Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du 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 07, 2019	2019_543561_0003 (A2)	003288-19, 003620-19	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 Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

Amended by DARIA TRZOS (561) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Licensee requested a wording change in the report.

Issued on this 7 th day of May, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 07, 2019	2019_543561_0003 (A2)	003288-19, 003620-19	Critical Incident System

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

The Village of Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

Amended by DARIA TRZOS (561) - (A2)

Amended 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): February 25, 26, 27, 28 and March 1, 2019.

The following complaint inspection was conducted concurrently with this Critical Incident System Inspection:

001502-19 - related to an injury, the home had also submitted a CIS report number 2854-000002-19.

During the course of the inspection, the inspector(s) spoke with Assistant General Manager, Assistant Director of Nursing Care (ADNC), Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs) and Personal Support Workers, residents.

During the course of the inspection, the inspector observed the provision of care, reviewed investigation notes, reviewed clinical records, reviewed annual evaluations, meeting minutes and training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 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 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 :

(A1)
1. The licensee failed to ensure that residents were protected from abuse by anyone.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2019, related to alleged abuse of resident #002 towards resident #001 that caused an injury to resident #001.
The CIS report and the clinical record review indicated that on an identified date in 2019, there was an altercation between resident #001 and resident #002 and resident was observed with an injury. Resident #001 was placed on monitoring. Progress note on an identified date after the incident, indicated that resident had a change in condition. Resident #001 also sustained a fall with injury and was sent for further assessment.

The investigation notes that were reviewed and interview with RPN #112 both confirmed the incident occurred between the two residents.
Clinical records reviewed identified that resident #002 had a history of identified behaviours towards other residents. The triggers for their behaviour were identified in the plan of care. The home was aware of resident #002's identified behaviours and triggers. There was a pattern of the identified behaviour with another resident as indicated by RPN #112. RPN #112 stated that there were no interventions in place for resident #001 or #002 implemented to ensure the safety of resident #001

In an interview with the ADNC, they stated that resident #002 had a history of responsive behaviour with other residents. The ADNC stated that the home had an intervention in place with a previous resident identified and stated that no other interventions were put in place other than every 30 minute checks when resident #001 was admitted to the home.

The home failed to ensure that resident #001 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: 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 failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A CIS report was submitted to the Director on an identified date in 2019, related to alleged abuse of resident #002 towards resident #001 that caused an injury to resident #001.

The CIS report and the clinical record review indicated that on an identified date in 2019, there was an altercation between resident #001 and resident #002 and resident was observed with an injury. Resident #001 was placed on monitoring. Progress note on an identified date after the incident, indicated that resident had a change in condition. Resident #001 also sustained a fall with injury and was sent for further assessment.

Resident #002's plan of care was reviewed and indicated that they had a history of identified behaviours. The plan of care indicated that prior to resident #001's admission to the home, triggers were identified and interventions were implemented for an identified behaviour towards another resident. When resident #001 was admitted to the home an incident occurred related to the trigger previously identified. No other interventions were implemented other than every 30 minute checks when resident #001 was admitted to the home.

Interview with RPN #112, indicated that no interventions were put in place to ensure that resident #001 was protected from resident #002. They stated that resident #002's behaviour showed the same pattern as with their previous identified resident.

Interview with the ADNC, indicated that the home implemented an identified intervention with a previous resident. They confirmed that there were no interventions in place other than every 30 minute checks for resident #001 when they were admitted.

The home failed to ensure that steps were taken to minimize the risk of altercations and harmful interactions between residents by identifying and implementing interventions. [s. 54. (b)]

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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 48(1)1 the licensee is required to have an interdisciplinary Fall Prevention and Management program and in accordance with O. Reg. 79/10, s. 30(1)1, the licensee is required to ensure that each of the required programs includes policies, procedures and protocols.

The home's policy titled "Head Injury Routine", Tab 04-37, revised August 20, 2018, indicated that the registered staff was responsible for starting the HIR immediately. When the form was completed and locked- the resident was to be checked once per shift for 24 hours and documented using follow up Progress note. Notify RN for the Village immediately to provide additional assessment and discuss a course of action with the nurse. The physician was to be notified as necessary. The nurse would update the charge nurse of the resident's status at least once during each shift. If at any time the resident becomes unstable or develops abnormal changes, they were to be sent to hospital immediately after consultation with the resident's family/POA and physician.

A CIS report was submitted to the Director on an identified date in 2019, related to alleged abuse of resident #002 towards resident #001 that caused an injury to resident #001.
Clinical records reviewed indicated that on an identified date in 2019, there was an incident between resident #002 and resident #001 causing an injury. After the incident resident #001 was placed on head injury routine (HIR). Progress notes indicated that after the HIR was complete resident had a change in condition. There was no evidence that the nurse in charge was notified or the physician was called. On an identified date in 2019, resident #001 fell and was sent for further assessment.
In an interview with RPN #111, they stated that did not call the physician to notify them of the change in condition after HIR was completed.

During interview with the ADNC, they confirmed that registered staff should have notified the physician after the resident had a change in condition. The ADNC acknowledged that the home's policy was not complied with.

The licensee failed to ensure that the HIR policy was complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A CIS report was submitted to the Director on an identified date in 2019, related to alleged abuse of resident #002 towards resident #001 that caused an injury to resident #001.

Clinical records reviewed indicated that resident #002 had a history of identified incidents and altercations with other residents. The home identified a trigger for resident #002's behaviours in the plan of care.
Interview with PSW #108, identified the trigger for resident #002's beahviours as indicated in the plan of care. They could not recall if identified interventions for the trigger was in place.
Interview with RPN #112, indicated that the intervention identified for the trigger was initiated at the time prior to resident #001's admission. They were not sure if the intervention was in place when resident #001 was admitted.

The written plan of care was reviewed and the identified intervention was not included in the written plan of care.

Interview with the ADNC, confirmed that the home put an intervention in place for the identified trigger. The ADNC confirmed that the intervention was not added to the written plan of care for resident #002 or #001.
The ADNC stated that registered staff and anyone that implemented an intervention was responsible for updating the written plans of care.

The licensee failed to ensure that the written plan of care set out the planned care for the resident related to responsive behaviours. [s. 6. (1) (a)]

Issued on this 7 th day of May, 2019 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DARIA TRZOS (561) - (A2)
Inspection No. / No de l'inspection :	2019_543561_0003 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003288-19, 003620-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 07, 2019(A2)
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 Tansley Woods 4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ripu Phull

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by resident #002 and all other residents in the home.

In the plan the home shall demonstrate how they will ensure that:
1. Residents are protected from abuse from resident #002.
2. Residents that are newly admitted to the home are protected from physical altercations by resident #002 and any other residents identified with responsive behaviours.

Please submit the written plan, quoting Inspection number 2019_543561_0003 and Inspector, Daria Trzos, by email to HamiltonSAO.moh@ontario.ca by April 9 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

(A2)
1. The licensee failed to ensure that residents were protected from abuse by anyone.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2019, related to alleged abuse of resident #002 towards resident #001 that

caused an injury to resident #001.
The CIS report and the clinical record review indicated that on an identified date in 2019, there was an altercation between resident #001 and resident #002 and resident was observed with an injury. Resident #001 was placed on monitoring. Progress note on an identified date after the incident, indicated that resident had a change in condition. Resident #001 also sustained a fall with injury and was sent for further assessment.

The investigation notes that were reviewed and interview with RPN #112 both confirmed the incident occurred between the two residents.
Clinical records reviewed identified that resident #002 had a history of identified behaviours towards other residents. The triggers for their behaviour were identified in the plan of care. The home was aware of resident #002's identified behaviours and triggers. There was a pattern of the identified behaviour with another resident as indicated by RPN #112. RPN #112 stated that there were no interventions in place for resident #001 or #002 implemented to ensure the safety of resident #001

In an interview with the ADNC, they stated that resident #002 had a history of responsive behaviour with other residents. The ADNC stated that the home had an intervention in place with a previous resident identified and stated that no other interventions were put in place other than every 30 minute checks when resident #001 was admitted to the home.

The home failed to ensure that resident #001 was protected from abuse by anyone.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was isolated 1 as it was one out of three residents in the home. The home had a level 3 history of on-going non-compliance with this section of the Act that included a previous Compliance Order (CO) issued in November 2017 (2017_587129_0012) and a Voluntary Plan of Correction (VPC) issued in June 2017 (2017_570528_0018) and a CO issued in October 2016 (2016_449619_0026). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Order # / Ordre no : 002

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

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 s. 54 of the O. Reg 79/10.

The licensee shall prepare, submit and implement a plan to ensure:
- steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

The plan must include, but is not limited, to the following:
1. Review of the plan of care and interventions in place for resident #002 and evaluate the current interventions in place.
2. Identify factors and risks that could potentially trigger altercations from resident #002.
3. Steps that will be taken to ensure that any newly admitted resident to a unit with potential risk are protected from these potential altercations.

Please submit the written plan, quoting Inspection number 2019_543561_0003 and Inspector, Daria Trzos, by email to HamiltonSAO.moh@ontario.ca by April 9, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

A CIS report was submitted to the Director on an identified date in 2019, related to alleged abuse of resident #002 towards resident #001 that caused an injury to resident #001.

The CIS report and the clinical record review indicated that on an identified date in 2019, there was an altercation between resident #001 and resident #002 and resident was observed with an injury. Resident #001 was placed on monitoring. Progress note on an identified date after the incident, indicated that resident had a change in condition. Resident #001 also sustained a fall with injury and was sent for further assessment.

Resident #002's plan of care was reviewed and indicated that they had a history of identified behaviours. The plan of care indicated that prior to resident #001's admission to the home, triggers were identified and interventions were implemented for an identified behaviour towards another resident. When resident #001 was admitted to the home an incident occurred related to the trigger previously identified. No other interventions were implemented other than every 30 minute checks when resident #001 was admitted to the home.

Interview with RPN #112, indicated that no interventions were put in place to ensure that resident #001 was protected from resident #002. They stated that resident #002's behaviour showed the same pattern as with their previous identified resident.

Interview with the ADNC, indicated that the home implemented an identified intervention with a previous resident. They confirmed that there were no interventions in place other than every 30 minute checks for resident #001 when they were admitted.

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

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was isolated 1 as it was one out of three residents in the home. The home had a level 3 history of on-going non-compliance with this section of the Act that included a previous Compliance Order (CO) issued in June 2017 (2017_570528_0018). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019

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:

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 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)
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 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 7 th day of May, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DARIA TRZOS (561) - (A2)

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 : Hamilton Service Area Office