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 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

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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
Nov 16, 2017	2017_420643_0019	023740-17	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC.
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

VILLA COLOMBO SENIORS CENTRE
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

ADAM DICKEY (643), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 13, 16-20, 23-27, 30 and 31, 2017.

The following compliance order follow-up was inspected concurrently with the RQI:

Log #014342-17 - related to transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC) - Administration, DOC - Clinical, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Programs manager, Food Services Coordinator, Infection prevention and control (IPAC) practitioner and continuous quality improvement (CQI) manager, Resident assessment instrument-minimum data set (RAI-MDS) coordinator, Residents' Council president, residents and substitute decision makers (SDM).

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council, monthly newsletters and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

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

4 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 devices or techniques when assisting residents.

The purpose of this inspection was to conduct a follow-up inspection for Compliance Order #001 issued under inspection report 2017_656596_0005 on June 16, 2017, related to safe transferring and positioning techniques. The licensee was ordered to be in compliance by September 27, 2017.

Inspection of transferring and positioning techniques was conducted for resident #021 as part of the follow-up inspection for CO #001.

Observation by the inspector on an identified date, revealed that resident #021 was assisted with transferring using a sit to stand mechanical lift for the purpose of toileting by PSWs #139 and #145. Observation of resident #021's resident room revealed a transfer logo in the resident's closet showing a full mechanical lift and sling size to be used with the resident.

Review of resident #021's current written plan of care, revealed that he/she was to be assisted with toileting by two staff members using a hoyer lift to transfer him/her to the toilet. The toileting method was updated in the written plan of care six months earlier. Resident #021 was assessed to be unable to weight bear by the Physiotherapist (PT) on an identified date.

In interviews, PSWs #139, 140 and #142 stated that resident #021 is assisted with transferring using a full mechanical lift with two person assistance when transferring from bed to chair or chair to bed. PSWs #139, 140 and #142 further stated that resident #021 is transferred using a sit to stand lift when being assisted with toileting. PSW #141 stated that resident #021 is toileted using physical assistance and no lift is used when toileting the resident.

In an interview, RPN #107 stated that resident #021 is unable to weight bear, and is assisted with toileting using a full mechanical lift. RPN #107 stated that a sit to stand lift is not a safe transferring method for residents who are not able to weight bear, or effectively follow directions when assisting them with transferring.

In an interview, DOC - Clinical #120 stated that resident's transfer methods are assessed by the PT and care plans are updated with any changes. DOC #120 further stated that the PT will discuss with the staff on the unit what type of transfer and sling should be used by an individual resident. The transfer methods would be updated in the resident room as well with a logo showing the type of lift used and note of the type and size of sling used. DOC #120 stated that for a resident that had differing transferring methods for toileting he/she would have a separate transfer logo on the resident washroom showing staff the type of transferring method used for toileting. DOC #120 stated that as resident #021 had been assessed as not being able to weight bear by the PT the sit to stand lift is not a safe transferring method for toileting the resident. DOC #120 acknowledged that the licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The severity of this noncompliance is potential for actual harm. The sample inspected was increased to three residents after noncompliance was identified and the scope was isolated to resident #021. A review of the home's compliance history revealed a compliance order had been issued under inspection report 2017_656596_0005 on June 16, 2017, for this legislative reference. As a result of ongoing noncompliance with O. Reg. 79/10, s. 36 a compliance order is warranted. [s. 36.]

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. 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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out the planned care for the resident.

During stage one of the Resident Quality Inspection (RQI), resident #006 was triggered for minimizing of restraining related to potential side rail restraint from the resident observation.

Observations by the inspector on two consecutive identified dates, revealed that resident #006 was using three positioning aids when seated in his/ her wheelchair.

Review of resident #006's current written plan of care revealed interventions for the use of two identified positioning aids as personal assistive service devices (PASD) when in the wheelchair for comfort and positioning. Review of resident #006's written plan of care failed to reveal any documentation of the third positioning aid as an intervention used for his/her care.

In an interview, PSW #112 stated that the third positioning aid is used for resident #006 in order to maintain positioning. PSW #112 further stated that the third positioning aid was used at all times when resident #006 was up in his/her wheelchair. PSW #112 stated that he/she was not sure if the identified positioning aid was included in resident #006's written plan of care as there were no tasks to complete on PCC related to the positioning aid.

In an interview, RPN #122 stated that the third positioning aid is in place for positioning of

an identified area of resident #006's body which he/she would not be able to reposition on his/her own. RPN #112 further stated that using the three above mentioned identified positioning aids does not limit resident #006's movement as he/she does not move voluntarily.

In an interview, DOC - Clinical #120 stated that the use of PASDs is assessed on a monthly basis, and monitored by the registered staff on the unit for appropriateness and effectiveness as an intervention. DOC #120 reviewed resident #006's assessment and noted that the third positioning aid was not included in the assessment or written plan of care. DOC #120 further stated that as the positioning aid was used as a care intervention for resident #006 that it should be included in the written plan of care. DOC #120 acknowledged that the licensee failed to ensure that the written plan of care for resident #006 set out the planned care for the resident. [s. 6. (1) (a)]

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

As a result of identified noncompliance with Ontario Regulation (O. Reg.)79/10, s.36. the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #003.

Review of resident #003's current written plan of care revealed that he/she was to be assisted with toileting by two staff members using a hoyer lift to transfer resident #003 to the bed where resident #003 would be toileted using an identified assistive device.

Observations by the inspector on an identified date, revealed that resident #003 was transferred to bed by PSWs #130 and #121. The inspector observed that resident #003 was not provided with the above mentioned identified assistive device for toileting, and PSW #130 stated that resident #003 would have his/her incontinent product changed after completing the toileting process.

In interviews, PSW's #130, #121 and #108 stated that resident #003 is assisted with toileting by transferring him/her back to bed allowing him/her to void/move his/her bowels in the incontinent product and be changed. PSW #121 stated that the staff had tried the above mentioned assistive device but were not using it as resident #003 did not like it. PSWs #130 and #108 stated that they did not use the identified assistive device when assisting resident #003 with toileting.

In an interview, RPN #109 stated that resident #003 is assisted with toileting by two staff members using the hoyer lift to transfer him/her back to bed and the above mentioned assistive device is used to assist the resident. RPN #109 further stated that resident #003 should not be toileted using the incontinent product unless he/she was too weak to sit up, and the home had the assistive devices available for resident use.

In an interview, DOC - Clinical #120 stated that it was the expectation of the home for PSW staff to follow a resident's kardex and written plan of care for the resident's identified needs. DOC #120 stated that if the PSW staff were noticing that an intervention was not working or needed to be reassessed it should be brought to the attention of the registered staff. DOC #120 stated that the PSW staff should be following resident #003's written plan of care unless the resident refuses the interventions. DOC #120 acknowledged that the licensee had failed to ensure that the care set out in the written plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 with ensuring:
- that the written plan of care for each resident sets out the planned care for the resident; and
- that the care set out in the written plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

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 has failed to ensure that any plan, policy, protocol strategy, or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

During stage one of the RQI, nutrition and hydration was triggered for resident #002 related to weight loss from the resident's census record.

As required by the Regulation (O. Reg. 79/10, s. 68 (2)) every licensee shall ensure that the organized program for nutrition and hydration includes the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures related to nutrition care and dietary services and hydration.

Review of the home's policy titled "Weight/Height Procedure" policy number 03-06-04 implemented August 2010, revealed that all residents are to be weighed on the resident's bath day during the first week of the month. All re-weighs must be completed as soon as possible following the monthly weight and no later than the 10th of each month. Weight variances of two kilograms (kg) or five per cent are re-weighed with the nurse manager present and documented as soon as possible.

Record review of resident #002's weight history on point-click care (PCC) revealed he/she had a weight recorded on an identified date. Resident #002's previous weight was recorded the previous month with a difference in the two recorded weights representing a loss of 10.2kg and 14.2 per cent.

In interviews, PSWs #104, #101 and #105 stated that resident weights are measured by

the PSW staff at the beginning of the month, and that the registered staff would notify PSW staff if a re-weigh was required. PSW #104 stated that he/she recalled weighing resident #002 on the above mentioned identified date, and there was a difference in his/her weight. PSW #104 did not recall if he/she had discussed the weight change with registered staff.

In an interview on October 19, 2017, RPN # 107 stated that it is the responsibility of the PSW staff to complete the resident weights, and a change of two kg would be flagged by the Registered Dietitian (RD) for a re-weigh to be completed. RPN #107 reviewed the weight history on PCC and indicated that there had been a 10kg difference between the October and September weights and there was likely an error as resident #002 usually had a good intake at meals. RPN #107 stated that he/she would have resident #002 re-weighed.

In an interview, RD #110 stated that it was the responsibility of the PSW staff to complete the resident weight measurements on the first bath day of each month and the registered staff would enter the weight measurements into PCC. RD #110 stated that a resident whose weight measurement had a change of two kg loss or gain would be noted by the registered staff and a re-weigh would be completed by the 10th of the month. RD #110 stated that resident #002's weight should have been noted by registered staff to be greater than a two kg difference and a re-weigh would have been expected to have been completed. RD #110 further stated that if resident #002 had a significant change in his/her weight over a one month period the registered staff would complete an electronic RD referral on PCC indicating the significant weight change to be assessed. RD #110 stated that he/she did not receive a referral related to resident #002's weight change.

In an interview, DOC - Administration #132 stated that it was the expectation of the home for PSW staff to complete all resident weight measurements during the first week of the month and registered staff to enter the weight measurements into PCC. Registered staff would note any residents with a two kg change in weight measurement or a significant change in weight to be re-weighed by the 10th of the month. DOC #132 acknowledged that with respect to resident #002's weight the staff had failed to comply with the home's policy on weight measurement. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI resident #008 was triggered for altered skin integrity from the staff interview and census record review.

Review of resident #008's weekly wound assessment completed on an identified date, revealed that the resident had an area of altered skin integrity on an identified body area. Review of resident #008's completed wound assessments from the preceding four month period, using the weekly wound assessment template on PCC revealed the resident's wound assessment was not completed for eight identified one-week periods.

Review of the home's policy titled,"Skin Care Program: Assessment and Care Planning", policy #02-05-04, effective August 2010, indicated that residents with impaired skin integrity are assessed at least weekly by a registered nurse.

In an interview, staff #136 who was the wound care coordinator until an identified date, stated that it is the wound care coordinator's responsibility to complete a wound assessment weekly for all residents exhibiting altered skin integrity. Staff# 136 confirmed that he/she took full responsibility for not completing resident #008's skin assessment weekly by using the weekly wound assessment as required by the home's protocol.

In an interview, DOC – Clinical #120 stated that the home's expectation was to complete the weekly assessment by using the weekly wound assessment template. DOC #120 acknowledged that resident #008's area of altered skin integrity was not assessed weekly. [s. 50. (2) (b) (iv)]

Issued on this 23rd day of November, 2017

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

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) :	ADAM DICKEY (643), STELLA NG (507)
Inspection No. / No de l'inspection :	2017_420643_0019
Log No. / No de registre :	023740-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 16, 2017
Licensee / Titulaire de permis :	VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC. 10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	VILLA COLOMBO SENIORS CENTRE 10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sabrina Filintisis

To VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_656596_0005, CO #001;

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 :

Upon receipt of this Compliance Order the licensee shall:

1. Identify all residents in the home that require the use of a mechanical lift and sit to stand lifts along with the specific sling to be used for transfer purposes.
2. Review with direct care staff each resident who requires assistance for transferring the method and devices to be used as outlined in the resident's written plan of care.
3. Develop an auditing system to ensure that direct care staff assist residents with transferring using the method and devices which are included in the resident's plan of care.
4. Maintain a written record of audits completed and staff attendance of written care plan reviews to be provided upon request.

Grounds / Motifs :

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

The purpose of this inspection was to conduct a follow-up inspection for Compliance Order #001 issued under inspection report 2017_656596_0005 on June 16, 2017, related to safe transferring and positioning techniques. The licensee was ordered to be in compliance by September 27, 2017.

Inspection of transferring and positioning techniques was conducted for resident #021 as part of the follow-up inspection for CO #001.

Observation by the inspector on an identified date, revealed that resident #021 was assisted with transferring using a sit to stand mechanical lift for the purpose of toileting by PSWs #139 and #145. Observation of resident #021's resident room revealed a transfer logo in the resident's closet showing a full mechanical lift and sling size to be used with the resident.

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The severity of this noncompliance is potential for actual harm. The sample inspected was increased to three residents after noncompliance was identified and the scope was isolated to resident #021. A review of the home's compliance history revealed a compliance order had been issued under inspection report 2017_656596_0005 on June 16, 2017, for this legislative reference. As a result of ongoing noncompliance with O. Reg. 79/10, s. 36 a compliance order is warranted. [s. 36.] (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2017

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 16th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

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

Name of Inspector / Nom de l'inspecteur : Adam Dickey

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