Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Public Copy/Copie 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
Sep 24, 2019	2019_704682_0022	016609-19	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Allendale
185 Ontario Street South MILTON ON L9T 2M4

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

AILEEN GRABA (682), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 27, September 4, 5, 6, 10, 11, 12, 2019.

The following Complaint Inspection was completed:

016609-19 related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nurse Manager, Manager or Resident Care, registered nursing staff, personal support workers and residents.

During the course of the inspection, the Inspector toured the home; reviewed clinical health records, meeting minutes, policies and procedures, medication incident reports, complaint log binder, annual evaluations, investigative notes, staffing schedules, observed residents and the administration of medications.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
3 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	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. 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 :

A complaint was submitted to the Director.
.
A clinical record review indicated that resident #001 had a medical condition. Resident's #001 care plan identified a focus for the medical condition with interventions. A clinical record review included a progress note that staff #101 notified the medical doctor (MD) and provided an update regarding resident #001. The electronic medication administration records (EMAR) indicated that staff #104 had administered medication on an identified date. Staff #104 documented in the progress notes post medication administration, that the resident's medical condition was unchanged. During an interview staff #101 confirmed when resident's #001 medical condition changed and their assessment was incomplete. Staff #101 confirmed that their assessment was incomplete. During an interview staff #104 also acknowledged that their assessment was incomplete when resident's #001 condition declined further. A progress note, written by staff #102 described their assessment and resident condition. During an interview with staff #102, they confirmed their shift worked and that their assessment was incomplete for resident #001. A progress note written by staff #100, indicated that resident #001 medical condition changed. During an interview staff #100 confirmed that they did not complete an assessment of the resident despite knowledge of resident's #001 condition. During an interview, the Senior Nurse Manager (SNM) stated expectations of assessments and that staff involved in resident #001 care did not meet the expectations of assessment related to the residents medical condition. The SNM stated that when resident #001 medical condition changed, their care plan was not updated to include interventions related to the changes in medical condition. The home failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when their care needs and condition changed. [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. 123. Emergency drug supply

Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,

(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;

(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;

(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and

(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee who maintained an emergency drug supply for the home failed to ensure:
(b) that a written policy was in place to address access to the supply.

A complaint log # 016609-19/ IL-69596-HA was submitted to the Director on August 23, 2019, related to alleged neglect of resident #001.

A review of policy titled; Emergency Box Policy, document no. MEDI-CL-ONT-006, effective October 01, 2018, stated the following:
4. "The Emergency Drug Box should be kept in the locked medication room or designated locked area and its access controlled."

A review of policy titled; Emergency or STAT Orders; Procedure #06-03-29; last reviewed July 2019, stated the following:
The Registered Staff on each resident home area (RHA) on each shift will:
1. "On receipt of an emergency or STAT physician's order, the medication, if listed, will be obtained from the locked emergency box located in the designated area and is accessible by registered staff and consultant pharmacist."

A clinical record review included a progress note, that indicated staff #100 was unable to open the emergency pharmacy box as the key was missing. A review of electronic correspondence dated August 14, 2019, indicated that staff #112 had taken the emergency supply box key home on an identified date. During an interview, staff #103 stated that resident's #001 condition changed. Staff #103 stated that they were not able to open the emergency box. During an interview, staff #100 stated that the medical orders were received on an identified date and needed clarification. During an interview, staff #111 stated that they were contacted by staff #103 to assist in opening the emergency supply boxes. Staff #111 stated that they were aware that the emergency supply keys were missing and they informed the Manager of Resident Care (MRC) #113. RN #111 also indicated the MRC #113, directed staff #111 that there was a spare key. During an interview, the SNM confirmed that the emergency box supply key was not available in the home between identified dates. The SNM confirmed that staff #111 was not aware that there was another spare key and did not inform the MRC or anyone else on the management team, at the time of the incident. The SNM acknowledged that the licensee written policies related to emergency drug supply that were in place did not provide directions to staff regarding access to the supply. [s. 123. (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 a written policy is in place to address access to the emergency drug supply, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A complaint was submitted to the Director.

A clinical review included a progress note, staff #101 documented that resident #001 medical condition had changed and that they completed an intervention. Additional progress notes indicated staff #101 would follow up with the MD in the morning for clarification. Physician orders with the new medication orders were reviewed. During an interview, the prescribing physician indicated that the medication was to be started on an identified date. The prescribing physician confirmed that the resident missed doses of the new medication that was ordered. During an interview staff #101 stated the medication ordered needed clarification. During an interview, staff #100 stated that the medication was not available and not given. During an interview, the SNM acknowledged that staff #101 did not clarify the new medication dosage. The SNM confirmed the medications were not administered to resident #001 in accordance with the directions for use as specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving resident #001 was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A complaint was submitted to the Director. A clinical review included physician orders from an identified date by staff #101. During an interview, the prescribing physician indicated that the new medication was to be started on an identified date. The prescribing physician confirmed that the resident missed doses. During an interview, staff #100 indicated that the medication was not available and not given on an identified date. Staff #100 confirmed that resident's #001 missed doses and they did not complete a medication incident report. During an interview, the SNM confirmed the medications were not administered to resident #001 on identified dates and staff #100 did not document the medication incident involving resident #001, together with a record of the immediate actions takento assess and maintain the resident's health. [s. 135. (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 every medication incident involving a resident is: (a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health and (b) reported to the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following is further evidence to support Compliance Order #001 issued on June 19, 2019, during complaint inspection 2019_560632_0011 to be complied September 20, 2019.

The licensee failed to ensure that resident #001 was not neglected by the licensee or staff. O.Reg. 79/10, s. 5, defines neglect as failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well being of one or more residents.

A complaint was submitted to the Director.

A) A clinical record review indicated that resident #001 had a medical condition. Resident's #001 plan of care identified a focus and interventions related to the medical condition. A progress note indicated that staff #101 noticed a change in medical condition Staff #104 documented in the progress notes that resident #001 had a change in medical condition. A progress note, written by staff #102, indicated resident's #001 medical condition was assessed. No further documentation was found related to resident #001 medical condition by staff #102. Further review included a progress note documented by staff #100 that indicated resident's #001 medical condition changed. Resident #001 was sent to hospital for further medical intervention. During an interview, the SNM stated expectations of an assessment to be included with resident #001 medical condition. The SNM confirmed that staff #101, staff #102, staff #104, and staff #100, did not complete an assessment as expected for resident #001 when their medical condition changed. The SNM confirmed that on identified shifts staff did not assess resident #001 as expected when their medical condition changed. The SNM stated that when resident #001 was identified to have a change in medical condition on identified dates, their care plan was not updated to include interventions when resident #001 care needs had changed. The SNM also confirmed that they could not provide documented evidence that resident #001 had interventions in place on an identified date. During an

interview staff #102 confirmed they did not document their interventions. Staff #102 acknowledged that they should have documented in the clinical file.

B) A review of physician orders included a medication order transcribed by staff #101. During an interview the prescribing physician indicated they were made aware that resident's #001 medical condition changed and that the medication ordered was clarified by staff on an identified date. The prescribing physician confirmed that the resident missed doses of medication on identified dates. During an interview, the Senior Nursing Manager (SNM) acknowledged that staff #100 clarified the new medication dosage on an identified date. The SNM confirmed the medications were not administered to resident #001 on identified dates. During an interview on an identified date, the SNM confirmed that staff were aware that resident #001 medical condition changed. The SNM stated that between identified dates, registered staff did not assess the resident as expected, complete any follow up or clarification regarding interventions or document assessments as expected related to the resident's #001 medical condition on identified dates. The SNM acknowledged that the pattern of inaction jeopardized resident #001, health and well being.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that assessments and reassessments and residents #001
responses to interventions related to their respiratory status were documented.

A complaint was submitted to the Director. A clinical record review included a progress note written by staff #102 and indicated resident #001 was assessed at an identified time. No further documentation was found related to staff #102 assessments or resident's #001 condition. Documentation regarding point of care (POC) tasks did not include interventions related to resident's #001 medical condition. During an interview staff #102 confirmed that they worked an identified shift and that they expected to be made aware of any changes of resident's #001 medical condition during the shift. Staff #102 confirmed they assessed resident's #001 at an identified time but forgot to document. RN #102 acknowledged that they should have documented in the clinical file. During an interview, the SNM stated that there was a task that can be created in POC but that this was not added for resident #001 when their condition changed. The SNM stated it is the expectation that staff document interventions and care provided into the clinical records during their shift. Staff #102 confirmed that documentation regarding medical condition at an identified time, was missing and the home did not ensure that resident #001 interventions related to medical condition were documented. [s. 30. (2)]

Issued on this 24th day of September, 2019

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

Original report signed by the inspector.

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) :	AILEEN GRABA (682), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2019_704682_0022
Log No. / No de registre :	016609-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 24, 2019
Licensee / Titulaire de permis :	The Regional Municipality of Halton 1151 Bronte Road, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	Allendale 185 Ontario Street South, MILTON, ON, L9T-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sean Weylie

To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

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) of the LTCHA.

Specifically, the licensee must:

a) Provide training/ education to RPN #100, RPN #104, RN #101, RN #102 related to specific symptoms requiring reassessment based on evidence based practice.

b) Ensure there is a process for the documentation practices related to the monitoring of residents.

c) Ensure attendance records and training content are maintained related to this training.

d) Ensure an ongoing auditing process at a frequency and schedule as determined by the licensee; to ensure registered staff are appropriately assessing, reassessing, evaluating and documenting interventions. Include who will be responsible for doing the audits and evaluating the results.

Grounds / Motifs :

1.
A complaint was submitted to the Director.

.
A clinical record review indicated that resident #001 had a medical condition. Resident's #001 care plan identified a focus for the medical condition with interventions. A clinical record review included a progress note that staff #101 notified the medical doctor (MD) and provided an update regarding resident #001. The electronic medication administration records (EMAR) indicated that staff #104 had administered medication on an identified date. Staff #104 documented in the progress notes post medication administration, that the resident's medical condition was unchanged. During an interview staff #101 confirmed when resident's #001 medical condition changed and their assessment was incomplete. Staff #101 confirmed that their assessment was incomplete. During an interview staff #104 also acknowledged that their assessment was incomplete when resident's #001 condition declined further. A progress note, written by staff #102 described their assessment and resident condition. During an interview with staff #102, they confirmed their shift worked and that their assessment was incomplete for resident #001. A progress note written by staff #100, indicated that resident #001 medical condition changed. During an interview staff #100 confirmed that they did not complete an assessment of the resident despite knowledge of resident's #001 condition. During an interview, the Senior Nurse Manager (SNM) stated expectations of assessments and that staff involved in resident #001 care did not meet the expectations of assessment related to the residents medical condition. The SNM stated that when resident #001 medical condition changed, their care plan was not updated to include interventions related to the changes in medical condition. The home failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when their care needs and condition changed. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 2 compliance history as they had on-going non-compliance none of which are the same subsection being cited that included:
~ compliance order (CO) #001 issued July 9, 2019, with a compliance due date of September 20, 2019, (2019_560632_0011)
~ voluntary plan of correction (VPC) issued November 15, 2018, (2018_543561_0013)

~ voluntary plan of correction (VPC) issued February 22, 2018, (2017_543561_0020) (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 23, 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, 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
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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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 24th day of September, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Aileen Graba

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