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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2022	2022_892762_0004	018216-21, 018247-21, 000055-22, 001867-22	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street Markham ON L6B 1E1

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

MOSES NEELAM (762)

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): February 7-11 and 14-16, 2022

In this complaint inspection the following intakes were inspected:
- Log /Critical Incident Report (CIR)related to abuse and falls
- Log related to abuse, medical condition, safe positioning, appropriate diagnostics and functioning equipment
- Log related to infection control, food and medication administration

During the course of the inspection, the inspector(s) spoke with with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), BSONurse, Dietary Aide (DA), Resident Care Coordinator (RCC), Food and Nutrition Manager (FNM), Assistant Director of Care (ADOC), and Director of Care (DOC)

The inspectors toured the home, observed the residents, provision of care, staff to resident interaction, staffing schedule, clinical health records, complaint records, and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 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. 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 licensee has failed to ensure that the Long-Term care home (LTCH) protected residents from abuse by anyone

Section 2 (1) of the Ontario Regulation 79/10 defines “physical abuse” as: the use of physical force by a resident that causes physical injury to another resident.

A critical incident report (CIR) was submitted to the director related to an incident that occurred between resident #001 and #002.

A review of the progress notes indicated resident #001 and resident #002 had an altercation. Prior to this incident, there were instances where both residents were noted to have responsive behaviors. When resident #001 and resident #002 had an altercation, resident #001 was injured as a result. In separate interviews, PSW #117 and RCC #118, indicated there was an altercation between the two residents that lead to a injury for resident #001.

As a result, there was harm as resident #002 injured resident #001 due to the incident.

Sources: CIR; progress notes; Interviews with PSW #117 and RCC #118

B) Two critical incident system (CIS) reports were submitted to the Ministry of Long-Term Care (MLTC) related to alleged staff to resident #005 emotional and verbal abuse.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as “a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.”

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as “a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.”

On a certain date, resident #005 reported to Personal Support Worker (PSW) #116 and Director of Care (DOC) that two direct care staff had made inappropriate comments towards them. The resident shared that when they requested assistance, they were told by the staff to wait. The resident stated they felt being punished and not treated equally due to their personal health condition. On a certain date resident #005 reported to the DOC and the Director of Social Services that the same two PSWs had threatened the resident.Through investigation, the Long-Term Care Home (LTCH) had substantiated both abuse incidents and disciplined the two PSWs involved.

PSW #116 shared that the two PSWs involved continued to taunt resident #005 and on occasions, had prevented other staff members from assisting the resident.

There was harm to resident #005 as their emotional well-being were negatively impacted because of the two staff’s abusive actions.

Sources: Observations; Interviews with PSW #116, DOC; Director of Social Services; LTCH’s investigation notes and pertinent documents, CIS report.

b) A CIS was submitted to the director, regarding an alleged physical abuse from a PSW staff to resident #007. Resident #007 reported to the Registered Practical Nurse (RPN) #129 that a PSW insisted they receive care and when they refused, the PSW's action hurt the resident physically. Resident #007’s progress notes and clinical records documented that they had sustained an injury related to the incident.

PSW #113 stated that resident #007 was able to make decision regarding their care.

The DOC confirmed that the involved PSW acknowledged their mistake and the abuse incident was substantiated.

There was harm to resident #007 as they sustained an injury and distress as a result of the staff's abusive actions.

Sources: Interviews with DOC, PSW #113; Resident #007's progress notes, skin and wound assessment, CIS report. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the the written plan of care for resident's #001, #012 and #013 indicates the planned care.

During an observation a certain symbol was noted next to the resident room. The residents most recent care plan, did not indicate this intervention. In an interview, RCC #107, indicated that the resident was to have the the intervention documented in their care plan.

Furthermore, in an interview, PSW #117 indicated the resident was consistently receiving a certain intervention for their behaviors, this was not noted in the care plan. Additionally, ADOC #102, indicated that the resident was to have the intervention documented in the care plan.

As a result, the resident was at risk for not receiving the intervention if symbol was lost.

Sources: Observations; care plan; and interviews with PSW #117, RCC #107 and ADOC #102 [s. 6. (1) (a)]

2. During an observation a certain symbol was noted next to the resident room. The residents most recent care plan, did not indicate this intervention. In an interview, RCC #107, indicated that the resident was to have the intervention documented in their care plan. Additionally, RCC #118, indicated that the intervention was not documented in the care plan.

As a result, the resident was at risk for not receiving the intervention if symbol was lost.

Sources: observation; care plan reviewed; interviews with RCC #107 and #118 [s. 6. (1) (a)]

3. During an observation a certain symbol was noted next to the resident room. The residents most recent care plan, did not indicate this intervention. In an interview, RCC #107, indicated that the resident was to have the intervention documented in their care plan. Additionally, RCC #118, indicated that the intervention was not documented in the care plan.

As a result, the resident was at risk for not receiving the intervention if symbol was lost. .

Sources: observation; care plan; interviews with RCC #107 and #118 [s. 6. (1) (a)]

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 a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents' #009 and #007

A complaint made to the director indicated that the resident was injured due to an incident. A review of progress notes indicated that the resident was provided care when the resident was resisting the care, as a result, the resident got injured due to an incident. A review of the care plan, indicated staff were not to continue if the resident was refusing care and return after sometime. In an interview, PSW #121 indicated that this was an unsafe care. As a result the resident was injured due to unsafe care.

Sources: Progress notes; Care plan; Interview with PSW #121

b) PSW #113 stated that staff can access information about residents' care needs.

Resident #007's care plan documented that they required a certain type of intervention during care. During an observation Inspector #752 noted PSW #113 assisted resident #007 to by not using that type of intervention.The PSW acknowledged that they should have used that type of intervention.

There was minimal risk for injuries to resident #007 when staff did not utilize safe interventions.

Sources: Observation; Interview with PSW #113; Resident #007's care plan and Kardex. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids being served at a temperature that is both safe and palatable to the residents

During a review of the staffing levels due to a complaint made to the director, it was noted that the there was a shortage of a PSW staff. As a result, serving of food was reviewed, as it was indicated by RPN #120, that it was served late, and the temperature of the food was not appropriate. A review of the food temperature logbook indicated that the the foods were the appropriate temperature when served. The FNM indicated that the temperature for these foods would have been taken between one to two hours before. In separate interviews, RPN #120 and DOC, indicated that resident #003 complained of the food being late and an inappropriate temperature, and the resident did not eat the food. As a result of the food being an inappropriate, the resident chose to miss their meal, as the food was not palatable.

Sources: Food temperature logs; Interviews with RPN #120 and DOC [s. 73. (1) 6.]

Issued on this 25th day of February, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MOSES NEELAM (762)
Inspection No. / No de l'inspection :	2022_892762_0004
Log No. / No de registre :	018216-21, 018247-21, 000055-22, 001867-22
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 24, 2022
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Woodhaven Long Term Care Residence 380 Church Street, Markham, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andre Dwyer

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

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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

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

Order / Ordre :

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

Specifically, the licensee must protect resident #001, #002 and #004 from abuse by doing the following:

- Provide PSW #130 and 131 with re-training related to emotional and verbal abuse so that they understand how to communicate appropriately with residents without belittling or threatening them.

- Provide PSW #132 with re-training related to physical abuse so that they understand how to use gentle approaches when caring for residents.

- Ensure resident #002 does not physically abuse Resident #001.

- Keep a record of all training including the date, persons who attended, the person providing the training.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the Long-Term care home (LTCH) protected residents from abuse by anyone

Section 2 (1) of the Ontario Regulation 79/10 defines “physical abuse” as: the use of physical force by a resident that causes physical injury to another resident.

A critical incident report (CIR) was submitted to the director related to an incident that occurred between resident #001 and #002.

A review of the progress notes indicated resident #001 and resident #002 had an altercation. Prior to this incident, there were instances where both residents were noted to have responsive behaviors. When resident #001 and resident #002 had an altercation, resident #001 was injured as a result. In separate interviews, PSW #117 and RCC #118, indicated there was an altercation between the two residents that lead to a injury for resident #001.

As a result, there was harm as resident #002 injured resident #001 due to the incident.

Sources: CIR; progress notes; Interviews with PSW #117 and RCC #118

B) Two critical incident system (CIS) reports were submitted to the Ministry of Long-Term Care (MLTC) related to alleged staff to resident #005 emotional and verbal abuse.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as "a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences."

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as "a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences."

On a certain date, resident #005 reported to Personal Support Worker (PSW) #116 and Director of Care (DOC) that two direct care staff had made

inappropriate comments towards them. The resident shared that when they requested assistance, they were told by the staff to wait. The resident stated they felt being punished and not treated equally due to their personal health condition. On a certain date resident #005 reported to the DOC and the Director of Social Services that the same two PSWs had threatened the resident.Through investigation, the Long-Term Care Home (LTCH) had substantiated both abuse incidents and disciplined the two PSWs involved.

PSW #116 shared that the two PSWs involved continued to taunt resident #005 and on occasions, had prevented other staff members from assisting the resident.

There was harm to resident #005 as their emotional well-being were negatively impacted because of the two staff’s abusive actions.

Sources: Observations; Interviews with PSW #116, DOC; Director of Social Services; LTCH’s investigation notes and pertinent documents, CIS report.

b) A CIS was submitted to the director, regarding an alleged physical abuse from a PSW staff to resident #007. Resident #007 reported to the Registered Practical Nurse (RPN) #129 that a PSW insisted they receive care and when they refused, the PSW's action hurt the resident physically. Resident #007’s progress notes and clinical records documented that they had sustained an injury related to the incident.

PSW #113 stated that resident #007 was able to make decision regarding their care.

The DOC confirmed that the involved PSW acknowledged their mistake and the abuse incident was substantiated.

There was harm to resident #007 as they sustained an injury and distress as a result of the staff’s abusive actions.

Sources: Interviews with DOC, PSW #113; Resident #007’s progress notes, skin and wound assessment, CIS report. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal harm to resident #001 when there was an altercation between resident #001 and #002; resident #007 when one PSWs caused the resident pain and injury while performing personal care; and resident #005 when the PSWs belittled and threatened the resident

Scope: This was widespread since three out of three residents had been abused by either the staff or co-resident.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 19 (1) of the LTCHA, on multiple occasions, including one Compliance Order (CO) on October 16, 2019, complied on May 27, 2020, one Written notification (WN) on an inspection that commenced on January 20, 2020, a Voluntary Plan of Correction (VPC) and Written Notification (WN) on an inspection that commenced on November 02, 2021. Multiple WN's, VPC's and CO's were issued to the home related to different sections and subsections of the legislation in the past 36 months (762) (762)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2022

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 February, 2022

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Moses Neelam

Service Area Office / Bureau régional de services : Central East Service Area Office