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
Jun 17, 2020	2019_820130_0017 (A1)	020780-19, 021578-19, 021630-19, 022344-19, 023010-19, 023743-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

West Park Health Centre
103 Pelham Road St. Catharines ON L2S 1S9

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

Amended by STACEY GUTHRIE (750) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

See extension of Compliance Due Date for s. 24 to July 31, 2020.

Issued on this 17th day of June, 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*

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West Park Health Centre
103 Pelham Road St. Catharines ON L2S 1S9

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

Amended by STACEY GUTHRIE (750) - (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): December 4, 5, 6, 9, 10,

11, 12, 13, 16 and 17, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed residents and resident care, reviewed relevant resident clinical records, investigation notes, critical incident reports and staff education reports.

This inspection was conducted related to the following intakes:

Log # 020780-19 related to prevention of abuse and neglect;

Log # 021578-19 related to prevention of abuse and neglect;

Log # 021630-19 related to prevention of abuse and neglect;

Log # 022344-19 related to prevention of abuse and neglect;

Log # 023010-19 related to prevention of abuse and neglect and responsive behaviours;

Log # 023743-19 related to critical incident reporting.

PLEASE NOTE: This Critical Incident inspection was conducted concurrently with the following Complaint inspection 2019_820130_0016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Interim Director of Care (IDOC), the Resident Assessment Instrument Coordinator (RAI), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **4 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home's policy titled: Zero Tolerance of resident Abuse and Neglect: Responses and Reporting, stated: (1) Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time (2) The person reporting the suspected abuse will follow the home's reporting process and provincial requirements to ensure the information is provided to the home Administrator/designate immediately.

A) On an identified date in 2019, the home submitted CI: 1500-000029-19, which described an allegation of staff to resident abuse, involving residents #005, #006 and #008.

The allegation of abuse was reported by PSW #106 to RN #107 on the same date

the CI was submitted. The RN immediately reported the allegation to the DOC and Administrator.

PSW #106 alleged that they witnessed PSW #105, abuse residents #005, #006 and #008 approximately two months prior to the report date. PSW #106 confirmed in an interview that they could not recall the dates the abuse occurred and that they did not immediately report the abuse in fear of retaliation from PSW #105.

B) On another identified date in 2019, the home submitted CI: 1500-000030-19, which described an allegation of staff to resident abuse of resident #003.

The allegation of abuse was reported by PSW #104, who alleged they witnessed PSW#105, abuse resident #003. PSW #104 confirmed in an interview that they could not recall the date the abuse occurred and that they did not immediately report the abuse in fear of retaliation from PSW #105.

The Administrator confirmed in an interview that both PSW #104 and #106 did not immediately report allegations of abuse of residents #003, #005, #006 and #008. [s. 24. (1)] (130)

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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment; Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered Resident Assessment Protocols (RAPs) and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD) and any significant change in resident's condition, either decline or improvement, to be reassessed along with RAPs by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.

The licensee did not comply with the conditions to which the licensee was subject for resident #001, #002 and 003, in relation to the completion of the RAI-MDS assessments.

A) The Annual RAI-MDS assessment completed for resident #001 on an identified date in 2019, identified 11/18 triggered new, modified or existing RAPs; however, there was no description of the problem/need of the resident and no care plan objectives specified for each of the triggered RAPS.

B) The Quarterly RAI-MDS assessment completed on an identified date in 2019, for resident #002 identified a significant change in status related to a decline, specifically triggered by behaviours. The resident was not reassessed using the MDS Full assessment within 14 days of the determination that a significant change had occurred. Reassessment of the significant change was recorded in a

progress note by the RAI Coordinator approximately three months later.

C) The Quarterly RAI-MDS assessment completed for resident #003 on an identified date in 2019, identified 13/18 triggered new, modified or existing RAPs. For each of the triggered RAPs, there was no description of the problem/need of the resident and no care plan objectives specified.

The RAI Coordinator confirmed in an interview that due to time constraints, not all RAI-MDS assessments were complete when submitted to the Canadian Institute for Health Information (CIHI).
[s. 101. (4)] (130)

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 the licensee meets the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system as set out in the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that resident #003 was reassessed at least weekly by a member of the registered nursing staff, when they were exhibiting altered skin integrity.

On an identified date in 2019, resident #003 was assessed by the wound care champion for alteration in skin to an identified area. The area of impaired skin was not reassessed until two weeks after the initial assessment and was reassessed every two weeks thereafter until a specified date two months later.

According to an assessment completed on a specified date in 2019, resident #003 was assessed for another area of impaired skin. A review of the clinical record indicated there was no reassessments completed of the affected area after the initial assessment.

The Interim DOC confirmed in an interview the resident #003 did not have weekly reassessments completed when they were exhibiting impaired skin integrity. [s. 50. (2) (b) (iv)] (130)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Findings/Faits saillants :

The licensee failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstance of an unexpected death, followed by the report required under subsection (4).

During a review of the clinical record for resident #011, it was identified that the resident was admitted to the home in 2019 with a number of diagnoses.

The resident had been admitted from their home as the resident had specific responsive behaviours . The clinical records indicated that the resident was assessed upon admission to the home and no concerns were noted with the resident's health condition. The following day, the resident exhibited specific behaviour. The RN called the physician to obtained a when necessary (PRN) order for a specific medication, which was administered to the resident at an identified time; a number of hours later, it was documented that the resident slept for most of the shift.

The next day, the PSW reported to the registered staff that resident #011 had a change in their level of consciousness and difficulty eating.

The following morning, the resident was administered the ordered medication due to a behavior and became drowsy. The resident was weak and lethargic. The resident's vital signs were obtained and it was identified that a vital sign was

unstable. The staff attempted to administer a treatment to the resident but resident refused. Staff called the physician and the resident's family.

At a specific time, the resident was administered the same prescribed medication for a specific behaviour. The registered staff indicated that this was effective; however, the resident again became lethargic and their condition was declining.

Registered staff spoke with the family about transferring resident to hospital; however, they did not want the resident transferred out. The physician was going to start the resident on a specific medication; however family did not want this implemented at that time. Later that day, the physician spoke with the family of resident #011 and they indicated they did not want any interventions at this time. The physician wrote specific orders in the event the resident continued to decline.

The following morning, the resident had an unwitnessed fall. No injuries were noted based on the post fall assessment.

On seventh day after their admission, the resident's condition deteriorated and medication was administered. A few hours later, the resident was noted to still be declining; analgesics were administered for comfort.

Three hours later, the resident was found in bed with no vital signs.
During interview with the ED and through review of the documentation, it was confirmed that the resident was not admitted for palliative care. The resident had a change in condition and died unexpectedly eight (8) days after admission.

Issued on this 17th day of June, 2020 (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 STACEY GUTHRIE (750) - (A1)
Inspection No. / No de l'inspection :	2019_820130_0017 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020780-19, 021578-19, 021630-19, 022344-19, 023010-19, 023743-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 17, 2020(A1)
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	West Park Health Centre 103 Pelham Road, St. Catharines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sharon Darby

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 CVH (No. 1) LP, 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. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

The licensee must be compliant s. 24 (1) 2.

The licensee must ensure that a person who has reasonable grounds to suspect abuse of a resident, reports the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

The licensee is ordered to complete the following:
1. Provide mandatory re-education for all staff on prevention of Abuse and Neglect, including reporting expectations, whistle-blowing protection, as well as the types of abuse and what constitutes neglect of a resident.
2. Initiate quality monitoring activities and analysis to ensure ongoing compliance with the home's abuse policy.
3. Ensure documentation is available on staff retraining on Prevention of Abuse and Neglect.

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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home's policy titled: Zero Tolerance of resident Abuse and Neglect: Responses and Reporting, stated: (1) Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time (2) The person reporting the suspected abuse will follow the home's reporting process and provincial requirements to ensure the information is provided to the home Administrator/designate immediately.

A) On an identified date in 2019, the home submitted CI: 1500-000029-19, which described an allegation of staff to resident abuse, involving residents #005, #006 and #008.

The allegation of abuse was reported by PSW #106 to RN #107 on the same date the CI was submitted. The RN immediately reported the allegation to the DOC and Administrator.

PSW #106 alleged that they witnessed PSW #105, abuse residents #005, #006 and #008 approximately two months prior to the report date. PSW #106 confirmed in an interview that they could not recall the dates the abuse occurred and that they did not immediately report the abuse in fear of retaliation from PSW #105.

B) On another identified date in 2019, the home submitted CI: 1500-000030-19, which described an allegation of staff to resident abuse of resident #003.

The allegation of abuse was reported by PSW #104, who alleged they witnessed PSW#105, abuse resident #003. PSW #104 confirmed in an interview that they could not recall the date the abuse occurred and that they did not immediately report the abuse in fear of retaliation from PSW #105.

The Administrator confirmed in an interview that both PSW #104 and #106 did not

immediately report allegations of abuse of residents #003, #005, #006 and #008. [s. 24. (1)] (130)

The severity of this issue was determined to be a level 1 as there was minimum risk to the resident. The scope of the issue was a level 3 as it was related to four residents. The home had a level 3 compliance history of a previous WN issued on February 12, 2019.
(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2020(A1)

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 17th day of June, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by STACEY GUTHRIE (750) - (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 : Hamilton Service Area Office