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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
May 30, 2022	2022_548756_0005 (A1)	019509-21	Complaint

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive Ottawa ON K1V 8N5

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

St. Patrick's Home
2865 Riverside Drive Ottawa ON K1V 8N5

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

Amended by LISA CUMMINGS (756) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This public inspection report has been revised to reflect the correct compliance history. The Complaint inspection, #2022_548756_0005, was completed on March 24, 2022.

Issued on this 30th day of May, 2022 (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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
May 30, 2022	2022_548756_0005 (A1)	019509-21	Complaint

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive Ottawa ON K1V 8N5

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

St. Patrick's Home
2865 Riverside Drive Ottawa ON K1V 8N5

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

Amended by LISA CUMMINGS (756) - (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): March 14, 15, 16, 17, 18, 22, 23 and 24, 2022.

The following intakes were completed during this Complaint inspection:

Log # 019509-21 inspected related to the provision of care and services, recreational activities and fall incidents.

During the course of the inspection, the inspector(s) spoke with the Vice President of Nursing (VP of Nursing), the Assistant Vice President of Nursing (AVP of Nursing), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), agency companions, recreational staff, and the resident.

During the course of the inspection, the inspectors reviewed the resident health care records and other pertinent documents including policies; Head Injury Routine Flowsheet (IX NSG E-11.00(a) – Appendix A), Head Injury Routine (HIR) (IX NSG E 11.10, revised April 2021), and Fall Prevention and Management (IX NSG E-11.00, revised April 2016). The Inspectors observed residents, resident home areas, the provision of care and services to residents, staff to resident interactions, resident to resident interactions and infection prevention and control practices.

A non-compliance under Ontario Regulation 79/10 s. 8 (1) (b) was included in this inspection report from concurrent inspection #2022_548756_0006.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Recreation and Social Activities

During the course of the original inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 Fall Prevention and Management Policy and the Head Injury Routine (HIR) Policy was complied with for residents #001, #003, and #006.

O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 49 (2) requires that this program include that when a resident has fallen, the resident is assessed, and a post-fall assessment is conducted using a clinically appropriate instrument as required.

The policy described that when a resident has fallen, the registered staff will complete a post fall assessment including physical assessment for injuries and document a Post Fall Assessment in Point Click Care. This includes documenting the status of the resident, notification of family, assessment, outcomes and interventions taken to prevent further falls or related injury.

Resident #001 had an unwitnessed fall that resulted in a transfer to hospital with an injury.

A review of the resident’s health care records confirmed that no post fall assessment was found for the resident's fall.

An RN confirmed that a post fall assessment was not completed at the time of the fall for the resident.

Sources: Fall Prevention and Management Policy, resident health care record and

interview with an RN and others. [s. 8.]

2. O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury and O. Reg. 79/10, s. 49 (1) requires the licensee to have a falls prevention and management program that includes strategies to mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's Head Injury Routine (HIR) Policy. The home's HIR policy required that all un-witnessed resident falls will be assessed as a potential head injury.

Resident #006 had an unwitnessed fall and a HIR was initiated. The HIR assessment was initiated but the initial assessment at the time of fall, the second 30 minute assessment, and a two hour assessment were missing.

The AVP of Nursing confirmed that the resident's HIR flowsheet was not completed. As a result, there was a risk that if resident #006 had sustained a head injury, it may not have been identified and treated.

Sources: Resident health care record, Head Injury Routine Flowsheet, Head Injury Routine (HIR) Policy, interview with AVP of Nursing and others. [s.8.]

3. Specifically, staff did not comply with the home's Head Injury Routine (HIR) Policy for resident #003. The home's HIR policy required that all unwitnessed resident falls be assessed as a potential head injury and if no alternate orders are given by the resident's physician, the HIR must continue.

Resident #003 had an unwitnessed fall and an HIR was initiated. The initial HIR assessment was completed and the next assessment was documented seven hours later. The VP of Nursing confirmed that the resident's HIR flowsheet was not completed. As a result, there was risk that if resident #003 had sustained a head injury, it may not have been identified and treated.

Sources: Resident #003's progress notes, HIR flowsheets, Head Injury Routine Policy, interview with the VP of nursing.

4. Specifically, staff did not comply with the home's Fall Prevention and Management Policy for resident #003.

The home's fall prevention and management policy indicated that if the fall occurs the registered staff will ensure that the resident is not moved prior to the completion of a preliminary assessment.

An agency companion staff found the resident on the floor and transferred resident #003 back to bed prior to the nursing assessment. Interviews with an RN and an RPN indicated that the agency companion staff did not call the registered staff to assess the resident before the transfer.

As such resident #003 was not assessed by the registered staff prior to their transfer, which may have led to a delay in the resident receiving an assessment for further injury.

Sources: Resident progress notes, Fall Prevention and Management Policy, interviews with an RN and an RPN. [s. 8. (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. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning.

The resident's plan of care indicated that the resident required assistance with oral care twice daily and as needed.

Interviews with two PSW's indicated that they are not assisting the resident with oral care in the morning. As such not providing oral care to the resident may increase the risk of harm to the resident’s oral tissues.

Sources: Resident plan of care, interview with PSW's. [s. 34. (1) (a)]

Issued on this 30th day of May, 2022 (A1)

[redacted]

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 LISA CUMMINGS (756) - (A1)
Inspection No. / No de l'inspection :	2022_548756_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019509-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 30, 2022(A1)
Licensee / Titulaire de permis :	St. Patrick's Home of Ottawa Inc. 2865 Riverside Drive, Ottawa, ON, K1V-8N5
LTC Home / Foyer de SLD :	St. Patrick's Home 2865 Riverside Drive, Ottawa, ON, K1V-8N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Morris

To St. Patrick's Home of Ottawa 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 :

O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 8 (1).

Specifically, the licensee shall ensure that their Falls Prevention and Management Policy is complied with.

To that effect, the licensee shall develop and implement education, monitoring, communication, and remedial processes as follows:

A) Educate all registered staff on the Falls Prevention and Management Policy, ensuring that education includes the head injury routine, post-fall assessments and the completion of an assessment by registered staff prior to the resident being transferred after a fall.

B) Ensure that post-fall assessments and head injury routine assessments are initiated and completed in compliance with the licensee's Fall Prevention and Management Policy and that registered staff communicate between shifts to ensure completion.

C) Conduct audits at least weekly, on different shifts, for a minimum of four consecutive weeks to assess compliance of the Falls Prevention and Management Policy, until consistent compliance is achieved.

D) Take immediate corrective action if deviations occur from the established Falls Prevention and Management Policy.

E) A written record must be kept for everything required under (a), (b), (c) and (d).

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 Fall Prevention and Management Policy and the Head Injury Routine (HIR) Policy was complied with for residents #001, #003, and #006.

O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 49 (2) requires that this program include that when a resident has fallen, the resident is assessed, and a post-fall assessment is conducted using a clinically appropriate instrument as required.

The policy described that when a resident has fallen, the registered staff will complete a post fall assessment including physical assessment for injuries and document a Post Fall Assessment in Point Click Care. This includes documenting the status of the resident, notification of family, assessment, outcomes and interventions taken to prevent further falls or related injury.

Resident #001 had an unwitnessed fall that resulted in a transfer to hospital with an injury.

A review of the resident’s health care records confirmed that no post fall assessment was found for the resident's fall.

An RN confirmed that a post fall assessment was not completed at the time of the fall for the resident.

Sources: Fall Prevention and Management Policy, resident health care record and interview with an RN and others. [s. 8.] (756)

2. O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury and O. Reg. 79/10, s. 49 (1) requires the licensee to have a falls prevention and management program that includes strategies to mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's Head Injury Routine (HIR) Policy. The home's HIR policy required that all un-witnessed resident falls will be assessed as a potential head injury.

Resident #006 had an unwitnessed fall and a HIR was initiated. The HIR assessment was initiated but the initial assessment at the time of fall, the second 30 minute assessment, and a two hour assessment were missing.

The AVP of Nursing confirmed that the resident's HIR flowsheet was not completed. As a result, there was a risk that if resident #006 had sustained a head injury, it may not have been identified and treated.

Sources: Resident health care record, Head Injury Routine Flowsheet, Head Injury Routine (HIR) Policy, interview with AVP of Nursing and others. [s.8.] (756)

(A1)
3. Specifically, staff did not comply with the home's Head Injury Routine (HIR) Policy for resident #003. The home's HIR policy required that all unwitnessed resident falls be assessed as a potential head injury and if no alternate orders are given by the resident's physician, the HIR must continue.

Resident #003 had an unwitnessed fall and an HIR was initiated. The initial HIR assessment was completed and the next assessment was documented seven hours later. The VP of Nursing confirmed that the resident's HIR flowsheet was not completed. As a result, there was risk that if resident #003 had sustained a head injury, it may not have been identified and treated.

Sources: Resident #003's progress notes, HIR flowsheets, Head Injury Routine Policy, interview with the VP of nursing.

4. Specifically, staff did not comply with the home's Fall Prevention and Management Policy for resident #003.

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 home’s fall prevention and management policy indicated that if the fall occurs the registered staff will ensure that the resident is not moved prior to the completion of a preliminary assessment.

An agency companion staff found the resident on the floor and transferred resident #003 back to bed prior to the nursing assessment. Interviews with an RN and an RPN indicated that the agency companion staff did not call the registered staff to assess the resident before the transfer.

As such resident #003 was not assessed by the registered staff prior to their transfer, which may have led to a delay in the resident receiving an assessment for further injury.

Sources: Resident progress notes, Fall Prevention and Management Policy, interviews with an RN and an RPN. [s. 8. (1)]

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

Severity: There was risk of harm to the residents who's head injury routines, transfers and post-fall assessments were not completed as per policy.
Scope: This non-compliance was a pattern as the head injury routine according to the Head Injury Routine (HIR) policy was not followed for two of the three residents, and the transfer and post-fall assessment was not completed for each one of the three residents according to the falls prevention and management policy reviewed during this inspection.
Compliance History: Two voluntary plan of corrections (VPC) and two written notifications (WN) were issued to the home related to the same subsection since March 19, 2019. (705004)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 08, 2022

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 30th day of May, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by LISA CUMMINGS (756) - (A1)

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

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