Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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119 King Street West 11th Floor
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Telephone: (905) 546-8294
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2018	2018_543561_0010	016033-18	Complaint

Licensee/Titulaire de permis

Shalom Village Nursing Home
60 Macklin Street North HAMILTON ON L8S 3S1

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

Shalom Village Nursing Home
70 Macklin Street North HAMILTON ON L8S 3S1

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

DARIA TRZOS (561)

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): July 9, and 11, 2018

Interviews were also completed offsite on July 17 and July 24, 2018.

A Critical Incident System (CIS) report number 2775-000007-18, log number 014449 -18, was submitted to the Director related to neglect of the resident by staff that resulted in harm to the resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Recreation Staff, Personal Support Workers (PSWs), family member and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed clinical records, investigation notes, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care on an identified date in 2018, related to neglect of resident #001, resulting in injury.

The licensee's investigation notes were reviewed by LTCH Inspector #561 and indicated that resident #001 was seen in a specific location and had an incident. The staff in the home tried to assist the resident several times, but the resident was uncooperative. After a period of time staff were alerted that the resident had a change in condition. Registered staff and PSWs assisted the resident and provided treatment. The resident was assessed by the physician and was diagnosed with several injuries.

Registered staff #102, #104 and PSW #103 were interviewed and confirmed the incident. After the incident, the resident's condition deteriorated.

The written plan of care at the time of the incident, for resident #001 was reviewed and indicated that the resident had identified behaviours. The written plan of care indicated that the resident was at high risk for a specific diagnosis had interventions in place for dealing with the identified diagnosis.

During the interview with registered staff #102, they confirmed that the interventions in the plan of care were not provided to the resident as specified in the plan.
The licensee failed to ensure that the care was provided to the resident as specified in the plan.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #014449-18 and a Complaint Inspection log #016033-18. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written hot weather related illness prevention and management plan that met the needs of the residents.

During an interview with registered staff #102, they indicated that the home did not have a protocol in place for heat advisories during weekends. The home was equipped with several doors that lead to an outdoor space; all doors were unlocked but closed. Once a person goes outside into the area, the doors are unlocked and they cannot be locked from the outside to prevent exit seeking residents from entering the area unattended. Registered staff #104 was interviewed and stated that during a heat advisory the doors to the area were to be locked. On an identified date, they did not receive warning about heat; therefore, the doors to the area were being left unlocked.

The DOC was interviewed and stated that prior to an incident, the policy was that the on call Supervisor after receiving a heat warning from Public Health, would notify the nurse in charge in the building via email. The DOC stated there was no protocol in place to ensure that staff become aware of the heat warning in case the Supervisor was not able to get that message out to them. On the identified date, the home had technical system issues and they were not informed of the heat warning and were not able to notify the nurse in charge of the heat warning. The doors were not locked to ensure that residents remained indoors. The home had revised the protocol after the incident.

The licensee failed to ensure that there was a written hot weather related illness prevention and management plan that met the needs of the residents.

This area of non-compliance was identified during a CIS Inspection log #014449-18 and a Complaint Inspection log #016033-18. [s. 20. (1)]

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

Interviews with PSW #105 and PSW #103 indicated that the doors to an identified outdoor space should always be locked. It was explained that PSW staff did not take residents outside as they would not be able to monitor residents outside, only recreation staff took residents outside for programs.
Registered staff #104 was interviewed and stated that the doors to the area were to be locked during winter and when there was a heat advisory.

The interview with the DOC indicated that the policy in the home was to keep doors closed but not locked during regular days. During heat advisory the expectation was to keep residents inside.

The home's policy titled "Resident Safety and Security", reference number 002020.47, last reviewed on December 23, 2015, indicated that the doors leading to outdoor secured areas such as courtyards or terraces were equipped with secured locks requiring a code to open. Doors were to be secured by this means unless they were under the direct supervision of a staff member.

The home's policy related to safety and security of residents was reviewed by the LTCH Inspector during the inspection and did not reflect the current lock system of doors leading to the area. The home was equipped with a specific device to lock those doors. There was no code used to open those doors as stated in the home's policy.

The Administrator was interviewed and acknowledged that the policy did not reflect the current system in the home. The Administrator also stated that the home was working towards changing the process to ensure that the area leading to the area was more secure and safe for residents.

The licensee failed to ensure that the doors to the area were locked when not supervised by staff members.

This area of non-compliance was identified during a CIS Inspection log #014449-18 and a Complaint Inspection log #016033-18. [s. 9. (1) 1.1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that home was equipped with a resident-staff communication that clearly indicated when activated where the signal was coming from.

During the inspection, LTCH Inspector #561 observed a secured outdoor space in the home. The home was equipped with a resident-staff communication system; however, when activated it did not sound and the staff were not able to hear the sound. Registered staff #106 was alerted by LTCH Inspector #561 and tested the alarm with the Inspector. The registered staff indicated that PSWs were carrying pagers, but the pagers were not activated when the alarm was pulled in the area. The sound could not be heard and the pagers were not activated as well. The registered staff confirmed that if the alarm was activated by someone in the area the PSWs or registered staff would not have been alerted if assistance was required.

The Administrator was interviewed and indicated that they were not aware that the alarm did not sound to alert staff of where the signal was coming from and stated that it would be fixed.

The licensee failed to ensure that the resident-staff communication response system clearly indicated when activated where the signal was coming from.

This area of non-compliance was identified during a CIS Inspection log #014449-18 and a Complaint Inspection log #016033-18. [s. 17. (1) (f)]

Issued on this 6th day of November, 2018

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

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

Ministére de la Santé et des Soins de longue durée

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2018_543561_0010
Log No. / Registre no:	016033-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 22, 2018
Licensee / Titulaire de permis :	Shalom Village Nursing Home 60 Macklin Street North, HAMILTON, ON, L8S-3S1
LTC Home / Foyer de SLD :	Shalom Village Nursing Home 70 Macklin Street North, HAMILTON, ON, L8S-3S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeanette O'Leary

To Shalom Village Nursing Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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, 2007.

Specifically, the licensee must:
1. Ensure that the care set out in the plan of care for resident #001 and any other resident in the home is provided to the residents 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 the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care on an identified date in 2018, related to neglect of resident #001, resulting in injury.

The licensee's investigation notes were reviewed by LTCH Inspector #561 and indicated that resident #001 was seen in a specific location and had an incident. The staff in the home tried to assist the resident several times, but the resident was uncooperative. After a period of time staff were alerted that the resident had a change in condition. Registered staff and PSWs assisted the resident and provided treatment. The resident was assessed by the physician and was diagnosed with several injuries.

Registered staff #102, #104 and PSW #103 were interviewed and confirmed the incident. After the incident, the resident's condition deteriorated.

The written plan of care at the time of the incident, for resident #001 was

reviewed and indicated that the resident had identified behaviours. The written plan of care indicated that the resident was at high risk for a specific diagnosis had interventions in place for dealing with the identified diagnosis.

During the interview with registered staff #102, they confirmed that the interventions in the plan of care were not provided to the resident as specified in the plan.

The licensee failed to ensure that the care was provided to the resident as specified in the plan.

This area of non-compliance was identified during a CIS Inspection log #014449 -18 and a Complaint Inspection log #016033-18.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 4 history as they had multiple NC with a Voluntary Plan of Correction (VPC) to the current area of concern issued under this section on December 7, 2017 (2016_573581_0001), and on November 2, 2015 (2015_322156_0017). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the Ontario Regulation 79/10.

Specifically, the licensee must:
1. Review and revise the hot weather related illness prevention and management plan to ensure it reflects current practices and meets the needs of the home.
2. Ensure that all staff in the home receive training on the revised policy related to the hot weather related illness prevention and management plan. The home shall keep records of the training.
3. Establish an auditing process to ensure that staff in the home comply with the home's hot weather related policy.

Grounds / Motifs :

1. The licensee failed to ensure that there was a written hot weather related illness prevention and management plan that met the needs of the residents.

During an interview with registered staff #102, they indicated that the home did not have a protocol in place for heat advisories during weekends. The home was equipped with several doors that lead to an outdoor space; all doors were unlocked but closed. Once a person goes outside into the area, the doors are unlocked and they cannot be locked from the outside to prevent exit seeking residents from entering the area unattended.
Registered staff #104 was interviewed and stated that during a heat advisory the doors to the area were to be locked. On an identified date, they did not receive warning about heat; therefore, the doors to the area were being left unlocked.

The DOC was interviewed and stated that prior to an incident, the policy was that the on call Supervisor after receiving a heat warning from Public Health, would notify the nurse in charge in the building via email. The DOC stated there was no protocol in place to ensure that staff become aware of the heat warning in case the Supervisor was not able to get that message out to them. On the identified date, the home had technical system issues and they were not informed of the heat warning and were not able to notify the nurse in charge of the heat warning. The doors were not locked to ensure that residents remained indoors. The home had revised the protocol after the incident.
The licensee failed to ensure that there was a written hot weather related illness prevention and management plan that met the needs of the residents.

This area of non-compliance was identified during a CIS Inspection log #014449 -18 and a Complaint Inspection log #016033-18.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 2 history as they had previous unrelated non-compliance with the legislation. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with s. 9 (1) of the Ontario Regulation 79/10.

Specifically they must:
1. Revise the policy related to doors in the home to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. Educate all staff in the home on the revised policy related to doors in the home. The licensee shall keep records of the training.
3. Ensure that doors are secured at all times, unless supervised by staff of the home.

Grounds / Motifs :

1. The licensee failed to ensure that doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

Interviews with PSW #105 and PSW #103 indicated that the doors to an identified outdoor space should always be locked. It was explained that PSW staff did not take residents outside as they would not be able to monitor residents outside, only recreation staff took residents outside for programs. The registered staff #104 was interviewed and stated that the doors to the area were to be locked during winter and when there was a heat advisory.

The interview with the DOC indicated that the policy in the home was to keep doors closed but not locked during regular days. During heat advisory the expectation was to keep residents inside.

The home's policy titled "Resident Safety and Security", reference number 002020.47, last reviewed on December 23, 2015, indicated that the doors leading to outdoor secured areas such as courtyards or terraces were equipped with secured locks requiring a code to open. Doors were to be secured by this means unless they were under the direct supervision of a staff member.

The home's policy related to safety and security of residents was reviewed by the LTCH Inspector during the inspection and did not reflect the current lock system of doors leading to the area. The home was equipped with a device to lock those doors. There was no code used to open those doors as stated in the home's policy.

The Administrator was interviewed and acknowledged that the policy did not reflect the current system in the home. The Administrator also stated that the home was working towards changing the process to ensure that the area leading to the area was more secure and safe for residents.
The licensee failed to ensure that the doors to the area were locked when not supervised by staff members.

This area of non-compliance was identified during a CIS Inspection log #014449 -18 and a Complaint Inspection log #016033-18.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 4 history as they had a Voluntary Plan of Correction (VPC) to the current area of concern issued on November 2, 2015 (2015_322156_0017). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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