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

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 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
Jan 26, 2021	2020_754764_0016	001510-20, 001893-20, 004268-20, 004870-20, 004992-20, 009244-20, 013042-20, 014790-20, 017508-20	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

Maynard Nursing Home
28 Halton Street Toronto ON M6J 1R3

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

NAZILA AFGHANI (764), IVY LAM (646), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 19, 23, 24, 25, 26, 27, 30 and December 1 and 2, 2020.

The following Critical Incident System (CIS) intakes were inspected:
Log #001510-20, Log #004268-20, Log #004870-20, Log #013042-20, Log# 014790-20 and Log # 017508-20- related to alleged abuse and neglect. Log #004992-20 and Log #009244-20- related to fall prevention program.
The following Compliance Order (CO) follow-up intake was inspected during this inspection: Log #001893-20 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DONC), Medical Director, Pharmacy consultant, Physiotherapist, Personal Expression Response Team (PERT) lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

Compliance order #001 related to LTCHA 2007, c. 8, s. 19. (1) from inspection

#2019_659189_0020, is being re-issued as follows:
The licensee failed to conduct post-training evaluation regarding abuse and neglect, for the staff to ensure comprehension of the training materials as required by step #3 of CO #001.

1. The licensee has failed to protect resident #007 from resident #006's physical abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the O. Reg. 79/10, "physical abuse" means, subject to subsection (c) the use of physical force by a resident that causes physical injury to another resident.

An incident occurred in which resident #006 caused physical injury to resident #007.

Resident #006's was able to make their own decisions and had a cognitive awareness of their actions.

Interview with DONC, Neighborhood Coordinator, RPN #108, #110, and PSW #113 acknowledged that resident #007 was not protected from abuse.

Sources: Incident Report, Prevention of Abuse and Neglect policy, interviews with DONC and other staff. [s. 19. (1)] (500)

2. The licensee has failed to ensure that one resident was protected from neglect.

For the purposes of the Act and this regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The resident had an order in place for biweekly assessment related to a medication they were receiving for their medical diagnosis. The biweekly assessment had not been discontinued by the physician and a new order for daily assessment was to be added. An error in transcription of the order occurred, leading to the assessment not being carried out for a period of three months. The resident began to have a change in their condition and as a result was sent to the hospital for assessment where they passed away.

Over the three-month period, the resident had several visits by the physician and review of treatment and medication orders completed. Registered staff of the home did not

identify that the resident had not had the assessment completed despite the continued administration of the medication.

The home’s medical director indicated that residents receiving the type of medication required clinical monitoring and assessment depending on their clinical presentation and registered staff should have used clinical judgement to recognize the resident should have received assessment.

A pharmacy consultant acknowledged that an error was made in transcription of the physician’s order and had not contacted the home to clarify the order.

The physician’s order was confirmed and signed off by two registered staff as discontinuing biweekly assessment without the initiation of daily assessments as ordered by the physician. The DONC and General Manager acknowledged that the resident had been neglected as registered staff did not verify the physician order and the resident did not receive assessments required by their diagnosis and administration of medication to treat their diagnosis.

Sources: Resident #008's clinical records, Physician orders, Home medication administration procedures policy, incident report, interview with Pharmacy consultant and RNs #123 and #122. [s. 19. (1)] (764)

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. 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 incidents related to allegations of abuse of a resident were immediately reported to the Director.

The resident had reported a staff member abused them in two different incidents.

Critical Incident reports indicated that both incidents were submitted one day after each incident to the Director.

Interview with DONC acknowledged that the incidents should have been immediately reported to the Director.

Sources: Critical incident reports, interview with DONC. [s. 24. (1)] (500)

2. The licensee has failed to ensure that an incident of resident to resident abuse was immediately reported to Director.

Review of critical incident report indicated the incident happened on an identified date and was reported after 3 days.

Review of the home's investigation notes indicated that RPN #110 witnessed resident #002 exhibit a responsive behavior toward resident #001 which caused distress to

resident #001. RPN #110 didn't report the incident as they didn't recognize it as a type of abuse that required a mandatory report.

Review of the home's education attendance list for prevention of abuse, neglect and retaliation, showed that RPN #110 received education regarding the types of abuse and abuse decision making trees.

During an interview with PERT lead, they stated that the incident between residents #001 and #002 constituted abuse of resident #001.

During an interview with RPN #110, they acknowledged that the incident constituted abuse of resident #001 but they did not realize it at the time of the incident..

During an interview with DONC, they indicated that the day after the incident, through review of the 24 hours report, they suspected abuse; but they did not report it until 3 days later.
During an interview with the General Manager, they acknowledged that the incident should have been immediately reported to the Director.

Sources: Critical incident reports, home investigation reports, interview with RPN #110 and other staff. [s. 24. (1)] (764)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 17th day of February, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NAZILA AFGHANI (764), IVY LAM (646), NITAL SHETH (500)
Inspection No. / No de l'inspection :	2020_754764_0016
Log No. / No de registre :	001510-20, 001893-20, 004268-20, 004870-20, 004992-20, 009244-20, 013042-20, 014790-20, 017508-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 26, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	Maynard Nursing Home 28 Halton Street, Toronto, ON, M6J-1R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Julie Music

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 Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

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)

Linked to Existing Order / Lien vers ordre existant: 2019_659189_0020, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.
Specifically, the licensee must:

1- Conduct huddles and review of residents' behavior plan of care, on all units at a frequency decided by home, to discuss strategies to protect residents from abuse by residents who exhibit behaviors.
2- Conduct huddles on all units at a frequency decided by the home, to discuss and review suspected and actual cases of resident abuse and neglect and the record of attendance.
3-Ensure all PSWs and registered staff (RNs and RPNs) complete evaluation test on prevention of abuse and neglect by Compliance Due Date (CDD) .
4- Evaluation test should include different types of abuse and neglect.
5- Maintain records of evaluation, including who completed it, when it occurred, who evaluated it, and the content of the evaluation.
6- Prevention of neglect in care of residents who receive identified medication :
6.1- Keep a current record of residents who are receiving identified medication and their physician order for identified assessment value .
6.2- Conduct weekly audit to ensure that residents are receiving identified assessment value as ordered by physician .
6.3- Provide re-training to all registered staff regarding:
- Nurses' role and responsibility in managing residents on identified medication,
- Nursing clinical indications for providing identified assessment value ,
- The process of discontinuation of physician's orders.

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

Grounds / Motifs :

1. . Compliance order #001 related to LTCHA 2007, c. 8, s. 19. (1) from inspection #2019_659189_0020, is being re-issued as follows:
The licensee failed to conduct post-training evaluation regarding abuse and neglect, for the staff to ensure comprehension of the training materials as required by step #3 of CO #001.

The licensee has failed to protect resident #007 from resident #006's physical abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the O. Reg. 79/10, "physical abuse" means, subject to subsection (c) the use of physical force by a resident that causes physical injury to another resident.

An incident occurred in which resident #006 caused physical injury to resident #007.

Resident #006's was able to make their own decisions and had a cognitive awareness of their actions.

Interview with DONC, Neighborhood Coordinator, RPN #108, #110, and PSW #113 acknowledged that resident #007 was not protected from abuse.

Sources: Incident Report, Prevention of Abuse and Neglect policy, interviews with DONC and other staff.

(500)

2. The licensee has failed to ensure that one resident was protected from neglect.

For the purposes of the Act and this regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The resident had an order in place for biweekly assessment related to a medication they were receiving for their medical diagnosis. The biweekly assessment had not been discontinued by the physician and a new order for daily assessment was to be added. An error in transcription of the order occurred, leading to the assessment not being carried out for a period of three months. The resident began to have a change in their condition and as a result was sent to the hospital for assessment where they passed away.

Over the three-month period, the resident had several visits by the physician and review of treatment and medication orders completed. Registered staff of the home did not identify that the resident had not had the assessment completed despite the continued administration of the medication.

The home's medical director indicated that residents receiving the type of medication required clinical monitoring and assessment depending on their clinical presentation and registered staff should have used clinical judgement to recognize the resident should have received assessment.

A pharmacy consultant acknowledged that an error was made in transcription of the physician's order and had not contacted the home to clarify the order.

The physician's order was confirmed and signed off by two registered staff as discontinuing biweekly assessment without the initiation of daily assessments as ordered by the physician. The DONC and General Manager acknowledged that the resident had been neglected as registered staff did not verify the physician order and the resident did not receive assessments required by their diagnosis and administration of medication to treat their diagnosis.

Sources: Resident #008's clinical records, Physician orders, Home medication administration procedures policy, incident report, interview with Pharmacy consultant and RNs #123 and #122. [s. 19. (1)] (764)

An order was made by taking the following factors into account:
Severity: Resident #007 was not protected from abuse by resident #006, which

resulted in actual harm.
Resident #008 experienced actual harm as their identified assessment value was not monitored resulting in hospitalization, and passed away.

Scope: This non-compliance was a pattern as 2 of 3 residents reviewed, were affected.
Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 19. (1) of LTCHA 2007. This subsection was issued as a CO, during inspection #2019_659189_0020.

(764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2021

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

1- Retraining of all registered staff regarding reporting of certain matters to the director.
2- Post evaluation should be conducted through brain- storming in using of decision tree in selected scenarios.
3- Keep record of training, name of attendees, date of attendance and notes of evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that incidents related to allegations of abuse of a resident were immediately reported to the Director.

The resident had reported a staff member abused them in two different incidents.

Critical Incident reports indicated that both incidents were submitted one day after each incident to the Director.

Interview with DONC acknowledged that the incidents should have been immediately reported to the Director.

Sources: Critical incident reports, interview with DONC (500)

2. The licensee has failed to ensure that an incident of resident to resident abuse was immediately reported to Director.

Review of critical incident report indicated the incident happened on an identified date and was reported after 3 days.

Review of the home's investigation notes indicated that RPN #110 witnessed resident #002 exhibit a responsive behavior toward resident #001 which caused distress to resident #001. RPN #110 didn't report the incident as they didn't recognize it as a type of abuse that required a mandatory report.

Review of the home's education attendance list for prevention of abuse, neglect and retaliation, showed that RPN #110 received education regarding the types of abuse and abuse decision making trees.

During an interview with PERT lead, they stated that the incident between residents #001 and #002 constituted abuse of resident #001.

During an interview with RPN #110, they acknowledged that the incident constituted abuse of resident #001 but they did not realize it at the time of the incident..

During an interview with DONC, they indicated that the day after the incident, through review of the 24 hours report, they suspected abuse; but they did not report it until 3 days later.
During an interview with the General Manager, they acknowledged that the incident should have been immediately reported to the Director.

Sources: Critical incident reports, home investigation reports, interview with RPN #110 and other staff.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm because not reporting certain matters to Director will increase the risk of harm for residents.
The scope was widespread because in all three of four situations that required

the home to immediately report to the Director that were reviewed, none were reported on time.
Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 24 (1) and one Written Notifications (WNs) and one Voluntary Plan of Correction (VPC) were issued to the home.
(764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

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 26th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nazila Afghani

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