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
Jan 10, 2022	2021_848748_0015 (A1)	009742-21, 012741-21, 012821-21, 013980-21, 015005-21	Critical Incident System

Licensee/Titulaire de permis

Waterdown Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Alexander Place
329 Parkside Drive P.O. Box 50 Waterdown ON L0R 2H0

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

Amended by EMMY HARTMANN (748) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This licensee inspection report has been revised to reflect an adjustment to the compliance due date (CDD) for compliance order (CO) #001 pursuant to Ontario Regulation 79/10, s. 50 (2). The Critical Incident Inspection #2021_848748_0015 was completed on October 29, November 1, 2, 3, 4, 5, 8, 9, 10, 12, 15, 16, 17, 2021.

A copy of the revised report is attached.

Issued on this 10th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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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
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Licensee/Titulaire de permis

Waterdown Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Alexander Place
329 Parkside Drive P.O. Box 50 Waterdown ON L0R 2H0

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

Amended by EMMY HARTMANN (748) - (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): October 29, November 1, 2, 3, 4, 5, 8, 9, 10, 12, 15, 16, 17, 2021.

The following intakes were completed during this Critical Incident Inspection:

Log #009742-21, was related to a fall of a resident resulting in injury.

Log #012741-21, was related to an allegation of staff to residents neglect, and continence care.

Log #012821-21, was related to a fall of a resident resulting in injury.

Log #013980-21, was related to an allegation of improper care of a resident; skin and wound, and hydration.

Log #015005-21, was related to an injury of unknown cause.

This inspection was completed concurrently with Complaint Inspection (CO) #2021_848748_0014. Non-compliance in section 6 (7) of the LTCHA was identified in this inspection, and issued in the complaint report.

During the course of the inspection, the inspector(s) spoke with residents, the Acting Administrator, Director of care (DOC), Restorative Care Coordinator, RAI Coordinator, Staffing Clerk, Receptionist, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), and personal support assistants (PSA).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that three residents' altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

1. A resident had altered skin integrity that was assessed and measured on an identified date. The next assessment was completed 14 days later, and the wound had increased in size. Another 14 days later, the wound was re-assessed to have deteriorated, and an increase in size was noted. The resident was seen by specialist on an identified date, and the next assessment was not completed until 25 days later, where the wound was noted to have further increased in size.

In a span of less than two months, the home implemented various interventions to promote healing of the resident's altered skin integrity.

The DOC reviewed the resident's clinical record and verified that their altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff, and that it had been clinically indicated.

By failing to assess the resident's altered skin integrity weekly, the effectiveness

of the interventions that were implemented to promote healing may not have been monitored.

Sources: A resident's clinical record; interview with DOC #101.

2. An assessment was completed of a resident's altered skin integrity, and a measurement was taken. The next assessments of their altered skin integrity were not completed until 100 days later, and then 16 days later.

The DOC reviewed the resident's clinical record and verified that their altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff, and that it had been clinically indicated.

There was a risk that a deterioration of the resident's altered skin integrity would not have been identified as it was not assessed on a weekly basis.

Sources: A resident's clinical record; interview with DOC #101.

3. A skin assessment was completed on a resident's altered skin integrity on an identified date, which indicated a new skin impairment. A review of their clinical record 13 days later, identified no further assessments of the area of skin impairment.

Inspector #683 observed the resident's altered skin integrity was still present, and an RN acknowledged that the resident's altered skin integrity had not healed.

An RN and the DOC reviewed the resident's clinical record and verified that their altered skin integrity was not reassessed at least weekly by a member of the registered staff, and that it was clinically indicated.

Sources: A resident's clinical record; interview with RN #121 and DOC #101.

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. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that residents' linens were changed at least once a week or more often as needed.

On an identified date, 12 residents in a specified Home Area required their bed linens to be changed; however, a PSW placed a towel and folded sheet on top of the bed linen, instead of changing the sheets.

The DOC acknowledged that the home's procedure was to change residents' bedding when they needed to be changed, and that the home's procedure was not implemented by the PSW, on the identified date.

Sources: Home's internal investigation notes; interview with DOC #101 [s. 89. (1) (a) (i)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents' substitute decision-makers (SDM) were notified of the results of an alleged neglect investigation immediately upon completion of the investigation.

An allegation that 17 residents did not receive care on a specified shift, was submitted to the licensee.

Two residents who required assistance with their activities of daily living were to be checked and given care on rounds, during a specific shift.

A) A resident's SDM was notified of the allegation that the resident was not provided care during a specific shift. There was no further documentation in their clinical record to suggest that their SDM was notified of the results of the alleged neglect investigation upon completion.

B) The Restorative Care Coordinator documented that they notified a resident's SDM that they were not provided care appropriately on a specific shift, and that their SDM wished to have a follow up call once the Acting Administrator completed their investigation. There was no further documentation in the resident's clinical record to suggest that their SDM was notified of the results of the investigation.

In an interview with the Acting Administrator, they acknowledged that they called some residents' families regarding the outcome of the alleged neglect investigation and that a general announcement was made at a family council meeting, but that the two residents' SDMs were not directly notified of the results of the investigation.

Sources: Two residents' clinical records; interview with the Administrator.

Issued on this 10th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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 EMMY HARTMANN (748) - (A1)
Inspection No. / No de l'inspection :	2021_848748_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009742-21, 012741-21, 012821-21, 013980-21, 015005-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 10, 2022(A1)
Licensee / Titulaire de permis :	Waterdown Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Alexander Place 329 Parkside Drive, P.O. Box 50, Waterdown, ON, L0R-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Priester

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 Waterdown Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must comply with s. 50 (2) of Ontario Regulation 79/10.

Specifically, the licensee must:
1. Ensure that resident #008, #011 and #013's areas of altered skin integrity are reassessed weekly by member of the registered nursing staff, if clinically indicated.
2. Complete a weekly audit of residents #008, #011 and #013 to ensure that weekly skin assessments are completed, if clinically indicated. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.
3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

Grounds / Motifs :

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

1. The licensee has failed to ensure that three residents' altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

A resident had altered skin integrity that was assessed and measured on an identified date. The next assessment was completed 14 days later, and the wound had increased in size. Another 14 days later, the wound was re-assessed to have deteriorated, and an increase in size was noted. The resident was seen by specialist on an identified date, and the next assessment was not completed until 25 days later, where the wound was noted to have further increased in size.

In a span of less than two months, the home implemented various interventions to promote healing of the resident's altered skin integrity.

The DOC reviewed the resident's clinical record and verified that their altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff, and that it had been clinically indicated.

By failing to assess the resident's altered skin integrity weekly, the effectiveness of the interventions that were implemented to promote healing may not have been monitored.

Sources: A resident's clinical record; interview with DOC #101.
(683)

2. An assessment was completed of a resident's altered skin integrity, and a measurement was taken. The next assessments of their altered skin integrity were not completed until 100 days later, and then 16 days later.

The DOC reviewed the resident's clinical record and verified that their altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff, and that it had been clinically indicated.

There was a risk that a deterioration of the resident's altered skin integrity would not have been identified as it was not assessed on a weekly basis.

Sources: A resident's clinical record; interview with DOC #101. (683)

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

3. A skin assessment was completed on a resident's altered skin integrity on an identified date, which indicated a new skin impairment. A review of their clinical record 13 days later, identified no further assessments of the area of skin impairment.

Inspector #683 observed the resident's altered skin integrity was still present, and an RN acknowledged that the resident's altered skin integrity had not healed.

An RN and the DOC reviewed the resident's clinical record and verified that their altered skin integrity was not reassessed at least weekly by a member of the registered staff, and that it was clinically indicated.

Sources: A resident's clinical record; interview with RN #121 and DOC #101.

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

Severity: There was minimal risk of harm to the residents as deterioration of their altered skin integrity may not have been identified when the weekly skin assessments were not completed.

Scope: This non-compliance was widespread as weekly skin assessments were not completed for three residents when clinically indicated.

Compliance History: 10 Written Notifications (WNs), 15 Voluntary Plans of Correction (VPCs) and two Compliance Orders (COs) were issued to the home related to different sub-sections of the legislation in the past 36 months.
(683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2022(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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of January, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by EMMY HARTMANN (748) - (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