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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_766500_0008	002772-20, 002773-20, 004816-20, 009192-20, 012484-20	Critical Incident System

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 (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

NITAL SHETH (500), BABITHA SHANMUGANANDAPALA (673)

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 16, 17, 20, 21, 22, 23 (off-site), 24, 27, 28, 29, 30, 31, August 1 (off-site), 4, 5, 6, 10, 11, 12, 2020.

The following intakes were completed during this inspection:
Log #004816-20 (CIS #2969-000007-20) and #009192-20 (CIS #2969-000009-20) related to a falls incident resulting in an injury, #012484-20 (CIS #2969-000011-20) related to duty to protect, and Follow-up intake log #002772-20 related to plan of care, and #002773-20 related to duty to protect.

Non-compliances identified during this inspection under s. 221 (1) and r. 26. (4) (a) were issued under complaint inspection report # 2020_766500_0007 which was completed concurrently.

Inspection # 2020_714673_0004 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Interim Administrator, Corporate Clinical Manager, Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents and Family Members.

During the course of the inspection, the inspector(s) observed residents' care areas, reviewed residents' and home's records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

3 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2019_766500_0032	500
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_766500_0032	500

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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Director related to resident #022 related to a fall with injury, transfer to hospital, and significant change in status.

Review of resident #022's progress notes indicated that they had an unwitnessed fall with injury for which they were transferred to hospital, diagnosed and treated.

Review of resident #022's progress notes indicated that they returned to the home with a Home Medication Instructions that stated to follow up with their general practitioner and perform a specified type of device care.

A review of a document obtained from resident's chart indicated that resident #022 had a specified device during the course of their stay in hospital and that the hospital recommends that the specified device remain due to the resident's health condition. It further stated for the home to complete a repeat assessment and the doctor to examine the resident. In an interview, Registered Practical Nurse (RPN) #124 stated they had initiated resident #022's re-admission to the home, but had not seen this document. In an interview, RPN #126 stated that they had seen the document but had not read it.

Review of Policy #NUR 020402, dated December 31, 2019, stated that an interdisciplinary, individualized care plan based on resident preferences and assessed needs will be developed for each resident to maximize independence, comfort, and dignity. This included assessment quarterly and after any change in condition that may affect a specified care area, by registered staff.

i) In an interview, RPN #124 stated that resident #022 had a history of recurrent infections. Review of the resident’s progress notes indicated that they had an infection for which they were treated. Review of resident #022’s assessments did not include a specified assessment after their infection, quarterly assessments, or after their change in status when they returned from the hospital. The only assessment completed was upon their admission to the home. RPN #124 acknowledged that resident #022 had not been reassessed when the resident's care needs changed.

ii) A review of the progress notes by RPN #124 indicated that the resident returned to the home with a specified device, but it was noted to be out of place. In an interview, RPN #124 stated that they had removed/discontinued resident #022’s specified device upon their return from hospital as it was out of place and informed charge nurse RN #125 and the resident’s POA but could not remember if the doctor had been informed. In an interview, RN #125 stated that they had not been informed of this incident by RPN #124.

In interviews, Interim Administrator #100 and RPN #124 acknowledged that there was no documentation to indicate that the doctor had been informed about the specified device removal and that there was no written order from them to remove/discontinue the specified device. They further stated that removing/discontinuing a specified device requires an order from the doctor and that RPN #124 should not have removed/discontinued resident #022’s specified device without an order.

Progress notes indicated that resident was sent to hospital due to a change in their health condition. Progress note indicated that the resident’s specified device which had been inserted was taken off resulting in negative impact on the resident’s health status. The resident passed away in hospital.

Interim Administrator #100 acknowledged that resident #022’s plan of care had not been reassessed after their change in condition following hospitalization. [s. 6. (10) (b)]

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. 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, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the Regulation (O. Reg. 79/10, s. 30 (1). 1) a written description of the program was required that included its goals and objectives and relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy regarding "Resident Falls" Policy # NUR 05-03-01, dated May 1, 2020, which is a part of the licensee's Falls Prevention and Management Program. As indicated in this policy:

-All residents who have potentially suffered a fall must be thoroughly examined by a registered staff member for possible injuries and documents the multidisciplinary progress notes of the incident, assessment findings, action taken, who was notified, results and incident report completed,
-The registered staff to complete risk management in Point Click Care (PCC),
-The physician and family member or the most responsible person of the resident must be informed,
-If a resident may have hit their head, Head Injury Routine (HIR) must be initiated,
-Huddle to be take place to identify root reason for the resident's falling.

A review of a CIS report indicated that the staff reported to the registered staff that the resident had reported to the family an incident resulting in injury on the resident's head.

During the home’s investigation, it was identified that the resident fell and sustained an injury. The resident confirmed about the incident during the investigation.

A review of the resident’s health records indicated that there was no documentation as per the policy, available for the resident’s fall incident, including risk management, HIR, huddle and notification to the physician, and the family member.

A review of a copy of an email sent by resident #030’s family member to the Interim Administrator indicated a concern for the family not being notified by the home about the resident’s fall.

During an interview with Agency Personal Support Worker (PSW) #107 confirmed that resident #030 had a fall incident. Agency PSW #107 indicated that RPN #106 arrived to see the resident after the resident had a fall.

During an interview, RPN #106 denied being aware about resident #030 having a fall during their shift.

Interview with the Interim Administrator confirmed that staff are required to follow the home’s policy. During their investigation, the home identified that RPN #106 failed to follow the home’s policy on falls, and did not report the incident to management, family and the doctor.

This non-compliance is issued as a result of staff failure to follow the home’s “Resident Falls” policy. [s. 8. (1) (a), s. 8. (1) (b)]

2. As required by the Regulation (O. Reg. 79/10, s. 48 (1). 4) the licensee was required to ensure that an interdisciplinary pain management program to identify pain in residents and manage pain was implemented in the home. As required by the regulation (O. Reg. 79/10, s. 30 (1). 1) a written description of the program that included its goals and objectives and relevant policies, procedures and protocols were required.

Review of a document provided by the home titled "Process Map: Re-admission From Hospital", indicated that medication reconciliation was to be completed with the hospital Medication Administration Record (MAR) and facility MAR, and that orders were to be confirmed with the Medical Doctor (MD). Other steps included a pain assessment to be completed in PCC and the care plan to be updated accordingly.

A review of a CIS report submitted to the Director, and review of resident #022's progress notes indicated that the resident had an unwitnessed fall with injury and was transferred to hospital.

Review of resident #022’s plan of care in place before their transfer to hospital indicated that they experienced pain. Review of resident #022’s physician orders showed that resident #022 had an order for pain medication every 4 hours if needed (PRN) which was put on hold when the resident was transferred to hospital.

Review of resident #022’s progress notes indicated that they returned to the home. During the course of resident #022’s hospital admission, their treatments/interventions included pain management. Review of resident #022’s discharge orders and medications from the hospital included pain medication every six hours as needed.

In an interview, RN #123 stated that it was important to follow the home’s process and review any PRN medications during medication reconciliation upon a resident’s return from hospital. RN #123 further stated that nurses should always look at the resident’s medication orders before and during hospitalization as part of medication reconciliation, confirm orders with the physician and document the orders in the physician’s orders document.

Review of the order review report completed during medication reconciliation, by RPN #124 indicated that the physician had renewed the order for pain medication every six hours as needed for pain for resident #022. However, review of the physician’s orders document indicated that RPN #124 did not transcribe this order renewal in the physician’s orders document. The order for pain medication every 4 hours if needed which was put on hold when the resident was transferred to hospital was also not reconciled.

In an interview, RPN #124 stated that the pain medication order may have been missed as it was an as needed (PRN) order.

Review of the resident #022’s pain assessment showed that the resident was in pain, and their pain score at “hurts a little more”; however, the document/assessment was incomplete. Review of the progress notes indicated that the resident was complaining and screaming of pain and refusing to take medications, food and fluids for over 10 hrs.

Review of the progress notes and physician’s orders indicated that after 10.5 hrs, RPN

#126 received telephone orders from the physician.

Review of the progress notes indicated that resident received the pain medication due to increased general pain with good effect.

In an interview, RN #125 stated that in resident #022’s case, RPN #124 should have completed a pain assessment in full and ordered the pain medication during reconciliation as it was an important part of the plan of care related to pain management for the resident due to their health condition. RN #125 acknowledged it was especially important considering it was a medication that was part of resident #022’s plan of care for pain management even before hospitalization. RN #125 further acknowledged that the medication reconciliation process had not been fully implemented as per the home’s expectations resulting in pain to resident #022. [s. 8. (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 following policy and protocol are complied with:
- Resident Falls and
- Process Map: Re-admission From Hospital, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #030 had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of a CIS report indicated that the staff reported to the registered staff that the resident had reported to the family an incident resulting in injury on the resident’s head. During the home’s investigation, it was identified that the resident fell and sustained an injury. The resident confirmed about the incident during the investigation.

A review of the resident’s health records indicated that there was no documentation available for the resident’s fall incident including a post fall assessment.

During an interview with Agency Personal Support Worker (PSW) #107 confirmed that resident #030 had a fall incident. Agency PSW #107 indicated that RPN #106 arrived to see the resident after the resident had a fall.

During an interview, RPN #106 denied being aware about resident #030 having a fall incident.

Interview with the Interim Administrator confirmed that staff were required to complete a post fall assessment after the resident’s fall.

This non-compliance was issued as a result of the staff failure to complete a post fall assessment for resident #030’s fall incident. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 24th day of September, 2020

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

Original report signed by the inspector.

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), BABITHA SHANMUGANANDAPALA (673)
Inspection No. / No de l'inspection :	2020_766500_0008
Log No. / Registre no:	002772-20, 002773-20, 004816-20, 009192-20, 012484-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 18, 2020
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 (Vaughan) 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Braic

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:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6. (10) (b) of the LTCHA, 2007.
Specifically, the
licensee must do the following:
1. Ensure for all residents that when a change in care needs is identified, the resident's care plan is reviewed and revised;
2. Review with all Registered staff in the home:
a. the home's policies and procedures for the specified care area, and
b. the home's procedures for device care for residents;
3. Implement an auditing process to ensure when a resident has a change in care needs, an assessment is completed as per the home's policy, and review and revision of the resident care plan is completed;
4. Maintain records of the audits including but not limited to the resident name, date of audit, result of audit, and any corrective action taken as a result of the audits.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Director related to

resident #022 related to a fall with injury, transfer to hospital, and significant change in status.

Review of resident #022's progress notes indicated that they had an unwitnessed fall with injury for which they were transferred to hospital, diagnosed and treated.

Review of resident #022's progress notes indicated that they returned to the home with a Home Medication Instructions that stated to follow up with their general practitioner and perform a specified type of device care.

A review of a document obtained from resident's chart indicated that resident #022 had a specified device during the course of their stay in hospital and that the hospital recommends that the specified device remain due to the resident's health condition. It further stated for the home to complete a repeat assessment and the doctor to examine the resident. In an interview, Registered Practical Nurse (RPN) #124 stated they had initiated resident #022's re-admission to the home, but had not seen this document. In an interview, RPN #126 stated that they had seen the document but had not read it.

Review of Policy #NUR 020402, dated December 31, 2019, stated that an interdisciplinary, individualized care plan based on resident preferences and assessed needs will be developed for each resident to maximize independence, comfort, and dignity. This included assessment quarterly and after any change in condition that may affect a specified care area, by registered staff.

i) In an interview, RPN #124 stated that resident #022 had a history of recurrent infections. Review of the resident's progress notes indicated that they had an infection for which they were treated. Review of resident #022's assessments did not include a specified assessment after their infection, quarterly assessments, or after their change in status when they returned from the hospital. The only assessment completed was upon their admission to the home. RPN #124 acknowledged that resident #022 had not been reassessed when the resident's care needs changed.

ii) A review of the progress notes by RPN #124 indicated that the resident returned to the home with a specified device, but it was noted to be out of place. In an interview, RPN #124 stated that they had removed/discontinued resident #022's specified device upon their return from hospital as it was out of place and

informed charge nurse RN #125 and the resident's POA but could not remember if the doctor had been informed. In an interview, RN #125 stated that they had not been informed of this incident by RPN #124.

In interviews, Interim Administrator #100 and RPN #124 acknowledged that there was no documentation to indicate that the doctor had been informed about the specified device removal and that there was no written order from them to remove/discontinue the specified device. They further stated that removing/discontinuing a specified device requires an order from the doctor and that RPN #124 should not have removed/discontinued resident #022's specified device without an order.

Progress notes indicated that resident was sent to hospital due to a change in their health condition. Progress note indicated that the resident's specified device which had been inserted was taken off resulting in negative impact on the resident's health status. The resident passed away in hospital.

Interim Administrator #100 acknowledged that resident #022's plan of care had not been reassessed after their change in condition following hospitalization. [s. 6. (10) (b)]

The severity of this issue is a level 3 (actual harm), the scope was a level 1 (isolated), as it related to one out of three residents reviewed and compliance history was level 3 (previous non-compliance to the same subsection) that included Voluntary Plan of Action (VPC) and Written Notification (WN) issued during Inspection #2019_766500_0032, dated February 4, 2020, and #2018_644507_0009, dated April 25, 2018. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2020

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 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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of September, 2020

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