Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
May 19, 2021	2021_800532_0007 (A1)	002445-21, 002470-21, 003505-21, 005097-21	Complaint

Licensee/Titulaire de permis

Lutheran Homes Kitchener-Waterloo
2727 Kingsway Drive Kitchener ON N2C 1A7

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

Trinity Village Care Centre
2727 Kingsway Drive Kitchener ON N2C 1A7

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

Amended by NUZHAT UDDIN (532) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Correction required to closing statement for s.19 to identify resident #001 and correction required to s.229 to clarify the number of home areas.

Issued on this 19th day of May, 2021 (A1)

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*

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

Amended by NUZHAT UDDIN (532) - (A1)

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): March 31, and April 1, 6-9, 13-15, 2021.

The following intakes were completed in this complaint inspection: Log #003505-21; Log #002445-21; Log #005097-21 related to abuse and neglect and Log # 002470-21 related to improper care and harm.

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of Care (DOC), assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Consultant, Fall Prevention Lead, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, residents and a family member.

The inspector(s) also toured resident home areas, observed resident care provision, dining, resident to staff interaction, and reviewed relevant resident clinical records and IPAC practices.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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

4 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. 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 were free from neglect from staff.

For the purpose 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. O. Reg. 79/10, s 5.

A) A resident was left on a bedpan for an extended period of time during which the resident was not assisted with care, a staff member did not complete their hourly safety checks of the resident and did not communicate that the resident was on a bedpan to the oncoming shift.

Failure to provide the resident with assistance and not completing hourly checks placed the resident at potential risk of harm.

Sources: CIS, investigation notes, DOC interview.

B) A complaint was received by the Ministry of Long Term Care (MLTC) about the care provided to a resident. The complainant alleged the home did not provide the resident with the care and assistance required to ensure the resident's safety and well-being.

The resident lived in the home for a specified period of time and during that short stay the following concerns were identified:

i) The resident had a history of urinary tract infections (UTIs) and during the identified period of time, the resident experienced increased confusion. As a result, the resident was self-transferring, forgetting to use their assistive device, and experienced a number of falls; one of which resulted in severe injuries.

A Registered Practical Nurse (RPN) documented that a urine sample was to be collected to rule out a possible UTI. The urine sample was never collected and at a later date the resident was hospitalized and diagnosed with a UTI.

During this period of physical decline, the Substitute Decision Maker (SDM) spoke

to the charge nurse and expressed their concerns that the resident did not have an adequate assistive device. The SDM was concerned about the resident's safety and increased risk for falls. The charge nurse referred the resident to the Occupational Therapist (OT), but took no further actions.

The SDM repeated their concerns to the Director of Care (DOC) on two separate dates, requesting for proper assistive devices for the resident, but the DOC offered no further follow-up or referrals. It was not until 11 days later, that the assistive device was provided to the resident. During this time, the resident sustained five falls.

The Falls Lead indicated that the assistive devices were available in the home and registered staff were able to assess residents, and installation of the equipment could be completed by the maintenance staff, once a referral was received.

The resident's SDM was not informed about two of the resident's falls, or injuries, and the registered staff failed to complete a skin assessment of the resident's injuries.

ii) The same resident was continent of bowel upon admission to the home. On as specified date, however, the SDM found the resident in a soiled continence product and it was unclear how long they had been left in that state. Additionally, on two separate occasions the resident was again found by their SDM to be incontinent.

The SDM requested a toileting routine for the resident, however, this was not implemented. There were no interventions in the plan of care under bowel and bladder continence and a plan of care for toileting had not been implemented.

Not ensuring that the resident was assessed and provided with appropriate treatment contributed to the resident experiencing a decline in health status, increased falls with injuries, and a UTI resulting in hospitalization.

Sources: Complainant, investigation note, RN interview, Fall Lead interview, SDM interview, DOC interview and other staff. [s. 19. (1)]

Additional Required Actions:

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

(A1)
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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Home's Policy on RESIDENT ABUSE - PM A1.10, review date February 20, 2021, stated that for every incident of alleged abuse, staff were to document on a Risk Management/Occurrence Note in point click care, complete the details tab (incident description, resident description, immediate action taken), complete the injuries tab, click new and use the occurrence note for first note and then make a follow-up note for the next three days. (Appendix C).

There were three alleged incidents related to staff to resident abuse reported to the Ministry of Long-Term Care.

a) Alleged staff to resident physical abuse.
b) Verbal/emotional abuse by staff towards a resident.
c) Staff to a resident neglect.

There was no immediate documentation of injuries or pain for the residents.

The Registered staff did not complete the risk management note or a follow-up note in full for the three residents; subsequently, there was no immediate assessment for potential injuries and no documentation related to direct actions taken.

Failing to comply with the policy resulted in a low risk of harm.

Sources: CIS, investigation notes, risk management, DOC interview. [s. 20. (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 zero tolerance of abuse and neglect of residents' policy was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Between March 31, 2021, and April 15, 2021, observations on all home areas were made and the following infection prevention and control practices were noted:

A) All personal protective equipment (PPE) carts on all five home areas, a sit-to-stand lift, and vital sign monitors were missing disinfectant wipes. Staff said they used alcohol-based hand rub (ABHR) and paper towels to disinfect their face shields, mechanical lifts and vital sign monitors when this occurred.

The Public Health Inspector indicated that using ABHR to clean PPE equipment and other devices was not recommended as it required a longer contact time.

B) Staff members were observed wearing eyeglasses with side attachments instead of face shields or goggles. A staff member was observed wearing goggles at the back of their head while interacting with the residents.

The Public Health Inspector stated that glasses with side attachments did not provide adequate coverage of staffs' face and eyes, and the lenses could be damaged when disinfected.

C) On Cherry Orchard home area, multiple residents were observed not sitting two meters apart in the dining room, nor was there plexiglass partitions in between the residents. One table had four residents and another table had three residents.

On Cherry Orchard, five residents were observed sitting less than two meters apart while in the small television lounge.

The Public Health Inspector stated residents should be socially distanced, maintaining a minimum two meter distance between each resident, when in the dinning room and other common areas within the home.

D) Multiple observations completed on all five home areas found that staff did not assist residents with hand hygiene before and after meals. The home's Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands" (JCYH), required that staff assist residents to clean their hands before and after meals.

ABHRs were available at point-of-care and in the dining rooms; however, staff did not assist the residents with hand washing, which presented increased risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Not ensuring that infection prevention and control measures were implemented as required increased the risk of infectious disease transmission throughout the home.

Sources: observations, DOC interview, Public Health Inspector interview, and other staff. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity.

A resident requested to be assisted to the dining room.

A staff was asked to assist the resident, and they replied that they only did "medical stuff," and that the resident required a PSW to assist them. The staff did not help the resident or call for assistance and the resident remained in the hallway.

The resident was not harmed because of the incident.

Sources: Observations, resident interview and RPN interview. [s. 3. (1) 1.]

Issued on this 19th day of May, 2021 (A1)

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 NUZHAT UDDIN (532) - (A1)
Inspection No. / No de l'inspection :	2021_800532_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002445-21, 002470-21, 003505-21, 005097-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 19, 2021(A1)
Licensee / Titulaire de permis :	Lutheran Homes Kitchener-Waterloo 2727 Kingsway Drive, Kitchener, ON, N2C-1A7
LTC Home / Foyer de SLD :	Trinity Village Care Centre 2727 Kingsway Drive, Kitchener, ON, N2C-1A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debby Riepert

To Lutheran Homes Kitchener-Waterloo, 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)

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.

Specifically, the licensee must:

1) Ensure that residents are not neglected by staff in the home.

2) Ensure that registered staff review the home's process to ensure that when a urine test is required, the request is documented, actioned and treatment plan is implemented.

3) Ensure registered staff follow the home's process for the assessment and implementation of toileting equipment and assistive devices for residents.

4) Ensure that each resident that is incontinent has a documented individualized plan as part of their plan of care and that the plan is implemented.

5) Ensure residents' substitute decision-makers (SDM) are notified about a resident's change in condition, including incidents that result in injury.

6) Document that registered staff reviewed the urine testing process, including the date, the staff member who facilitated the process review, and the names of the staff members who attended. A record of staff attendance must be kept in the home.

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. The licensee has failed to ensure that residents were free from neglect from staff.

For the purpose 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. O. Reg. 79/10, s 5.

A) A resident was left on a bedpan for an extended period of time during which the resident was not assisted with care, a staff member did not complete their hourly safety checks of the resident and did not communicate that the resident was on a bedpan to the oncoming shift.

Failure to provide the resident with assistance and not completing hourly checks placed the resident at potential risk of harm.

Sources: CIS, investigation notes, DOC interview. (532)

(A1)

2. B) A complaint was received by the Ministry of Long Term Care (MLTC) about the care provided to a resident. The complainant alleged the home did not provide the resident with the care and assistance required to ensure the resident's safety and well-being.

The resident lived in the home for a specified period of time and during that short stay the following concerns were identified:

i) The resident had a history of urinary tract infections (UTIs) and during the identified period of time, the resident experienced increased confusion. As a result, the resident was self-transferring, forgetting to use their assistive device, and experienced a number of falls; one of which resulted in severe injuries.

A Registered Practical Nurse (RPN) documented that a urine sample was to be collected to rule out a possible UTI. The urine sample was never collected and at a later date the resident was hospitalized and diagnosed with a UTI.

During this period of physical decline, the Substitute Decision Maker (SDM) spoke to

the charge nurse and expressed their concerns that the resident did not have an adequate assistive device. The SDM was concerned about the resident's safety and increased risk for falls. The charge nurse referred the resident to the Occupational Therapist (OT), but took no further actions.

The SDM repeated their concerns to the Director of Care (DOC) on two separate dates, requesting for proper assistive devices for the resident, but the DOC offered no further follow-up or referrals. It was not until 11 days later, that the assistive device was provided to the resident. During this time, the resident sustained five falls.

The Falls Lead indicated that the assistive devices were available in the home and registered staff were able to assess residents, and installation of the equipment could be completed by the maintenance staff, once a referral was received.

The resident's SDM was not informed about two of the resident's falls, or injuries, and the registered staff failed to complete a skin assessment of the resident's injuries.

ii) The same resident was continent of bowel upon admission to the home. On as specified date, however, the SDM found the resident in a soiled continence product and it was unclear how long they had been left in that state. Additionally, on two separate occasions the resident was again found by their SDM to be incontinent.

The SDM requested a toileting routine for the resident, however, this was not implemented. There were no interventions in the plan of care under bowel and bladder continence and a plan of care for toileting had not been implemented.

Not ensuring that the resident was assessed and provided with appropriate treatment contributed to the resident experiencing a decline in health status, increased falls with injuries, and a UTI resulting in hospitalization.

Sources: Complainant, investigation note, RN interview, Fall Lead interview, SDM interview, DOC interview and other staff.

An order was made by taking the following factors into account:

Severity: Not ensuring the resident was assessed, monitored and provided

appropriate treatment resulted in actual risk of harm.

Scope: The scope of this non-compliance was a pattern because neglect was identified for two of the three residents reviewed during this inspection.

Compliance History: Written Notification (WN) was issued to the home related to same section of the legislation in the past 36 months. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 28, 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

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 19th day of May, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by NUZHAT UDDIN (532) - (A1)

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 : Central West Service Area Office