Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2018	2018_743536_0005	007081-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of Norfolk County
50 Colborne Street South SIMCOE ON N3Y 3H3

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

Norview Lodge
44 Rob Blake Way P.O. Box 604 SIMCOE ON N3Y 4L8

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

CATHIE ROBITAILLE (536), KELLY HAYES (583), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): April 10, 11, 12, 13, 16, 18, 19, 20, 23, 24 and 25, 2018.

The following inspections were completed concurrently with the Resident Quality (RQI) Inspection.

Inquiries

Log #003740-18, CIS #M624-000003-18 –pertaining to unexpected death
Log #008113-18, CIS #M624-000006-18-pertaining to abuse

Critical Incident System (CIS) Reports

Log #028517-17, CIS #M624-000018-17-pertaining to abuse
Log #007833-18, CIS #M624-000007-18-pertaining to abuse
Log #008208-18, CIS #M624-000008-18-pertaining to abuse

Complaints

Log #022071-17-pertaining to personal support services

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, Registered Dietitian (RD), Social Worker, Supervisor of Programs and Volunteer Services , Resident Assessment Instrument-Minimum Data Set Co-Ordinator(RAI-MDS) staff, Nursing and Personal Care Supervisors, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed meal services, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including but not limited to: staffing schedules, clinical health records, investigation reports, meeting minutes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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	Legendé 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) On an identified date, resident #015 was not administered their prescribed medication in accordance with the directions specified by the resident's physician. The identified Electronic Medication Administration Record (EMAR) for resident #015, identified that the physician had ordered the resident to have a specified medication at an identified time. The EMAR for an identified date, revealed that the resident's pain level was an identified number out of ten prior to the missed dose of medication. The next pain level recorded was an identified date and time, prior to the next scheduled dose of medication and was unchanged from the previous level. A review of the Institute for Safe Medication Practices (ISMP), system improvement strategies identified the importance of focus reinforced with nursing staff and the home to consider ways to minimize distractions and interruptions during medication passes. Interview with the Director of Care (DOC), identified that pain levels are done prior to each analgesic administration. The DOC also confirmed that the resident's dose of the identified medication was omitted and not provided in accordance with the directions for use specified by the prescriber.

B) On an identified date, resident #016 was not administered their prescribed medication in accordance with the directions specified by the resident's physician. The identified EMAR for resident #016, identified that the resident's physician had ordered the resident to receive the identified medication at a specified time. On the date of the medication incident, the EMAR revealed that the resident's pain level was an identified number out of ten prior to the missed dose of medication. The next two pain levels for resident #016 were elevated from the previous pain level. On an identified date and time, the progress note stated that resident #016 was given an as needed (PRN) medication. The resident indicated that their pain level at that time had improved. One hour later another progress note stated the resident's pain level had again improved. A review of the Institute for Safe Medication Practices (ISMP) stated: that it is best practice to administer medications before checking it off on the EMAR. This will help limit missed doses. Interview with the DOC confirmed that the resident's dose of the specified medication was omitted and not provided in accordance with the directions for use specified by the prescriber.

C) On an identified date, resident #017 was not administered their prescribed medication in accordance with the directions specified by the resident's physician. The identified EMAR for resident #017, identified that the physician ordered the resident to receive the identified medication at identified times. The Medication Incident Report identified that the medication had been signed for at specified times and that the resident had been given an extra dose of the specified medication at an identified time. A review of the Institute for Safe Medication Practices (ISMP) stated: it is recommended that nursing

diligent at double checking hour of administration on the EMAR for all medications.Interview with the DOC confirmed that the resident's dose of the specified medication was administered at an identified date and time and was not administered in accordance with the directions for use specified by the prescriber. [511] [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Substitute Decision Maker(SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #019 was admitted to the home on an identified date. They had an identified medical history related to skin integrity dating back many years. Record review of the skin assessment completed by the home, showed that there were no skin issues on admission to the home.

A review of resident's progress notes identified that on a specified date an abnormality on the residents skin was noted. A note was left for the Doctor/Nurse Practitioner's for further assessment. Review of the Physician's order showed that on a specified date, the Nurse Practitioner (NP) assessed the resident and documented what they had observed and assessed.

Resident #019's progress notes revealed that on a specified date, the resident complained of discomfort to an identified area of their body. A referral to Physician/Nurse Practitioner was made for further assessment but, it was later noted that no assessment was completed.

Review of resident #019's progress notes and home's investigation notes showed that on a specified date, the resident's daughter noticed an abnormality different to what they had previously seen, and brought it to staff's attention. They added that this area of altered skin integrity did not look like this upon admission. The resident's Physician was called by the resident's daughter and came in to assess the resident the same day.

The home's policy titled Communication to Family Members, last revised: October 26, 2016, stated that registered staff need to immediately notify family/substitute decision maker of any changes in resident's condition.

Review of home's investigation notes and interview with Registered Nurse (RN) #104, confirmed that the resident's SDM was not contacted when there was a change in resident's condition. The SDM was not provided an opportunity to participate in the development of resident #019's plan of care. [696] [s. 6. (5)]

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 and ensuring that Substitute Decision Maker was provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible.

A) During the Resident Quality Inspection (RQI) stage two, resident #004 triggered for an increase in their responsive behaviour, from their previous Minimum Data Set(MDS) assessment, to their most recent MDS assessment.

A review of the resident's clinical record identified a Resident Assessment Protocol (RAP) for both periods, that described the resident behaviour to have deteriorated and that it would be addressed in the mood and behaviour care plan. A review of the resident's care plan described the staff were to document the intensity, duration and frequency to determine a pattern of the behaviour to possibly determine the cause. No

further documentation was available that identified the intensity, duration and frequency to determine a pattern of the behaviour to possibly determine the cause.

During interview, Registered Practical Nurse(RPN) #109 confirmed that the intervention for documenting the intensity, duration and frequency was to determine a pattern of behaviour and identify behavioural triggers, where possible. Interview with Registered Nurse(RN) #117 confirmed that resident #004 had demonstrated responsive behaviours, and the behavioural triggers for the resident were not identified, where possible. The care plan failed to identify behavioural triggers for resident #004.

B) During the RQI stage two, resident #010 triggered for an increase in their responsive behaviour, from their previous MDS assessment, to their most recent MDS assessment.

A review of the resident's clinical record identified that the resident had no behaviours in the MDS and corresponding RAP. On an identified date, a new RAP described the resident had exhibited a specified behaviour on one to three days in the seven day observation period, and that this would be documented in the resident’s care plan. A review of the seven day observation flow sheet, confirmed the resident had exhibited the specified behaviour on three of the seven days. A review of the resident's care plan described that the staff were to document the intensity, duration and frequency, to determine a pattern of the behaviour to possibly determine the cause. No further documentation was available that identified the intensity, duration and frequency to determine a pattern of the behaviour.

During interview, RN #109 confirmed the intervention for documenting the intensity, duration and frequency was to determine a pattern of behaviour and identify behavioural triggers, where possible. Interview with RPN #123 confirmed resident #010 had demonstrated responsive behaviours and that documentation to identify the intensity, duration and frequency was not completed in order to determine a potential trigger. The care plan failed to identify behavioural triggers for resident #010.

The licensee failed to ensure that for resident #004 and #010, who demonstrated responsive behaviours, that the behavioural triggers for the residents were identified, in the residents plan of care where possible. [s. 53. (4) (a)]

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 and ensuring that each resident demonstrating responsive behaviours, that the behavioural triggers for the resident are identified, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques to assist residents with eating, including safe positioning of residents who required assistance were used.

A dining observation of the lunch service was completed in a specified dining room on an identified date. Resident #018 was being fed by volunteer #125 in an identified chair while in a specified position. Registered Practical Nurse (RPN) #115 confirmed that the resident was not positioned as required and repositioned the resident. A review of the nutrition plan of care identified resident #018 was at high nutrition risk related to a number of identified reasons.

During interview with the Registered Dietitian and with the Supervisor of Programs and Volunteers on specified dates, it was identified that the homes staff and students were to position residents while feeding using some the below strategies unless specified otherwise in the plan of care, based on the home's training:

- Residents were to be feed in an upright position
- Residents were not to be feed in tilt position
- Resident were not to be slumped to one side
- When volunteers or students identified issues with positioning, they were to notify registered staff as the home's staff were required to do the repositioning

On an identified date, RPN #115 confirmed that resident #018 who required assistance with feeding was not positioned safely. [s. 73. (1) 10.]

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 and ensuring that proper techniques to assist residents with eating, including safe positioning of residents who required assistance are used, to be implemented voluntarily.

WN #5: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with. In accordance with O. Reg.79/10, s. 8(1) in the Act requires the licensee to have a program that meets the assessed needs of resident's individualized personal care, including hygiene care and grooming, on a daily basis.

Specifically, staff did not comply with the licensee's policy regarding Personal Hygiene-HSS/NVL, dated May 2013, which was part of the licensee's Nursing program. The policy stated the toiletries required for special needs will be individually purchased and labelled.

During a tour of the home on a specified date and time, the following personal hygiene items were identified on two of the eight home areas, to be in use and not individually labelled:

A) An identified unit spa room had two containers of Vitarub that were open with product removed and one stick of Nivea Deodorant not labelled. An interview with Personal Support Worker (PSW) #120 stated they worked full time and that all personal bath items, creams and lotions were to be labelled with the resident name to prevent cross contamination during use. The staff member stated that residents' personal items were to be placed in their own individualized baskets that were kept in the spa room.

B) Another identified unit spa room had two containers of Vitarub, one black comb, one bottle of Natura body lotion and one Speedstick deodorant not labelled. During interview PSW #121 stated they worked full time and that all personal toiletries were to be individually labelled. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

On an identified date, a review was completed of the Family Council minutes for 2017 meeting under new business, the minutes identified that the program and volunteer supervisor were going to follow up on three concerns voiced by the council with the home which included:

i) More lighting needed at the front entrance
ii) Littering of trash at main entrance
iii) Beds being turned back too early in the day

On review of the June 2017, meeting minutes, answers to all of the concerns brought forth at the February meeting were addressed. During the time of the inspection, the program and volunteer supervisor was unavailable for interview. During interview with the Administrator, they confirmed that a written response had not been provided to the Family Council within ten business days of receiving the concern. [s. 60. (2)]

Issued on this 1st day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHIE ROBITAILLE (536), KELLY HAYES (583), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2018_743536_0005
Log No. / No de registre :	007081-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 17, 2018
Licensee / Titulaire de permis :	The Corporation of Norfolk County 50 Colborne Street South, SIMCOE, ON, N3Y-3H3
LTC Home / Foyer de SLD :	Norview Lodge 44 Rob Blake Way, P.O. Box 604, SIMCOE, ON, N3Y-4L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Nolan

To The Corporation of Norfolk County, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that resident #015, #016, and all other residents prescribed to receive narcotics including palliative residents, are administered the narcotics at the time prescribed by the physician.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) On an identified date, resident #015 was not administered their prescribed medication in accordance with the directions specified by the resident's physician. The identified Electronic Medication Administration Record (EMAR) for resident #015, identified that the physician had ordered the resident to have a specified medication at an identified time. The EMAR for an identified date, revealed that the resident's pain level was an identified number out of ten prior to the missed dose of medication. The next pain level recorded was an identified date and time, prior to the next scheduled dose of medication and was unchanged from the previous level. A review of the Institute for Safe Medication Practices (ISMP), system improvement strategies identified the importance of focus reinforced with nursing staff and the home to consider ways to minimize distractions and interruptions during medication passes. Interview with the Director of Care (DOC), identified that pain levels are done prior to each analgesic administration. The DOC also confirmed that the resident's dose of the identified medication was omitted and not provided in accordance with the directions for use specified by the prescriber.

B) On an identified date, resident #016 was not administered their prescribed medication in accordance with the directions specified by the resident's

physician. The identified EMAR for resident #016, identified that the resident's physician had ordered the resident to receive the identified medication at a specified time. On the date of the medication incident, the EMAR revealed that the resident's pain level was an identified number out of ten prior to the missed dose of medication. The next two pain levels for resident #016 were elevated from the previous pain level. On an identified date and time, the progress note stated that resident #016 was given an as needed (PRN) medication. The resident indicated that their pain level at that time had improved. One hour later another progress note stated the resident's pain level had again improved. A review of the Institute for Safe Medication Practices (ISMP) stated: that it is best practice to administer medications before checking it off on the EMAR. This will help limit missed doses. Interview with the DOC confirmed that the resident's dose of the specified medication was omitted and not provided in accordance with the directions for use specified by the prescriber.

C) On an identified date, resident #017 was not administered their prescribed medication in accordance with the directions specified by the resident's physician. The identified EMAR for resident #017, identified that the physician ordered the resident to receive the identified medication at identified times. The Medication Incident Report identified that the medication had been signed for at specified times and that the resident had been given an extra dose of the specified medication at an identified time. A review of the Institute for Safe Medication Practices (ISMP) stated: it is recommended that nursing staff be diligent at double checking hour of administration on the EMAR for all medications.Interview with the DOC confirmed that the resident's dose of the specified medication was administered at an identified date and time and was not administered in accordance with the directions for use specified by the prescriber. [511]

This order is made up on the application of the factors of severity (2), scope (3), and compliance history (4), in keeping with s. 131(2) of the Regulation, in respect to severity of potential harm for resident #015, #016 and #017, the scope of this being a widespread issue in the home, and the licensee history of non-compliance with a VPC issued August 22, 2017(2017_558123_0011), and a WN issued February 25, 2016 (2015_322156_0023). [511]
(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 20, 2018

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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 May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Cathie Robitaille

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