Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2020	2020_569508_0015 (A1)	002861-20, 005612-20, 010839-20, 011143-20, 012111-20, 014647-20, 017196-20, 017842-20	Critical Incident System

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court BURLINGTON ON L7N 3N6

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

Millennium Trail Manor
6861 Oakwood Drive NIAGARA FALLS ON L2E 6S5

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

Amended by ROSEANNE WESTERN (508) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home requested a few days extension on the compliance order for s. 19(1) with a CDD of October 27, 2020. This was approved due to COVID-19 outbreak and staff not available to complete education and comply order by the 27th.

New CDD is October 30, 2020. Please see report and compliance order for s. 19(1) for details.

Issued on this 26th day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2020	2020_569508_0015 (A1)	002861-20, 005612-20, 010839-20, 011143-20, 012111-20, 014647-20, 017196-20, 017842-20	Critical Incident System

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3700 Billings Court BURLINGTON ON L7N 3N6

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

Millennium Trail Manor
6861 Oakwood Drive NIAGARA FALLS ON L2E 6S5

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

Amended by ROSEANNE WESTERN (508) - (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): September 8, 9, 10, 14, 15, 17, 18, 22, 23, 24, 2020.

The following intakes were completed during this complaint inspection:

-Log #002861-20 related to resident to resident abuse;

-Log #010839-20 related to resident to resident abuse;

-Log #005612-20 related to an injury of a resident of unknown cause;

-Log #011143-20 related to an injury of a resident of unknown cause;

-Log #012111-20 related to a fall resulting in an injury;

-Log #017196-20 related to alleged staff to resident abuse;

-Log #017842-20 related to alleged staff to resident abuse

Please Note: This Critical Incident System (CIS) inspection was conducted concurrently during complaint inspection report #2020_569508_0014.

During the course of the inspection, the inspectors toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures, internal investigative notes, the home's staffing plan and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOCs), the Resident Assessment Instrument (RAI) Coordinator, Human Resources Manager, Nursing Operational Assistant, registered staff, Personal

Support Workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect by staff in the home.

A resident had a change in their condition throughout the night shift and into day shift in 2020.

The resident's treatment plan indicated that resident wanted to be transferred to hospital if deemed required by the attending physician.

RPN #130 assessed the resident and identified that they had a change in their condition. The RPN provided an intervention to the resident and RN #129 was notified. The RN directed the RPN to monitor resident.

The PSW received report that morning that the resident had a change in their condition throughout the night. Later that morning, the PSW was called into the resident's room by another PSW as they had concerns related to the resident's condition. PSW #116 reported to the RPN and later to RN #129 that the resident should be transferred out to hospital as per the resident's care treatment plan.

The resident was again reassessed and it was noted that the resident was experiencing complications. RN #129 decided to refer the resident to the Nurse Practitioner (NP) when they came in.

RN #129 reported to RN #124, who was reporting in for the day shift, that the resident had a change in their condition. RN #124 went and assessed the resident but also decided to wait for the NP.

The NP came in that morning. There was no report provided to the NP regarding

this resident's condition and the NP confirmed they were not called. The NP only became aware that this resident had an issue when they reviewed report.

The NP assessed the resident and confirmed the resident had a change in their condition and required further interventions that could not be provided at the home. The NP transferred the resident to hospital where the resident was admitted and received treatment for their diagnosis.

RN #124 and RN #129 acknowledged that there was actual harm to the resident when they did not call the NP/physician or a Manager on call and failed to transfer the resident out to the hospital when they had a sudden change in condition.

Sources: Interviews with PSW #116, RN #124 and RN #129, the LTCH investigative notes, resident clinical records. [s. 19. (1)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 Acute Changes in Resident Condition policy included in the required Nursing program was complied with for a resident.

LTCHA s. 8(1)(a) requires an organized program of nursing services for the home to meet the assessed needs of the resident.

Specifically, the home did not comply with the "Acute Changes in Resident Condition" policy, dated July 3, 2020.

The policy directed registered staff to notify the attending physician or Nurse Practitioner (NP) to offer an enhanced assessment when a resident has an acute sudden change in their condition.

A resident had a change in their condition throughout the night shift and into day shift in 2020.

The resident's treatment plan indicated that resident wanted to be transferred to hospital if deemed required by the attending physician.

RPN #130 assessed the resident and identified that they had a change in their condition. The RPN provided an intervention to the resident and RN #129 was notified. The RN directed the RPN to monitor resident.

The PSW received report that morning that the resident had a change in their condition throughout the night. Later that morning, the PSW was called into the resident's room by another PSW as they had concerns related to the resident's condition. PSW #116 reported to the RPN and later to RN #129 that the resident

should be transferred out to hospital as per the resident's care treatment plan.

The resident was reassessed and it was noted that the resident had symptoms. RN #129 decided to refer the resident to the Nurse Practitioner (NP) when they came in.

RN #129 reported to RN #124, who was reporting in for the day shift, that the resident had a change in their condition. RN #124 went and assessed the resident but also decided to wait for the NP.

The NP came in that morning. There was no report provided to the NP regarding this resident's condition and the NP confirmed they were not called. The NP only became aware that this resident had an issue when they reviewed report.

The NP assessed the resident and confirmed the resident had a change in their condition and required further interventions that could not be provided at the home. The NP transferred the resident to hospital where the resident was admitted and received treatment for their diagnosis.

RN #124 and RN #129 acknowledged that there was actual harm to the resident when they did not call the NP/physician or a Manager on call and failed to transfer resident out to the hospital when they had a sudden change in condition.

Sources: Interviews with NP, RN #124 and #129 , resident clinical records, home’s investigative notes and the Acute Changes in Resident Condition policy, revised July 3, 2020. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that care was provided to a resident as specified in their plan.

The resident who required the assistance of 1-2 staff was not provided assistance as required with their care. PSW staff left the resident to sleep for an extensive period of time and did not provide the assistance they required including assistance with their meal. The resident did not consume their meal which was a potential risk for this resident due to their diagnosis. The DOC confirmed that care was not provided to this resident.

Sources: Interview with DOC and other staff, record reviews, CIS report. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care is provided to resident #005 as specified in their plan, to be implemented voluntarily.

Issued on this 26th day of October, 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 ROSEANNE WESTERN (508) - (A1)
Inspection No. / No de l'inspection :	2020_569508_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002861-20, 005612-20, 010839-20, 011143-20, 012111-20, 014647-20, 017196-20, 017842-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 26, 2020(A1)
Licensee / Titulaire de permis :	955464 Ontario Limited 3700 Billings Court, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	Millennium Trail Manor 6861 Oakwood Drive, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Turcotte

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 955464 Ontario Limited, 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA:

1. Provide education to RPN #113, RPN #130, RN #124 and RN #129 on the home's Abuse policy, specifically neglect, including the definition of neglect;
2. Ensure that the 'Managers on Call' list and schedule including their contact information is posted in all units in addition to the RN office;
3. Ensure the 'Managers on Call' list and schedule is communicated to all registered staff, including agency staff where staff can locate this information;
4. Document the education including the date completed and staff signatures.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #009 was protected from neglect by staff in the home.

A resident had a change in their condition throughout the night shift and into day shift in 2020.

The resident's treatment plan indicated that resident wanted to be transferred to hospital if deemed required by the attending physician.

RPN #130 assessed the resident and identified that they had a change in their condition. The RPN provided an intervention to the resident and RN #129 was notified. The RN directed the RPN to monitor resident.

The PSW received report that morning that the resident had a change in their condition throughout the night. Later that morning, the PSW was called into the resident's room by another PSW as they had concerns related to the resident's condition. PSW #116 reported to the RPN and later to RN #129 that the resident should be transferred out to hospital as per the resident's care treatment plan.

The resident was again reassessed and it was noted that the resident was experiencing complications. RN #129 decided to refer the resident to the Nurse Practitioner (NP) when they came in.

RN #129 reported to RN #124, who was reporting in for the day shift, that the resident had a change in their condition. RN #124 went and assessed the resident but also decided to wait for the NP.

The NP came in that morning. There was no report provided to the NP regarding this resident's condition and the NP confirmed they were not called. The NP only became aware that this resident had an issue when they reviewed report.

The NP assessed the resident and confirmed the resident had a change in their condition and required further interventions that could not be provided at the home. The NP transferred the resident to hospital where the resident was admitted and received treatment for their diagnosis.

RN #124 and RN #129 acknowledged that there was actual harm to the resident when they did not call the NP/physician or a Manager on call and failed to transfer the resident out to the hospital when they had a sudden change in condition.

Sources: Interviews with PSW #116, RN #124 and RN #129, the LTCH investigative notes, resident clinical records.

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

Severity: The resident had a change in their condition. This resulted in actual harm to the resident as the resident had to be transferred to hospital where they were admitted and required acute care interventions.

Scope: This non-compliance was isolated as three allegations of abuse/neglect were

inspected, one out of three resulted in non-compliance.

Compliance History: Two Voluntary Plan of Correction (VPCs) were issued to the home related to this section in the past 36 months.

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

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

Specifically the licensee must:

1. Provide education to RPN #113, RPN #130 and RN #124 on the home's Acute Changes in Resident Condition policy and ensure sign off sheets are completed for these staff;
2. Document the education including the date completed and staff signatures.

Grounds / Motifs :

1. The licensee has failed to ensure that the Acute Changes in Resident Condition policies and procedures included in the required Nursing program were complied with for resident #009.

LTCHA s. 8(1)(a) requires an organized program of nursing services for the home to meet the assessed needs of the resident.

Specifically, the home did not comply with the "Acute Changes in Resident Condition" policies and procedures, dated July 3, 2020.

The policy directed registered staff to notify the attending physician or Nurse Practitioner (NP) to offer an enhanced assessment when a resident has an acute sudden change in their condition.

A resident had a change in their condition throughout the night shift and into day shift in 2020.

The resident's treatment plan indicated that resident wanted to be transferred to hospital if deemed required by the attending physician.

RPN #130 assessed the resident and identified that they had a change in their condition. The RPN provided an intervention to the resident and RN #129 was notified. The RN directed the RPN to monitor resident.

The PSW received report that morning that the resident had a change in their condition throughout the night. Later that morning, the PSW was called into the resident's room by another PSW as they had concerns related to the resident's condition. PSW #116 reported to the RPN and later to RN #129 that the resident should be transferred out to hospital as per the resident's care treatment plan.

The resident was reassessed and it was noted that the resident had symptoms. RN #129 decided to refer the resident to the Nurse Practitioner (NP) when they came in.

RN #129 reported to RN #124, who was reporting in for the day shift, that the resident had a change in their condition. RN #124 went and assessed the resident but also decided to wait for the NP.

The NP came in that morning. There was no report provided to the NP regarding this resident's condition and the NP confirmed they were not called. The NP only became aware that this resident had an issue when they reviewed report.

The NP assessed the resident and confirmed the resident had a change in their condition and required further interventions that could not be provided at the home. The NP transferred the resident to hospital where the resident was admitted and received treatment for their diagnosis.

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

RN #124 and RN #129 acknowledged that there was actual harm to the resident when they did not call the NP/physician or a Manager on call and failed to transfer resident out to the hospital when they had a sudden change in condition.

Sources: Interviews with NP, RN #124 and #129 , resident clinical records, home's investigative notes and the Acute Changes in Resident Condition policy, revised July 3, 2020.

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

Severity: The staff did not follow the home's Acute Changes in Condition policy nor the resident's care treatment plan which resulted in actual harm to the resident.

Scope: This non-compliance was isolated as there was one policy out of four that were not complied with.

Compliance History: One Voluntary Plan of Correction was issued to the home in the past 36 months.

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 13, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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:

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

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.

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

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 26th day of October, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by ROSEANNE WESTERN (508) - (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