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
Feb 07, 2020	2020_704682_0002 (A1)	024311-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare St. Catharines
283 Pelham Road St. Catharines ON L2S 1X7

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

Amended by AILEEN GRABA (682) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Minor edits to licensee CO #001 order and grounds

Issued on this 7 th day of February, 2020 (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

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
Feb 07, 2020	2020_704682_0002 (A1)	024311-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare St. Catharines
283 Pelham Road St. Catharines ON L2S 1X7

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

Amended by AILEEN GRABA (682) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 10, 13, 15, 16, 2020.

The following Critical Incident System inspection was conducted:

024311-19 related to plan of care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Physiotherapist Assistant (PTA), Personal Support Workers (PSW), families and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes and policy and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A critical incident (CI) was submitted to the Director.

The clinical record was reviewed which included the care plan that identified resident #001 had an intervention to prevent injury.

During an interview staff #104 and staff #105 confirmed that the resident did not have the identified intervention at the time of the incident on an identified date. Staff #104 confirmed that the care set out in the plan of care was not provided to resident #001 as specified in the plan.

B) The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A clinical record review included the care plan, which identified that resident #001 had various interventions. During observations on an identified date, resident #001 did not have the intervention in place. During an interview, staff #103 confirmed that resident #001 should have had the intervention as it was included in their plan of care. Staff #103 acknowledged that it was not in place. Staff #103 confirmed that the care set out in the plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A clinical review included a care plan that identified resident #003 had the potential for injury. A review of the progress notes identified the following incidents; on an identified date resident #003 had an incident. On an identified date, resident #003 had a subsequent incident and staff #103 assisted resident #003. On an identified date, resident #003 had another incident. Staff #103 assisted resident #003.

Observations were done of resident #003 on an identified date. At the same time of the observations staff #109 and staff #110 were interviewed. Staff #110 confirmed that they were assigned to resident #003 and indicated that they were

not aware of any concerns related to resident #003. During an interview on an identified date, staff #106 confirmed that they were aware of resident #003 interventions in the care plan but stated that they had a rationale for not following the plan of care.

The home failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A critical incident (CI) was submitted to the Director.

A review of the CI indicated that staff #104 responded to the incident and resident #001 was transferred to a facility for further medical intervention. A clinical review identified that resident #001 was assessed. Further review also identified a care plan identifying a potential for injury related to a medical condition. A review of progress notes identified the following incidents: On an identified date, resident #001 had an incident. On an identified date, resident #001 had an incident; and on a subsequent date resident #001 had another incident. Staff #108 also identified resident #001 was a risk. A review of resident's #001 assessments completed on identified dates indicated resident #001 was a risk. On an identified date after the last incident, resident #001 was reassessed by staff #112 and the assessment indicated that they remained a risk.

During and interview, staff #102 confirmed that they did not reassess resident's #001 after the incidents. During an interview the Director of Care (DOC) verified that they expected a reassessment when the plan of care was not effective or there changes with the resident health condition. The DOC confirmed that they were not aware of the previous incidents and considered those examples that would necessitate a reassessment. The DOC expected resident #001 to be reassessed at the time of the incidents and confirmed resident #001 was not reassessed and their plan of care reviewed and revised when care set out in the plan was not effective. [s. 6. (10) (c)]

4. The licensee failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A review of the progress notes identified the following incidents; on an identified date, resident #003 had an incident. On an identified date, resident #003 had an incident. Staff #107 assisted resident #003. On an identified date, resident #003 had an incident. Staff #103 assisted resident #003. An assessment on an identified date, indicated that resident #003 was a risk. On an identified date, another assessment was completed and indicated that resident #003 was a risk.

During an interview, the DOC confirmed that they were not aware of the incidents The DOC considered the incidents as examples that would necessitate a reassessment. During an interview, staff #107 confirmed that they should have reassessed resident #003. The DOC confirmed resident #003 was not reassessed and their plan of care reviewed and revised when care set out in the plan were not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002 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

Issued on this 7 th day of February, 2020 (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
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AILEEN GRABA (682) - (A1)
Inspection No. / No de l'inspection :	2020_704682_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024311-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 07, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare St. Catharines 283 Pelham Road, St. Catharines, ON, L2S-1X7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Freeman

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must be compliant with s.6 (10) of the LTCHA.

Specifically, the licensee shall ensure that:
A) Resident #001 and resident #003 receive a comprehensive assessment and that their plans of care are reviewed and revised.

B) The home's comprehensive assessment for residents includes but is not limited to:
• Compliance with licensee's policy

C) Training is provided to staff on the home's policy and how to complete and evaluate the results of the home's comprehensive assessment.

D) Attendance records and training content are maintained related to this training.

Grounds / Motifs :

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

1. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A critical incident (CI) was submitted to the Director.

A review of the CI indicated that staff #104 responded to the incident and resident #001 was transferred for further medical intervention.

A clinical review identified that resident #001 was assessed. Further review also identified a care plan identifying a potential for injury. A review of progress notes identified the following incidents: On an identified date, resident #001 had an incident. On an identified date, resident #001 had an incident; and on a subsequent date resident #001 had another incident. On an identified date, staff #108 also identified resident #001 was a risk. A review of resident's #001 assessments completed on identified dates indicated resident #001 was a risk. On an identified date after the last incident, resident #001 was reassessed by staff #112 and the assessment indicated that they remained a risk.

During and interview, staff #102 confirmed that they did not reassess resident's #001 after the incidents. During an interview the Director of Care (DOC) verified that they expected a reassessment when the plan of care was not effective or when there were changes with the resident's health condition. The DOC confirmed that they were not aware of the previous incidents and considered those examples that would necessitate a reassessment. The DOC expected resident #001 to be reassessed at the time of the incidents and confirmed resident #001 was not reassessed and their plan of care reviewed and revised when care set out in the plan was not effective. [s. 6. (10) (c)] (682)

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

(A1)
2. The licensee failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A review of the progress notes identified the following incidents; on an identified date, resident #003 had an incident. On an identified date, resident #003 had an incident. Staff #107 assisted resident #003. On an identified date, resident #003 had an incident and staff #103 assisted resident #003.

An assessment on an identified date, indicated that resident #003 was a risk. On an identified date, another assessment was completed and indicated that resident #003 was a risk.

During an interview, the DOC confirmed that they were not aware of the incidents The DOC considered the incidents as examples that would necessitate a smoking reassessment. During an interview, staff #107 confirmed that they should have reassessed resident #003. The DOC confirmed resident #003 was not reassessed and their plan of care reviewed and revised when care set out in the plan were not effective. [s. 6. (10) (c)]

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 2 as it related to two of three residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this subsection of the ACT that included:
~ Voluntary plan of correction (VPC) issued May 14, 2019, (2019_569508_0016)
~ Written notification (WN) issued September 12, 2017, (2017_663682_0007)
~ Written notification (WN) issued May 11, 2017, (2017_551526_0007)
~ Compliance order (CO) #001 issued May 11, 2017, with a compliance due date of September 12, 2017, (2017_551526_0007) (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2020

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee shall ensure that:
A) The care set out in resident #001 and resident #003 plan of care is provided as specified in their plans of care.

B) An audit is completed at a frequency and schedule determined by the licensee; to monitor if staff are providing care as set out in resident's #001 and resident's #003 plan of care.
ii) Corrective action is taken when the audit identified care set out in the plan of care was not provided as specified in the plan.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A critical incident (CI) was submitted to the Director.

The clinical record was reviewed which included the care plan that identified resident #001 had an intervention to prevent injury.

During an interview staff #104 and staff #105 confirmed that the resident did not have the identified intervention at the time of the incident on an identified date. Staff #104 confirmed that the care set out in the plan of care was not provided to resident #001 as specified in the plan. (682)

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

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A clinical review included a care plan that identified resident #003 had the potential for injury. A review of the progress notes identified the following incidents; on an identified date resident #003 had an incident. On an identified date, resident #003 had a subsequent incident and staff #103 assisted resident #003. On an identified date, resident #003 had an incident. Staff #103 assisted resident #003.

Observations were done of resident #003 on an identified date. At the same time of the observations, staff #109 and staff #110 were interviewed. Staff #110 confirmed that they were assigned to resident #003 and indicated that they were not aware of any concerns related to resident #003.

During an interview on an identified date, staff #106 confirmed that they were aware of resident #003 interventions in the care plan but stated that they had a rationale for not following the plan of care.

The home failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan. [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was minimal harm/risk to resident #001. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 2 compliance history as they had one or more non-compliance none of which are the same subsection being cited:
~ Voluntary plan of correction (VPC) issued May 14, 2019, (2019_569508_0016)
~ Written notification (WN) issued September 12, 2017, (2017_663682_0007)
~ Written notification (WN) issued May 11, 2017, (2017_551526_0007)
~ Compliance order (CO) #001 issued May 11, 2017, with a compliance due date of September 12, 2017, (2017_551526_0007)
(682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
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 7 th day of February, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by AILEEN GRABA (682) - (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