing the resident, as staff #134 advised him/her to take his/her break due to a specified medical condition.

Staff #134 told the inspector that staff #114 was already in the elevator when he/she informed him/her and staff #100 that he/she was leaving the unit for his/her break.

In interviews, staff #100 and #133 stated that resident #002 was cognitively well and able to call for assistance as needed, but that he/she did not have an individualized toileting plan. Staff #100 further stated that staff #114 was aware that resident #002 was incontinent prior to leaving the unit and that he/she

refused to return to the unit to provide assistance with toileting to resident #002 and take the break thereafter.

Staff #111 acknowledged that resident #002 had been neglected by staff #114, as he/she refused to assist resident #002 with toileting first, then take the break after. Staff further stated that staff #114's was disciplined as result of this incident.

The severity of this incident is actual harm/risk as the resident #002 had required assistance. The scope of this incident is isolated. The previous compliance history revealed ongoing non-compliance with VPC. As a result of this non-compliance with LTCHA 79/10, s.19 (1), a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

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 20th day of October, 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 : Julienne NgoNloga

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