Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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

Amended Public Copy/Copie modifiée 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
Oct 14, 2021	2021_905683_0015 (A1)	013681-21, 013703-21	Complaint

Licensee/Titulaire de permis

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Niagara Long Term Care Residence
120 Wellington Street P.O. Box 985 Niagara On The Lake ON L0S 1J0

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Requested additional time to ensure all direct care staff are educated on the home's abuse and neglect policy.

Issued on this 14th day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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120 Wellington Street P.O. Box 985 Niagara On The Lake ON L0S 1J0

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

Amended by LISA BOS (683) - (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): September 20, 21, 22 and 23, 2021.

This inspection was completed concurrently with critical incident inspection #2021_905683_0016.

The following intakes were completed during this complaint inspection:

Log #013681-21 was related to critical incident response, nutrition and hydration and infection prevention and control; and

Log #013703-21 was related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Clinical Infomatics, Business Manager, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary staff, housekeeping staff, and residents.

During the course of the inspection, the Inspector(s) toured the home, observed the provision of care, infection prevention and control practices, meal service and reviewed clinical health records, screening records, video footage, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Nutrition and Hydration

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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 protect a resident from neglect.

O. Reg. 79/10, s. 5 defines neglect as the 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 resident experienced a medical emergency. A Personal Support Worker (PSW) called for help, another PSW attempted an intervention, and the resident became unresponsive. The Registered Practical Nurse (RPN) who responded to the incident did not initiate any medical interventions and instead, left the resident and notified a Registered Nurse (RN). The RN attempted an intervention and initiated Cardiopulmonary Resuscitation (CPR), and a code blue was called.

A RN and RPN indicated that specific equipment was available for use when a resident was experiencing a medical emergency but was not used.

A RN indicated that if a resident experienced a medical emergency, a code blue should be called immediately. A code blue was not called immediately for a resident.

A RN and the Director of Care (DOC) acknowledged that in the event of a medical emergency where the resident was unresponsive, CPR should be initiated immediately. CPR was not initiated immediately for a resident.

Staff failed to provide a resident with appropriate lifesaving care. There were no attempts at a specified intervention by registered staff, there was a delay in initiating a code blue and a delay in initiating CPR.

Sources: A CI report; a resident's clinical record; video footage; interviews with PSWs, a RPN, RN, the DOC and other staff. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the emergency plans provided for dealing with a specified medical emergency.

A resident experienced a medical emergency and a complaint was submitted to the Director regarding the home's response to the medical emergency.

The DOC acknowledged that the resident experienced a medical emergency and that the home did not have emergency plans for that type of medical emergency.

The home's emergency plans did not provide direction for staff on what to do in the event of a specified medical emergency, which placed residents at risk of not receiving appropriate lifesaving care.

Sources: A CI report; a resident's clinical record; video footage; interviews with PSWs, a RPN, RN, the DOC and other staff. [s. 230. (4) 1. v.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents by not completing active screening for COVID-19 as required by Directive #3.

Directive #3 for Long-Term Care homes under the LTCHA, 2007, requires Long-Term Care homes to ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, with the exception of first responders in emergency situations.

A complaint was submitted to the Director regarding active screening not being completed for individuals visiting a resident for a non-emergency situation.

The home's "COVID-19 Active Screening" policy indicated that active screening was to be performed by a designated screening staff on all persons entering and exiting the home to prevent the spread of COVID-19. The sign-in/out sheets of all staff and visitors were to be kept by the home for look back and potential contact tracing if required.

The home was unable to produce any documentation to confirm the individuals were screened into the home, though the Administrator acknowledged they entered the home that day.

By failing to complete active screening of individuals entering the home on, there was risk that COVID-19 symptoms may not have been identified which could impact resident safety.

Sources: Directive #3 for Long-Term Care homes under the LTCHA, 2007, dated July 16, 2021; a complaint submitted to the Director; COVID-19 Active Screening policy; reports by a screening staff; interview with the Administrator and other staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the "Swallowing Assessment" policy included in the required Dietary Service and Hydration Program was complied with, for a resident.

LTCHA s. 11 (1) (a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of residents.

O. Reg. 79/10, s. 68 (1) (a) and O. Reg. 79/10, s. 68 (2) requires that the program includes the development and implementation of policies and procedures related to nutrition care and dietary services.

Specifically, staff did not comply with the home's "Swallowing Assessment" policy, which indicated when a resident was experiencing difficulty swallowing, the registered staff would complete an initial swallowing assessment and refer to the Registered Dietitian (RD) for further assessment. The RD was to observe a meal to assess food and fluid consumption and further assess causes for swallowing difficulties.

A resident had trouble swallowing, and an initial assessment was completed by the registered staff. A referral was sent to the RD to reassess the resident and when they completed their assessment, they changed the resident's diet order without completing an observation of the resident.

In an interview with the RD, they acknowledged that when they completed their swallowing assessment, they were not on site and did not complete an observation of the resident. They indicated that they usually made observations with diet changes.

In an interview with the Director of Care (DOC), they acknowledged that the RD should have observed the resident to assess food and fluid consumption and further assess causes for swallowing difficulties, as per the home's "Swallowing Assessment" policy.

By failing to observe a resident when completing their swallowing assessment as per the home's policy, a resident was at risk of being on an inappropriate diet texture.

Sources: A resident's clinical record; Swallowing Assessment policy; interviews with the RD, DOC and other staff. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

Ontario

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Ministère des Soins de longue durée

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Issued on this 14th day of October, 2021 (A1)

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

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 Operations Division
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Division des opérations relatives aux soins de longue durée
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Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA BOS (683) - (A1)
Inspection No. / No de l'inspection :	2021_905683_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013681-21, 013703-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 14, 2021(A1)
Licensee / Titulaire de permis :	DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc. 161 Bay Street, Suite 2100, TD Canada Trust Tower, Toronto, ON, M5J-2S1
LTC Home / Foyer de SLD :	Niagara Long Term Care Residence 120 Wellington Street, P.O. Box 985, Niagara On The Lake, ON, L0S-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chris Poos

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To DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc., 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 comply with LTCHA s. 19 (1).

Specifically, the licensee must:
1. Ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to protect a resident from neglect.

O. Reg. 79/10, s. 5 defines neglect as the 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 resident experienced a medical emergency. A Personal Support Worker (PSW) called for help, another PSW attempted an intervention, and the resident became unresponsive. The Registered Practical Nurse (RPN) who responded to the incident did not initiate any medical interventions and instead, left the resident and notified a Registered Nurse (RN). The RN attempted an intervention and initiated Cardiopulmonary Resuscitation (CPR), and a code blue was called.

A RN and RPN indicated that specific equipment was available for use when a resident was experiencing a medical emergency but was not used.

A RN indicated that if a resident experienced a medical emergency, a code blue should be called immediately. A code blue was not called immediately for a resident.

A RN and the Director of Care (DOC) acknowledged that in the event of a medical emergency where the resident was unresponsive, CPR should be initiated immediately. CPR was not initiated immediately for a resident.

Staff failed to provide a resident with appropriate lifesaving care. There were no attempts at a specified intervention by registered staff, there was a delay in initiating a code blue and a delay in initiating CPR.

Sources: A CI report; a resident's clinical record; video footage; interviews with PSWs, a RPN, RN, the DOC and other staff.

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

Severity: Registered staff did not attempt a specified intervention when a resident was experiencing a medical emergency, a code blue was not immediately called and CPR was not immediately initiated when a resident went unresponsive which jeopardized the health of the resident.

Scope: This was an isolated case as no further concerns were identified with neglect.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 19 (1) and two Compliance Orders (CO) and two Written Notifications (WN) were issued to the home. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2021(A1)

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: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services.
2. Evacuation of the home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home.
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

Order / Ordre :

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

The licensee must comply with s. 230 (4) of O. Reg. 79/10.

Specifically, the licensee must:
1. Update the Emergency Plan for dealing with medical emergencies to include staff roles and responsibilities when responding to a specified incident. The plan is to be based on best practice guidelines and must include, but is not limited to the following:
i) the role of PSW staff
ii) the role of registered staff
iii) specific interventions, when they are to be used, whose responsibility it is to perform them, and where they should be performed
iv) identify any applicable equipment and where it is stored
2. Provide education to all direct care staff on the updated Emergency Plan for dealing with the specified medical emergency.
3. Maintain records of the education including the date it was provided, and names of staff who completed it.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the emergency plans provided for dealing with a specified medical emergency.

A resident experienced a medical emergency and a complaint was submitted to the Director regarding the home’s response to the medical emergency.

The DOC acknowledged that the resident experienced a medical emergency and that the home did not have emergency plans for that type of medical emergency.

The home's emergency plans did not provide direction for staff on what to do in the event of a specified medical emergency, which placed residents at risk of not receiving appropriate lifesaving care.

Sources: A CI report; a resident’s clinical record; video footage; interviews with PSWs, a RPN, RN, the DOC and other staff.

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

Severity: There was actual harm to the resident as an emergency plan for dealing with the medical emergency may have assisted staff in providing the resident with appropriate care.

Scope: This was an isolated case as no concerns were identified with other required emergency plans.

Compliance History: Non-compliance was issued to the home related to different sections of the legislation in the past 36 months. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 17, 2021

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 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:

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 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

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

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 14th day of October, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LISA BOS (683) - (A1)

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 : Hamilton Service Area Office