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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2019	2019_810654_0003 (A1)	011600-19, 011919-19, 011920-19, 011921-19, 012111-19	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

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

Amended by SIMAR KAUR (654) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Resident number #016 and #018 are corrected from #116 and #118 in the Licensee report.

Issued on this 19th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

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

Amended by SIMAR KAUR (654) - (A1)

Amended 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 09, 12, 13, 14, 15, 16, and 19, 2019.

The following intakes were completed in this inspection:

log #011600-19, related to change in condition, and

log #012111-19, related to prevention of abuse and neglect.

The following follow up inspections were inspected:

log #011919-19, related to plan of care,

log #011920-19, related to the policy to promote zero tolerance of abuse and neglect, and

log #011921-19, related to the safe use of transferring and positioning devices.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physiotherapist (PT), Occupational Therapist (OT), Mobility Aids Consultant, Residents, and Resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed residents health records, staffing schedules, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **0 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. 20. (1)	CO #002	2019_776613_0016	645
O.Reg 79/10 s. 36.	CO #001	2019_776613_0017	645
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_776613_0016	645

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On an identified date and time, while conducting an inspection, Inspector #645 observed the shower room door on the second floor unlocked, open and unsupervised. Inside a hoyer lift was noted.

During an interview with housekeeper #131, they verified that the shower room door was supposed to be kept closed and locked. They then proceeded to close and lock the door.

On the same day at another identified time, the nursing storage room door on the third floor was observed open. Inspector #645 observed a paper wedge placed in the key hole to prevent the door from closing. In the storage room, bottles of hand sanitizer, alcohol swabs, bottles of normal saline, shaving creams, mouth washes, razor blades, and bottles of shampoo were stored.

During an interview with RN #132, they verified that the door to the nursing storage room was supposed to be kept closed and locked. They then proceeded to close and lock the door. Similarly on the second floor, the nursing storage room door was observed open and unlocked. On all the occasions, residents were observed in a close proximity to the storage rooms and there were no staff members in the area.

During an interview with the ADOC, they confirmed that the nursing storage and shower room doors should always be closed and locked when they were not being supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

A complaint was submitted to the Ministry of Long-Term Care (MOLTC), related to resident #002's care being neglected at the home.

During an observation of resident #002 on an identified date and time, two specified falls prevention and management equipment were observed on the resident's dresser table in their room. The resident was observed in their bed.

A review of resident #002's written plan of care under fall risk focus indicated that the resident was at moderate risk of fall. Interventions indicated staff to encourage the resident to use the above mentioned falls prevention and management equipment when in bed.

Review of the resident's progress notes on two identified dates, indicated that the resident did not use one of the above mentioned specified falls prevention and management equipment during their physiotherapy assessments. Interview with the home's physiotherapist indicated the same.

Interview and observation of resident #002 with RPN #108 confirmed that the resident did not use the two above mentioned falls prevention and management equipments on the identified date. The RPN indicated that on the same day, they had provided one of the falls prevention and management equipment to PSW #107 to put it on the resident.

Interview with PSW #107 indicated that they had provided the morning care and dressed the resident on the identified date. PSW #107 had also put the resident to bed after meal service on the same day. The PSW confirmed that, they forgot to put the falls prevention and management equipment mentioned above on the resident in the morning and did not use the second falls prevention and management equipment when they had put them to bed after meal service. The PSW further indicated that the resident did not the use the specified falls prevention and management equipment from approximately the last three weeks, nor did they ask the registered staff for it to use on the resident.

Interview with RPN #108 and ADOC #125 indicated that the above mentioned falls prevention and management equipment interventions were used by the home for the falls prevention and management program. They further indicated that the above mentioned falls prevention interventions were not implemented for resident #002. [s. 48. (1) 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 there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #3: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were dependent on staff for turning and repositioning were turned and repositioned every two hours.

Resident #016 was selected and observed for a follow up inspection on an identified date. During an observation at an identified time, resident was positioned supine in the bed, alert but not oriented to time and place. RPN #132 was providing medication to the resident at the time.

Record review of the resident's plan of care under skin care focus, indicated that the resident needed to be turned and repositioned every two hours to prevent skin breakdown.

At a second observation on the same day at another identified time, the resident was observed in the same position, and there was no turning and repositioning performed for the resident.

Interview with RPN #132 indicated that the resident was in the same position for an identified time period and confirmed that the resident was not turned and repositioned.

On the same floor, resident #018 was selected to increase the resident sample size. The resident's plan of care, indicated that the resident needed to be turned and repositioned every two hours.

On a second identified date, the inspector observed the resident on three different occasions and times. On all the occasions, the resident was observed in the same position.

Interview with PSW #134 indicated that they repositioned the resident once throughout the shift as they were busy looking after other residents. PSW #134 indicated that the resident needed to be turned and repositioned every two hours.

Interview with the ADOC confirmed that resident #016 and #018 needed to be turned and repositioned every two hours. They reiterated that it was the expectation of the home that staff turn and reposition residents to prevent skin breakdown. [s. 50. (2) (d)]

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 residents who are dependent on staff for turning and repositioning are turned and repositioned every two hours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, and different approaches had been considered in the revision of the plan of care.

A complaint was submitted to the MOLTC, related to resident #002's care being neglected at the home.

In an Interview with the complainant they indicated resident #002 had multiple falls in the past two months and did not have falls prevention interventions.

A review of resident #002's progress notes indicated five falls during an identified time period in 2019. A review of resident #002's Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired with poor decision-making skills. They required supervision with one-person assistance for locomotion on the unit and toileting.

A review of resident #002's written plan of care, under fall risk focus indicated that the resident is at moderate risk of fall.

Interview with PSW #126 and RPN #108 indicated resident #002 usually had an unsteady gait. The resident does not call the staff for assistance before getting up from their bed and often forgets to use their walker.

Interview with ADOC #125 and the Falls Prevention Program Lead in the home indicated that resident #002 had been identified to be at risk of falls after a specified meal service as the resident tried to walk without assistance. The ADOC further indicated that the resident had most falls during a specified shift and they should be kept near the nursing station for monitoring after meals.

Review of the written plan of care revised on an identified date, noted that there was no specific strategy identified to reduce the resident's risk of fall in the evening. In an interview with ADOC #125, they reviewed resident #002's plan of care and indicated that after the resident's fall incident on an identified date, no different approaches were considered in the revision of the resident's plan of care to address their risk of fall after meals. [s. 6. (11) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, the home, furnishings and equipment was kept clean and sanitary.

A complaint was submitted to the MOLTC, related to resident #001's continence care and their wheelchair were not kept clean.

Review of the resident's health records indicated that the resident had deceased on an identified date in 2019 .

Review of resident #001's progress note, documented by occupational therapist (OT) on an identified date indicated, the resident's wheelchair cushion was replaced by mobility aid consultant #104 from an external company, as it was soaked in urine.

Interview with the mobility aid consultant indicated that, they went to check on the resident's wheelchair with the home's previous ED due to a complaint that was received by the ED. Resident #001's wheelchair cushion was replaced with a new cushion as it was smelling of urine.

On an identified date, inspectors #654 and #645 made observations on an

identified floor as follows:
-Resident #013's wheelchair was observed unclean; with stains on the cushion.
-Resident #011's wheelchair with roho cushion was observed unclean; with food particles stuck on the cushion cover.
-Resident 012's walker was observed unclean with stains on it.

During an interview resident #013 stated that staff clean their wheelchair once in a blue moon. The resident further indicated that they cleaned their own wheelchair with water and soap.

Interview with PSW #126 and #105 indicated that night PSWs are responsible to clean residents, wheelchairs and walkers following their weekly bath schedule. The PSWs further indicated that they do not document once they clean the residents equipments.

ADOC #100 observed the above-mentioned residents, wheelchairs and walker with inspector #654 and confirmed that they were not kept clean. The ADOC further acknowledged that home did not have a process to ensure that resident equipments were kept clean. [s. 15. (2) (a)]

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 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 were documented.

Record reviews of the current plan of care for residents #016 and #018, indicated that both residents needed to be turned and repositioned every two hours to prevent skin breakdown. Further review of the clinical records for both residents indicated that there was no documentation available regarding every two hours turning and repositioning.

Interviews with RN #132 and RN #133 confirmed that there was no documentation available regarding the turning and repositioning for both residents. They reiterated that the PSWs used to document on the Point of Care (POC) after they perform the care. RN #132 indicated that registered staff are expected to activate the POC documentation task for the PSWs to document the turning and repositioning, and they were not sure what happened in this case.

Interview with the ADOC confirmed that there was no documentation available for the turning and repositioning of both residents. They indicated that under the skin care program, staff are expected to document the two hours turning and repositioning on the POC. [s. 30. (2)]

Issued on this 19th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SIMAR KAUR (654) - (A1)
Inspection No. / No de l'inspection :	2019_810654_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011600-19, 011919-19, 011920-19, 011921-19, 012111-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 19, 2019(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Weston Terrace Care Community 2005 Lawrence Avenue West, TORONTO, ON, M9N-3V4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Bastian

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SIMAR KAUR (654) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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