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
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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
Aug 30, 2021	2021_766500_0022	002962-21, 004874-21, 005373-21, 007207-21, 007835-21, 009664-21, 010141-21	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

The Village of Erin Meadows
2930 Erin Centre Boulevard Mississauga ON L5M 7M4

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

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): July 29, August 2- 6, 9, and 10, 12 (off-site) 2021.

The following intakes were inspected during this Critical Incident System inspection (CIS) inspection:
-Intake #010141-21, #009664-21, #007207-21, and #002962-21 related to a fall incident resulted in injury,
-Intake #007835-21, and #005373-21 related to duty to protect and,
-Intake #004874-21 related to improper care.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager of Long-term Care (LTC), Director of Nursing Care (DONC), Assistant Director of Nursing Care (ADONC), Director of Environmental Services, Neighbourhood Care Coordinator (NCC), Foot Care Nurse, Registered Staff, Personal Support Workers (PSWs) and Resident(s).

During the course of the inspection, the inspector observed residents' care areas, reviewed residents' and home's records, the home's heat related illness prevention and management program, and observed Infection Prevention and Control (IPAC) Practices.

Inspector Stephanie Luciani (#707428) attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

3 WN(s)
1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy on Falls Prevention and Management Program was complied with.

The home’s Falls Prevention and Management Program indicated:
- a person who discovered the fall should immediately call the registered team member on the unit,
- do not move the resident until they had been cleared by a registered team member,
- a registered team member was required to complete a head to toe assessment to determine if there was an injury and proceed with medical attention if necessary,
- move the resident and assist to a chair or a bed using proper lift and transfer procedures,
- if resident was unable to stand, the total mechanical lift would be used for safety if appropriate.

Resident #001 had an unwitnessed fall on an identified day. Personal Support Worker (PSW) #110 went to the room and found the resident on the floor. Registered Practical Nurse (RPN) #109 was called into the room, and without completing an identified assessment, asked PSW #110 to assist and have the resident stand up and sit on a walker. The resident was complaining of pain. Neighbourhood Care Coordinator (NCC) #105 arrived at the resident’s room and helped them to wheel the resident to their bed and transferred them onto the bed. The resident was given pain medication and an assessment completed by RPN #109. RPN #109 noted injury and transferred the resident to hospital for further assessment.

Staff indicated that they were expected to follow the home's Falls Prevention and Management policy, and they should have not transferred the resident prior to completing an assessment for the resident.

Sources: Home's investigation notes, Critical Incident System (CIS) Report, Interviews with NCC #105 and the Assistant General Manager Long-term Care (LTC). [s. 8. (1)]

2. Resident #003 had a fall while receiving care by two staff members. During this process, the resident slipped and fell to the floor. Both staff members immediately assisted the resident up. One staff stayed with the resident while the other went to call the nurse. The nurse arrived and completed an assessment and identified an injury to the resident. The Nurse Practitioner assessed the resident and no concerns noted. On a next day, a team member noted the resident with an injury and pain. Upon further assessment, the team member noted that the resident was in pain when performing range of motion. The resident was transferred to hospital due to injuries.

A review of the home's investigation notes, and interviews with staff indicated that they were expected to follow the home's Falls Prevention and Management policy, and they should have not transferred the resident prior to completing a post fall assessment for the resident.

Sources: Home's investigation notes, CIS Report, Interviews with PSW #121 and #122, RPN # 123 and the Assistant General Manager LTC. [s. 8. (1)]

3. Resident #005 fell on the floor while PSW #115 was providing personal care. PSW #116 heard a sound of the resident's fall and went to the room and saw the resident with an injury. RPN #117 arrived at the room and went back to get a vital sign machine. By the time RPN #117 returned, PSW #115 and #116 transferred the resident back to the bed, without RPN #117 completing their post fall assessment. The resident sustained injuries. The resident was assessed by the nurse and sent to the hospital for further assessment and returned to the home the same day. At a later date, staff informed the RPN that the resident had more injuries and pain. The RPN called the physician and an X-ray was ordered, which confirmed an injury and the resident was transferred to hospital.

Staff indicated that they were expected to follow the home's Falls Prevention and Management policy, and they should have not transferred the resident back to the bed

prior to completing a post fall assessment for the resident.

Sources: Home's investigation notes, CIS Report, Interviews with PSW #115 and #116, NCC #106 and the Assistant General Manager Long-term Care LTC. [s. 8. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Resident #003 had a fall while receiving care by two staff members. During this process, the resident slipped and fell to the floor. Both staff members immediately assisted the resident up. One staff stayed with the resident while the other went to call the nurse. The nurse arrived and completed an assessment and identified an injury to the resident. The Nurse Practitioner assessed the resident and no concerns noted. On a next day, a team member noted the resident with an injury and pain. Upon further assessment, the team member noted that the resident was in pain when performing range of motion. The resident was transferred to hospital due to injuries.

A review of the home's investigation notes, and interviews with staff indicated that they were expected to follow safe transferring and positioning techniques for the resident during care.

Sources: Home's investigation notes, CIS Report, Interviews with PSW #121 and #122, RPN #123 and the Assistant General Manager LTC. [s. 36.]

2. Resident #005 fell on the floor while PSW #115 was providing personal care. PSW #116 heard a sound of the resident's fall and went to the room and saw the resident with an injury. RPN #117 arrived at the room and went back to get a vital sign machine. By the time RPN #117 returned, PSW #115 and #116 transferred the resident back to the bed, without RPN #117 completing their post fall assessment. The resident sustained injuries. The resident was assessed by the day shift nurse sent to the hospital for further assessment and returned to the home the same day. On March 26, 2021, staff informed the RPN that the resident had more injuries and pain. The RPN called the physician and an X-ray was ordered, which confirmed an injury and the resident was transferred to hospital.

Staff indicated that they were expected to follow safe transferring and positioning techniques for the residents during care.

Sources: Home's investigation notes, CIS Report, Interviews with PSW #115 and #116, NCC #106 and the Assistant General Manager Long-term Care LTC. [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

Resident #006 sustained an injury, while PSW #118 was removing an identified assistive device off the resident during care. PSW #118 noticed a change in the resident's body areas and without reporting it to the nurse, attempted to remove the identified assistive device.

The resident's care plan indicated to report to the nurse immediately of any change during daily care.

Staff interviews verified that they should have reported to the registered staff when they observed a change in the resident's body areas prior to removing it.

Sources: Care plan, CIS, Interviews with PSW #118 and the Director of Nursing Care (DONC). [s. 6. (7)]

2. The licensee has failed to ensure that resident #004's provision of the care set out in the plan of care for bathing is documented.

Resident #004's care plan indicated that the resident refused an identified care and received alternative for care.

Point of Care (POC) records indicated that the resident's identified care was not documented. The resident's alternative care was not documented, and it only indicated that either the resident refused the care or unavailable for care.

Staff confirmed that the resident refused care alternative care should have been documented in POC.

Sources: POC record, Interviews with PSW #112, RPN #113, and the DONC. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to resident #006 as specified in the plan, to be implemented voluntarily.

Issued on this 30th day of August, 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

Ordre(s) de l’inspecteur

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

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) : NITAL SHETH (500)

Inspection No. / No de l’inspection : 2021_766500_0022

Log No. / No de registre : 002962-21, 004874-21, 005373-21, 007207-21, 007835-21, 009664-21, 010141-21

Type of Inspection / Genre d’inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 30, 2021

Licensee / Titulaire de permis : Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5

LTC Home / Foyer de SLD : The Village of Erin Meadows
2930 Erin Centre Boulevard, Mississauga, ON, L5M-7M4

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Denis Zafirovski

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) b of O. Reg. 79/10.
Specifically, the licensee must:
- educate all direct care staff on the home's Falls Prevention and Management policy, including review of the key components of post fall assessments such as, head to toe, range of motion, skin assessment, pain assessment etc.,
- review responsibilities of staff members when resident fall occurs,
- develop and implement audit tools to ensure staff compliance with the home's policy on Falls Prevention and Management,
- keep and maintain records of the training including date, name of the educator, content used for education, staff attendance and audit record with corrective action plans,
-document the audit and continue auditing for a period of one month after the education is completed, and until no further concerns arise with the staff compliance with the policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy on Falls Prevention and Management Program was complied with.

The home's Falls Prevention and Management Program indicated:
- a person who discovered the fall should immediately call the registered team member on the unit,
- do not move the resident until they had been cleared by a registered team

member,
- a registered team member was required to complete a head to toe assessment to determine if there was an injury and proceed with medical attention if necessary,
- move the resident and assist to a chair or a bed using proper lift and transfer procedures,
- if resident was unable to stand, the total mechanical lift would be used for safety if appropriate.

Resident #001 had an unwitnessed fall on an identified day. Personal Support Worker (PSW) #110 went to the room and found the resident on the floor. Registered Practical Nurse (RPN) #109 was called into the room, and without completing an identified assessment, asked PSW #110 to assist and have the resident stand up and sit on a walker. The resident was complaining of pain. Neighbourhood Care Coordinator (NCC) #105 arrived at the resident's room and helped them to wheel the resident to their bed and transferred them onto the bed. The resident was given pain medication and an assessment completed by RPN #109. RPN #109 noted injury and transferred the resident to hospital for further assessment.

Staff indicated that they were expected to follow the home's Falls Prevention and Management policy, and they should have not transferred the resident prior to completing an assessment for the resident.

Sources: Home's investigation notes, Critical Incident System (CIS) Report, Interviews with NCC #105 and the Assistant General Manager Long-term Care (LTC). [s. 8. (1)] (500)

2. Resident #003 had a fall while receiving care by two staff members. During this process, the resident slipped and fell to the floor. Both staff members immediately assisted the resident up. One staff stayed with the resident while the other went to call the nurse. The nurse arrived and completed an assessment and identified an injury to the resident. The Nurse Practitioner assessed the resident and no concerns noted. On a next day, a team member noted the resident with an injury and pain. Upon further assessment, the team member noted that the resident was in pain when performing range of motion. The resident was transferred to hospital due to injuries.

A review of the home’s investigation notes, and interviews with staff indicated that they were expected to follow the home’s Falls Prevention and Management policy, and they should have not transferred the resident prior to completing a post fall assessment for the resident.

Sources: Home’s investigation notes, CIS Report, Interviews with PSW #121 and #122, RPN # 123 and the Assistant General Manager LTC. [s. 8. (1)] (500)

3. Resident #005 fell on the floor while PSW #115 was providing personal care. PSW #116 heard a sound of the resident’s fall and went to the room and saw the resident with an injury. RPN #117 arrived at the room and went back to get a vital sign machine. By the time RPN #117 returned, PSW #115 and #116 transferred the resident back to the bed, without RPN #117 completing their post fall assessment. The resident sustained injuries. The resident was assessed by the nurse and sent to the hospital for further assessment and returned to the home the same day. At a later date, staff informed the RPN that the resident had more injuries and pain. The RPN called the physician and an X-ray was ordered, which confirmed an injury and the resident was transferred to hospital.

Staff indicated that they were expected to follow the home’s Falls Prevention and Management policy, and they should have not transferred the resident back to the bed prior to completing a post fall assessment for the resident.

Sources: Home’s investigation notes, CIS Report, Interviews with PSW #115 and #116, NCC #106 and the Assistant General Manager Long-term Care LTC. [s. 8. (1)]

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

Severity: There was actual risk to the injured residents because the staff did not comply with the home’s Falls Prevention and Management policy and moved the residents after they sustained a fall without the registered staff completing an assessment.

Scope: This was a widespread as three out of four residents were identified in

this non-compliance.

Compliance History: The licensee continues to be in non-compliance with r. 8 (1) (b) of the LTCHA, resulting in in a compliance order (CO) being issued. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2021

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with r. 36 of O. Reg. 79/10.
Specifically, the licensee must:
- educate all direct care staff on Safe Transferring and Positioning Techniques including case studies related to when a resident falls,
- review consideration of key components of transferring and positioning before initiating personal care to maintain residents' safety,
- identify and review responsibilities of each person involved in two person assistance during care to maintain residents' safety
- develop and implement audit tools to ensure staff compliance with Safe Transferring and Positioning,
-keep and maintain records of the training including date, name of the educator, content used for education, staff attendance and audit record with corrective action plans,
-document the audits and continue auditing for a period of one month after the education is completed, and until no further concerns arise with the staff compliance with Safe Transferring and Positioning Techniques.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Resident #003 had a fall while receiving care by two staff members. During this process, the resident slipped and fell to the floor. Both staff members immediately assisted the resident up. One staff stayed with the resident while the other went to call the nurse. The nurse arrived and completed an assessment and identified an injury to the resident. The Nurse Practitioner assessed the resident and no concerns noted. On a next day, a team member

noted the resident with an injury and pain. Upon further assessment, the team member noted that the resident was in pain when performing range of motion. The resident was transferred to hospital due to injuries.

A review of the home's investigation notes, and interviews with staff indicated that they were expected to follow safe transferring and positioning techniques for the resident during care.

Sources: Home's investigation notes, CIS Report, Interviews with PSW #121 and #122, RPN #123 and the Assistant General Manager LTC. [s. 36.] (500)

2. Resident #005 fell on the floor while PSW #115 was providing personal care. PSW #116 heard a sound of the resident's fall and went to the room and saw the resident with an injury. RPN #117 arrived at the room and went back to get a vital sign machine. By the time RPN #117 returned, PSW #115 and #116 transferred the resident back to the bed, without RPN #117 completing their post fall assessment. The resident sustained injuries. The resident was assessed by the day shift nurse sent to the hospital for further assessment and returned to the home the same day. On March 26, 2021, staff informed the RPN that the resident had more injuries and pain. The RPN called the physician and an X-ray was ordered, which confirmed an injury and the resident was transferred to hospital.

Staff indicated that they were expected to follow safe transferring and positioning techniques for the residents during care.

Sources: Home's investigation notes, CIS Report, Interviews with PSW #115 and #116, NCC #106 and the Assistant General Manager Long-term Care LTC. [s. 36.]

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

Severity: There was actual harm to the residents because the staff did not implement safe transferring and positioning techniques while providing personal care.

Scope: This was a pattern as two out of four residents were identified in this

non-compliance.

Compliance History: The licensee continues to be in non-compliance with r. 36 of the LTCHA, resulting in in a CO being issued. (500)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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:

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 30th day of August, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Nital Sheth

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