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
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
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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
Jul 17, 2018	2018_654618_0015	008217-17, 015692-17, 021392-17, 022370-17, 024243-17, 001242-18, 002259-18, 006202-18, 006244-18	Critical Incident System

Licensee/Titulaire de permis

Villa Colombo Homes for the Aged Inc.
40 Playfair Avenue TORONTO ON M6B 2P9

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

Villa Colombo Homes for the Aged
40 Playfair Avenue TORONTO ON M6B 2P9

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

CECILIA FULTON (618)

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): June 1, 4, 5, 6, 7, 8, 11, and 12, and interview on June 24, 2018.

The following Critical Inspection Logs were inspected during this inspection:
Log # 024243-17, related to Prevention of Abuse and Responsive Behaviours.
Logs # 022370-17, 008792-17, and 002259-18, related to Prevention of abuse
Log # 008217-17, related to Falls prevention.
Log # 015692-17, related to Hospitalization and change in condition.
Logs # 001242-18 and 006244-18, related to Personal Support Services.

During the course of the inspection, the inspector(s) spoke with The Director of Resident Services, Nurse Managers (NM), Registered Staff (RN/RPN), Personal Support workers (PSW) and residents.

During the course of this inspection the inspector made observations of residents, and staff to resident interactions, reviewed clinical records and pertinent policies and procedures.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

This inspection was initiated to inspect an incident of resident to resident abuse reported in a Critical Incident Report, submitted October 2017.

Review of the CIR revealed that in October 2017, Resident #011 wandered into the room of resident #007 and a physical altercation ensued which resulted in injury to resident #007.

Record review revealed that resident #011 was a recent admission to the home. Admission records received from the CCAC and admission assessment documents of the home did not identify that resident #011 had any behaviours of wandering or aggression, but they did have behaviours of resisting care, and being socially inappropriate, and was identified as a possible candidate for a unit designated for more serious cognitive impairment.

Resident #011 had a CPS of 4/6 and they were independent to ambulate.

Record review revealed that resident #011, started to exhibit behaviours of wandering on the unit and into co-residents rooms on the first day of their admission and exhibited these behaviours on a daily basis through to the date of this altercation.

Review of a physician progress note revealed that this resident was discussed at a Multi-disciplinary meeting and in the progress note, the physician stated that the biggest concern was the residents wandering which could pose a risk to themselves or co-residents.

Interview with the Social worker revealed that based on the discussion at that Multi-disciplinary meeting, they had put the resident on a wait list to a more suitable unit and had initiated discussion with the family regarding this room transfer.

Interview with the BSO lead, RPN #101, revealed that they had received a referral to assess this resident, but as of the date of the altercation their assessment had not been completed. The BSO lead did reveal that the resident did not exhibit this behaviour when

they were engaged with someone. The BSO lead also revealed that this resident had been put on the assignment for the BSO-PSW on that unit, and receiving approximately half to one hour or activity from that staff member during the shifts that staff member was working.

Interview with PSW #102, who was working as a BSO-PSW on the unit revealed that staff were award of the resident's wandering tendencies which included going into other residents rooms. PSW #102 revealed resident #011 could also become aggressive towards other residents, and identified resident #011's triggers were noise, and being re-directed. PSW #102 revealed that when resident #011 was exhibiting behaviours, their role would be to engage the resident in activities, such as playing cards, or taking them off the unit for a walk, and also letting other staff know that the resident was wandering so that they should pay closer attention to the residents' whereabouts. PSW #102 revealed that on days when the resident was exhibiting behaviours, besides keeping a closer eye on the resident, they would involved them in approximately 30 to 60 minutes of one to one activity.

Interview with the Director of Resident services revealed that referrals to BSO should be acted on with in 48 hours, and if for some reason that BSO lead is not available, some other staff would take over the referral.

The Director of Resident services revealed that the BSO assessment had not occurred as it should have and as a consequence of that, resident #011's responsive behaviours were not managed in a way that minimized the risk to other residents.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1, as the issue was isolated.
The home had a level 2 compliance history as they had no non-compliance with this section of the LTCHA. [s. 54. (a)]

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. 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 protected residents from abuse by anyone.

This inspection was initiated to inspect an incident of resident to resident abuse reported in a Critical Incident Report, submitted October 2017.

Review of the CIR revealed that in October 2017, resident #011 wandered into the room of resident #007 and a physical altercation ensued which resulted in injury to resident #007.

Record review revealed that resident #011 was a recent admission to the home. Admission records received from the CCAC and admission assessment documents of the home did not identify that resident #011 had any behaviours of wandering or aggression, but they did have behaviours of resisting care. Resident #011 had a CPS of 4/6, and they were independent to ambulate.

Record review revealed that resident #011, started to exhibit behaviours of wandering very early in their admission and that their behaviours of being resistive to care also included being aggressive towards staff.

Review of the progress notes from the date of resident #011's admission through to the date of this altercation revealed daily episodes of wandering as well as resisting care and aggressive response to staff. There is no documentation of aggression towards co-residents, however interview with PSW #102 revealed that the resident was known to demonstrate aggression towards co-residents.

Interview with resident #007 revealed that resident #011 had wandered into their room on a couple of previous occasions, but that when told to get out, resident #011 left without incident. Resident #007 revealed that they had not reported this to staff, as it was not a concern.

Resident #007 revealed that on this occasion, resident #011 did not leave when they were told, but rather they sat down in a chair in resident #007's room. Resident #007 stated that they said get out again, and then resident #011 got up and picked up a grab stick off resident #007's bed and hit resident #007 with it. The altercation escalated into a physical fight.

The altercation ended when a staff member intervened.

Record review revealed that resident #007 incurred multiple abrasions to their shoulder and cheek as well as bruising to right wrist and bruise on left hand as well as hematoma on left forehead. Hospitalization was not required.

Interview with the BSO lead revealed that all new residents are DOS monitored for seven days from the date of admission. The BSO lead revealed that their role in this admission work would be to review the DOS monitoring on either a daily or every three day time frame, determined by the resident's status. The BSO lead could not recall the details of her review of resident #011's DOS records, and had not made any notes the progress notes.

A physician progress note revealed that this resident was discussed at a Multi-disciplinary meeting and in the progress note, the physician raised the issue that this residents wandering could pose a risk to themselves or co-residents.

Interview with the Social worker revealed that based on review of resident #011, they had put the resident on a wait list to a more suitable unit and had initiated discussion with the family regarding this.

Record review revealed that a BSO referral was initiated for resident #011. This was confirmed in interview with the BSO lead, and they also confirmed that this referral had not been completed as of the date of this incident. The BSO lead revealed that referrals should be assessed within two days of receipt of the referral. The BSO lead also revealed that they had made notes in a note book, but they were not able to locate that book. They had not made any notes in PCC regarding this resident or their involvement in resident #011's care.

Interview with the Director of Resident services confirmed that this referral had not been completed and that the expectation for action on a BSO referral is 24-48 hours and that the risks and interventions to related to resident #011's behaviours had not been fully

identified and consequently co-residents were not fully protected from abuse.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1, as the issue was isolated.
The home had a level 4 compliance history as they had no non-compliance with this section of the LTCHA that included:
Compliance order issued on June 23, 2017, in inspection number 2017_642606_0005.
Compliance order issued June 19, 2016, in inspection number 2016_398605_0014.
Voluntary Plan of Correction issued February 17, 2016, in inspection number 2016_334565_0002. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 15th day of August, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CECILIA FULTON (618)
Inspection No. / No de l'inspection :	2018_654618_0015
Log No. / No de registre :	008217-17, 015692-17, 021392-17, 022370-17, 024243-17, 001242-18, 002259-18, 006202-18, 006244-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 17, 2018
Licensee / Titulaire de permis :	Villa Colombo Homes for the Aged Inc. 40 Playfair Avenue, TORONTO, ON, M6B-2P9
LTC Home / Foyer de SLD :	Villa Colombo Homes for the Aged 40 Playfair Avenue, TORONTO, ON, M6B-2P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Comeau

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To Villa Colombo Homes for the Aged Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with r. 54 (a) of the LTCHA.

Specifically, the licensee shall ensure:
1. Timely identification of wandering residents who pose a risk to themselves and to others.
2. Implement best practice approach to monitoring of wandering residents.
3. Accurate documentation and reporting of wandering behaviours.
4. A quality management system to ensure timely response to BSO referrals.

Grounds / Motifs :

1. 1. The licensee has failed to protected residents from abuse by anyone.

This inspection was initiated to inspect an incident of resident to resident abuse reported in a Critical Incident Report, submitted October 2017.

Review of the CIR revealed that in October 2017, resident #011 wandered into the room of resident #007 and a physical altercation ensued which resulted in injury to resident #007.

Record review revealed that resident #011 was a recent admission to the home. Admission records received from the CCAC and admission assessment documents of the home did not identify that resident #011 had any behaviours of

wandering or aggression, but they did have behaviours of resisting care. Resident #011 had a CPS of 4/6, and they were independent to ambulate.

Record review revealed that resident #011, started to exhibit behaviours of wandering very early in their admission and that their behaviours of being resistive to care also included being aggressive towards staff.

Review of the progress notes from the date of resident #011's admission through to the date of this altercation revealed daily episodes of wandering as well as resisting care and aggressive response to staff. There is no documentation of aggression towards co-residents, however interview with PSW #102 revealed that the resident was known to demonstrate aggression towards co-residents.

Interview with resident #007 revealed that resident #011 had wandered into their room on a couple of previous occasions, but that when told to get out, resident #011 left without incident. Resident #007 revealed that they had not reported this to staff, as it was not a concern.

Resident #007 revealed that on this occasion, resident #011 did not leave when they were told, but rather they sat down in a chair in resident #007's room. Resident #007 stated that they said get out again, and then resident #011 got up and picked up a grab stick off resident #007's bed and hit resident #007 with it. The altercation escalated into a physical fight.

The altercation ended when a staff member intervened.

Record review revealed that resident #007 incurred multiple abrasions to their shoulder and cheek as well as bruising to right wrist and bruise on left hand as well as hematoma on left forehead. Hospitalization was not required.

Interview with the BSO lead revealed that all new residents are DOS monitored for seven days from the date of admission. The BSO lead revealed that their role in this admission work would be to review the DOS monitoring on either a daily or every three day time frame, determined by the resident's status. The BSO lead could not recall the details of her review of resident #011's DOS records, and had not made any notes the progress notes.

A physician progress note revealed that this resident was discussed at a Multi-

disciplinary meeting and in the progress note, the physician raised the issue that this residents wandering could pose a risk to themselves or co-residents.

Interview with the Social worker revealed that based on review of resident #011, they had put the resident on a wait list to a more suitable unit and had initiated discussion with the family regarding this.

Record review revealed that a BSO referral was initiated for resident #011. This was confirmed in interview with the BSO lead, and they also confirmed that this referral had not been completed as of the date of this incident. The BSO lead revealed that referrals should be assessed within two days of receipt of the referral. The BSO lead also revealed that they had made notes in a note book, but they were not able to locate that book. They had not made any notes in PCC regarding this resident or their involvement in resident #011's care.

Interview with the Director of Resident services confirmed that this referral had not been completed and that the expectation for action on a BSO referral is 24-48 hours and that the risks and interventions to related to resident #011's behaviours had not been fully identified and consequently co-residents were not fully protected from abuse.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1, as the issue was isolated.
The home had a level 4 compliance history as they had no non-compliance with this section of the LTCHA that included:
Compliance order issued on June 23, 2017, in inspection number 2017_642606_0005.
Compliance order issued June 19, 2016, in inspection number 2016_398605_0014.
Voluntary Plan of Correction issued February 17, 2016, in inspection number 2016_334565_0002. [s. 19. (1)] (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

Order # / Ordre no : 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. 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 will ensure resident #007 and any other resident is safe from physical abuse.

The licensee will do the following to ensure resident #007 and any other residents are protected from abuse:

1. Timely identification of wandering residents who pose a risk to themselves and to others.
2. Implement best practice approach to monitoring of wandering residents.
3. Accurate documentation and reporting of wandering behaviours.
4. A quality management system to ensure timely response to BSO referrals.

Grounds / Motifs :

1. he licensee has failed to protected residents from abuse by anyone.

This inspection was initiated to inspect an incident of resident to resident abuse reported in CIS C577-000073-17, dated October 18, 2017.

Review of the CIS revealed that on October 18, 2017, resident #011 wandered into the room of resident #007 and a physical altercation ensued which resulted in injury to resident #007.

Record review revealed that resident #011 was admitted to the home on September 27, 2017. Admission records received from the CCAC and admission assessment documents of the home did not identify that resident

#011 had any behaviours of wandering or aggression, but they did have behaviours of resisting care. Resident #011 had a CPS of 4/6, and they were independent to ambulate.

Record review revealed that resident #011, started to exhibit behaviours of wandering very early in their admission and that their behaviours of being resistive to care also included being aggressive towards staff.

Review of the progress notes from the date of resident #011's admission through to the date of this altercation on October 18, 2017 revealed daily episodes of wandering as well as resisting care and aggressive response to staff. There is no documentation of aggression towards co-residents, however interview with PSW #102 revealed that the resident was known to demonstrate aggression towards co-residents.

Interview with resident #007 revealed that resident #011 had wandered into their room on a couple of previous occasions, but that when told to get out, resident #011 left without incident. Resident #007 revealed that they had not reported this to staff, as it was not a concern.

Resident #007 revealed that on this occasion, resident #011 did not leave when they were told, but rather they sat down in a chair in resident #007's room. Resident #007 stated that they said get out again, and then resident #011 got up and picked up a grab stick off resident #007's bed and hit resident #007 with it. The altercation escalated into a physical fight.

The altercation ended when a staff member intervened.

Record review revealed that resident #007 incurred multiple abrasions to their shoulder and cheek as well as bruising to right wrist and bruise on left hand as well as hematoma on left forehead. Hospitalization was not required.

Interview with the BSO lead revealed that all new residents are DOS monitored for seven days from the date of admission. The BSO lead revealed that their role in this admission work would be to review the DOS monitoring on either a daily or every three day time frame, determined by the resident's status. The BSO lead could not recall the details of her review of resident #011's DOS records, and had not made any notes the progress notes.

A physician progress note, dated October 4, 2017, revealed that this resident was discussed at a Multi-disciplinary meeting and in the progress note, the physician raised the issue that this residents wandering could pose a risk to themselves or co-residents.

Interview with the Social worker revealed that based on review of resident #011, they had put the resident on a wait list to a more suitable unit and had initiated discussion with the family regarding this.

Record review revealed that a BSO referral was initiated for resident #011 on October 5, 2017. This was confirmed in interview with the BSO lead, and they also confirmed that this referral had not been completed as of the date of this incident. The BSO lead revealed that referrals should be assessed within two days of receipt of the referral. The BSO lead also revealed that they had made notes in a note book, but they were not able to locate that book. They had not made any notes in PCC regarding this resident or their involvement in resident #011's care.

Interview with the Director of Resident services confirmed that this referral had not been completed and that the expectation for action on a BSO referral is 24-48 hours and that the risks and interventions to related to resident #011's behaviours had not been fully identified and consequently co-residents were not fully protected from abuse.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1, as the issue was isolated.
The home had a level 4 compliance history as they had no non-compliance with this section of the LTCHA that included:
Compliance order issued on June 23, 2017, in inspection number 2017_642606_0005.
Compliance order issued June 19, 2016, in inspection number 2016_398605_0014.
Voluntary Plan of Correction issued February 17, 2016, in inspection number 2016_334565_0002. (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

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 17th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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