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
Feb 12, 2021	2021_661683_0001 (A1)	015440-20, 015441-20, 015443-20, 015444-20, 015445-20, 015676-20, 021953-20, 022340-20, 024603-20, 025283-20, 025305-20	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 Hamilton ON L8N 4A6

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

St. Joseph's Villa, Dundas
56 Governor's Road Dundas ON L9H 5G7

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 12nd day of February, 2021 (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

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56 Governor's Road Dundas ON L9H 5G7

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

Amended by LISA BOS (683) - (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): January 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25 and 26, 2021.

This inspection was completed concurrently with complaint inspection #2021_661683_0002.

The following intakes were completed during this critical incident inspection:

log #015676-20, CIS #2975-000035-20 was related to falls prevention and management;

log #021953-20, CIS #2975-000056-20 was related to the prevention of abuse and neglect;

log #022340-20, CIS #2975-000060-20 was related to falls prevention and management;

log #024603-20, CIS #2975-000066-20 was related to falls prevention and management;

log #025283-20, CIS #2975-000068-20 was related to responsive behaviours; and

log #025305-20, CIS #2975-000069-20 was related to falls prevention and management.

The following follow up inspections were completed concurrently with this critical incident inspection:

log #015445-20 was related to CO #001 from inspection #2020_661683_0010 regarding LTCHA, s. 24 (1);

log #015444-20 was related to CO #002 from inspection #2020_661683_0008 regarding O. Reg. 79/10, s. 36;

log #015443-20 was related to CO #003 from inspection #2020_661683_0008 regarding O. Reg. 79/10, s. 49;

log #015440-20 was related to CO #004 from inspection #2020_661683_0008 regarding O. Reg. 79/10, s. 131 (2); and

log #015441-20 was related to CO #005 from inspection #2020_661683_0008 regarding LTCHA, s. 19 (1).

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director(s) of Care (DOC), Assistant Director(s) of Care (ADOC), Resident Care Managers (RCM), Resident Assessment Instrument (RAI) Coordinator, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) observed the provision of care, resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, training records, auditing records, internal investigation notes and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #004	2020_661683_0008	682
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #005	2020_661683_0008	683
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2020_661683_0010	683
O.Reg 79/10 s. 49.	CO #003	2020_661683_0008	683

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

The home's Resident Handling - Lifts, Transfers and Repositioning policy indicated that for residents who had fallen, there was a no lift policy in place to ensure both staff and resident safety. Specifically, the policy indicated that "a mechanical lifting device will be used to 'lift' any resident who has fallen to the floor if they are unable to safety assist themselves (i.e. resident can weight bear

and is able to stand up when a chair is placed in front of them to assist themselves)."

A) A resident sustained a fall which resulted in an injury. The head to toe assessment completed by a Registered Practical Nurse (RPN) indicated that the resident was able to stand up with minimal assistance.

In an interview with a RPN, they indicated that minimal assistance with hands on support was used to get the resident up off the floor.

In interviews with a Resident Care Manager (RCM) and Director of Care (DOC), they acknowledged that staff were not to provide any hands-on support to assist residents up after a fall. They indicated that the policy was for a mechanical lifting device to be used unless the resident was able to safely assist themselves to stand up.

The home's no lift policy was put in place to ensure both staff and resident safety and a RPN put a resident at risk for further pain/injury when they used hands on assistance to help the resident up after a fall.

Sources: Critical Incident (CI) report; Resident Handling - Lifts, Transfers and Repositioning policy; a resident’s clinical record; interviews with a RPN, RCM, DOC and other staff.

B) A resident sustained a fall and a RPN documented that the resident was helped up and put back into bed. The following day, the resident expressed pain and they were transferred to hospital and diagnosed with an injury.

In interviews with a PSW and RPN, who responded to the resident's fall, they identified that they used a transfer method that required physical support to get the resident up off the floor after the fall.

In interviews with a RCM and DOC, they acknowledged that staff were not to provide any hands on assistance to help residents up after a fall. They indicated that the policy was for a mechanical lifting device to be used unless the resident was able to safely assist themselves to stand up, and that the staff should not have used a transfer method that required physical support to lift the resident up after their fall.

A PSW and RPN put a resident at further risk of pain/injury when they transferred them up off the floor using physical support, instead of a mechanical lift or no physical assistance, as per their policy, which was put in place to ensure both staff and resident safety.

Sources: CI report; Resident Handling - Lifts, Transfers and Repositioning policy; a resident's clinical record; interviews with a PSW, RPN, RCM, DOC and other staff. [s. 36.]

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a responsive behaviour incident, assessments, effectiveness of interventions and resident responses were documented.

The licensee's Documentation Guidelines for Registered Nurses policy indicated that any documentation not completed at the time of the shift of observation must be identified as "late entry," the reason for late entry must be specified and should not exceed 48 hours.

A CI report indicated that documentation was "missed" by a RPN regarding a responsive behaviour incident observed by a PSW. The PSW reported the incident between two residents to the RPN, who did not document the incident until six days later.

The day after the incident, another RPN documented that one of the residents involved in the altercation had an area of altered skin integrity. They stated that they did not see any documentation of the incident between the two residents that occurred the day prior, so they suspected the area of altered skin integrity was from an unrelated source.

The RPN who failed to document the incident stated that they assessed the resident's area of altered skin integrity the next day and acknowledged that they still did not document or inform anyone of the incident reported to them by the PSW the day prior.

A RCM stated that the RPN did not document any assessments or action taken related to the incident for six days. The late entry documentation within the resident's clinical record was greater than 48 hours of the incident and did not specify the reason as to why they did not document within the shift.

By not documenting timely assessments and actions taken in response to the incident, oncoming staff did not suspect the resident's area of altered skin integrity was from an altercation with a co-resident and no new interventions were in place which put both residents at risk of future incidents.

Sources: CI report; Documentation Guidelines for Registered Nursing Staff policy; resident clinical records; interviews with a PSW, RPNs, RCM and other staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were advised at the beginning of every shift of each resident whose behaviours required heightened monitoring because those behaviours posed a potential risk to the residents or others.

A CI report indicated that there was an incident between two residents that was reported to a RPN by a PSW. In an interview with a RPN that worked the following day, they confirmed that they did not receive any verbal or written communication that identified the responsive behaviour incident, risks or action plan at the change of shift. The RPN who was originally informed of the incident stated that they were overwhelmed that day, and that they did not report or document the incident until several days later.

A RCM confirmed that the RPN informed them of the altercation between residents six days after the incident via electronic correspondence. They also confirmed that the RPN did not communicate the incident to direct care staff at the change of shift or print a copy of the responsive behaviour note for the physician's communication book on the date of the incident.

By not advising all direct care staff of behaviours, risk and action plans at the change of shift for care plan review and discussion, the residents were both at risk for future incidents.

Sources: CI report; Identification of and Management of a Resident with Responsive Behaviours policy; resident clinical records; interviews with RPNs, RCM, and other staff. [s. 55. (b)]

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 all direct care staff are advised at the beginning of ever shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

Issued on this 12nd day of February, 2021 (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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA BOS (683) - (A1)
Inspection No. / No de l'inspection :	2021_661683_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015440-20, 015441-20, 015443-20, 015444-20, 015445-20, 015676-20, 021953-20, 022340-20, 024603-20, 025283-20, 025305-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 12, 2021(A1)
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, Hamilton, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Dundas 56 Governor's Road, Dundas, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jaimie Williams

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 St. Joseph's Health System, 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)

Linked to Existing Order / Lien vers ordre existant: 2020_661683_0008, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:
1. Ensure that staff use safe transferring techniques when assisting residents up off the floor after a fall;
2. Re-educate PSW #117, RPN #120 and RPN #130 on the home's Resident Handling - Lifts, Transfers and Repositioning policy;
3. Document the education including the date the education was provided, and the staff member who provided the education;
4. Perform a minimum of one audit each week on a resident who has fallen (if applicable) to ensure that staff assisted the resident off the floor in accordance with the home's policy; and
5. Document the audits and continue auditing until no further concerns arise with staff assisting residents up after a fall in accordance with the home's policy.

Grounds / Motifs :

1. Compliance order #002 related to O. Reg. 79/10, s. 36 from inspection #2020_661683_0008 issued on July 24, 2020, with a compliance due date of September 18, 2020, is being re-issued as follows:

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

The home's Resident Handling - Lifts, Transfers and Repositioning policy indicated that for residents who had fallen, there was a no lift policy in place to ensure both staff and resident safety. Specifically, the policy indicated that "a mechanical lifting device will be used to 'lift' any resident who has fallen to the floor if they are unable to safety assist themselves (i.e. resident can weight bear and is able to stand up when a chair is placed in front of them to assist themselves)."

A) A resident sustained a fall which resulted in an injury. The head to toe assessment completed by a Registered Practical Nurse (RPN) indicated that the resident was able to stand up with minimal assistance.

In an interview with a RPN, they indicated that minimal assistance with hands on support was used to get the resident up off the floor.

In interviews with a Resident Care Manager (RCM) and Director of Care (DOC), they acknowledged that staff were not to provide any hands-on support to assist residents up after a fall. They indicated that the policy was for a mechanical lifting device to be used unless the resident was able to safely assist themselves to stand up.

The home's no lift policy was put in place to ensure both staff and resident safety and a RPN put a resident at risk for further pain/injury when they used hands on assistance to help the resident up after a fall.

Sources: Critical Incident (CI) report; Resident Handling - Lifts, Transfers and Repositioning policy; a resident's clinical record; interviews with a RPN, RCM, DOC and other staff.

B) A resident sustained a fall and a RPN documented that the resident was helped up and put back into bed. The following day, the resident expressed pain and they were transferred to hospital and diagnosed with an injury.

In interviews with a PSW and RPN, who responded to the resident's fall, they identified that they used a transfer method that required physical support to get the resident up off the floor after the fall.

In interviews with a RCM and DOC, they acknowledged that staff were not to provide

any hands on assistance to help residents up after a fall. They indicated that the policy was for a mechanical lifting device to be used unless the resident was able to safely assist themselves to stand up, and that the staff should not have used a transfer method that required physical support to lift the resident up after their fall.

A PSW and RPN put a resident at further risk of pain/injury when they transferred them up off the floor using physical support, instead of a mechanical lift or no physical assistance, as per their policy, which was put in place to ensure both staff and resident safety.

Sources: CI report; Resident Handling - Lifts, Transfers and Repositioning policy; a resident's clinical record; interviews with a PSW, RPN, RCM, DOC and other staff. [s. 36.]

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

Severity: There was actual risk of harm to the residents as a resident was diagnosed with an injury and by staff using an unsafe transfer method, it may have increased the risk of pain or further injury to the resident.

Scope: Out of the three residents reviewed, two residents were not transferred up off the floor after a fall safely in accordance with the home's policy.

Compliance history: The licensee continues to be in non-compliance with s. 36 of O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #002 was issued on July 24, 2020 (inspection #2020_661683_0008) with a compliance due date of September 18, 2020. In the past 36 months, 18 other COs were issued to different sections of the legislation, all of which have been complied. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 22, 2021(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

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 12nd day of February, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by LISA BOS (683) - (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