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 prévue le Loi de 2007 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

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 public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017;	2017_661683_0009 (A1)	015099-17, 018907-17	Complaint

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended in relation to duplication of findings on order #003.

Issued on this 23 day of October 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 25, 28, 29, 30, 2017

The following intakes were completed during this inspection:

015099-17 - Falls Prevention & Management

018907-17 - Falls Prevention & Management, Personal Support Services, Prevention of Abuse & Neglect, Nutrition & Hydration, Continence Care & Bowel Management, Accommodation Services

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Nursing, RAI Coordinator, Food and Environmental Services Supervisor (FESS), Director of Programming, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary aide and residents.

During the course of the inspection, the inspector reviewed clinical records, internal investigation notes, and observed the provision of care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **0 VPC(s)**
- **3 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. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full

body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

i) Resident #002 was to receive a bath or shower on two specific days each week. A review of their Point of Care (POC) bathing records from August 2017, identified that there were three occasions where they did not receive their scheduled baths, and these baths were not made up.

PSW #106 identified that the home was short staffed on two identified dates in August 2017, which was why the resident did not receive their bath.

ii) Resident #005 was to receive a bath or shower on two specific days each week. A review of their POC bathing records from August 2017, identified that there was one occasion where the resident did not receive their scheduled bath, and the bath was not made up.

iii) Resident #006 was to receive a bath or shower on two specific days each week. A review of their POC bathing records from August 2017, identified that there was one occasion where the resident did not receive their scheduled bath, and the bath was not made up.

PSW #106 acknowledged that when the home was working short staffed, the bathing shift was pulled, and in some cases, the baths were not completed. This reassignment of staff, at times, resulted in residents not being bathed twice a week. They identified that when they were not able to complete a bathing activity as per the bathing schedule, they would record "not applicable" in their POC records for the affected residents.

PSWs #106, #107, #110 and #112 identified that baths were sometimes missed when they were short staffed. PSW #105 identified that they worked short staffed often.

Interview with the Office Manager on an identified date in 2017, identified that the home had been working short staffed a "fair amount lately," and that it was more prominent over the past three months.

Interview with the Director of Nursing on an identified date in 2017, identified that they had recently been working short staffed, but that it had not been happening for long. They also identified strategies currently in place in an attempt to "make up"

missed bathing, to fill vacant shifts and vacant positions to reduce working below the desired staffing compliment. They confirmed that residents #002, #005 and #006 were not bathed, at a minimum, twice a week by the method of their choice during the month of August 2017. [s. 33. (1)]

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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of the home's critical incident report and staff interviews identified that resident #001 had unwitnessed falls on identified dates in 2017. The falls occurred in a specific area of the home and resulted in altered skin integrity. On an

identified date, the resident was taken to hospital and diagnosed with a condition which resulted in a significant change in their health status.

Resident #001 was identified as a high risk for falls and had interventions in place to minimize the risk for falls. As per their plan of care, the resident was to have a specific falls intervention in place.

Review of the home's internal incident report identified that the specific falls intervention was not in place when the resident fell.

Interview with the Director of Nursing on an identified date in 2017, confirmed that as per their internal investigation, resident #001's falls intervention was not in place on the date of their most recent fall, as specified in their plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

i) Review of complaint log #018907-17, progress notes and staff interviews identified that on an identified date in 2017, resident #002 had an incident that resulted in an alteration in skin to a specified body part. A progress note from 2017, identified that when the incident occurred, the resident did not have an identified adaptive device in place as it was refused by the resident.

Resident #002 had an identified diagnosis. As per their plan of care, they were to have specific adaptive devices in place.

A progress note from an identified date in 2017, included a comment which suggested an intervention be added to the resident's care plan, in the event that they refused their adaptive device. The note requested that the resident be assessed and their plan of care updated. Review of the resident's care plan did not identify the suggested intervention from the progress note.

The resident was observed at lunch on three occasions in August 2017. The resident received one of their adaptive devices on all days, however did not receive the other adaptive device on two of the three occasions.

Interview with the FESS on an identified date in 2017, acknowledged that the plan of care identified the specific adaptive device and that the expectation was the staff

would provide the resident with the adaptive device, unless otherwise specified. They identified that resident #002 would often refuse a specific adaptive device. As a result of the incident on the identified date in 2017, the home made changes to identified equipment in the home, which the FESS believed reduced the risk of injury. The FESS also identified that staff were encouraged to provide specific interventions to residents to reduce the risk of injury.

Interview with the Director of Nursing on an identified date in 2017, identified that the resident was cognitive and able to make their own decisions, and that they sometimes refused a specific adaptive device. They believed the risk of residents injuring themselves was reduced with the adjustments made to the equipment. They acknowledged that updates could have been added to the residents care plan to reflect the risk of injury if they refused their adaptive device.

ii) Resident #008 was on an identified diet. As per their plan of care, they were to have a specific adaptive device. The resident was observed at lunch on three occasions in August 2017. During lunch on one of the identified dates, the resident did not receive their adaptive device. Interview with the FESS on an identified date in 2017, identified that the resident sometimes refused their adaptive device and sometimes did not.

iii) Resident #009 was on an identified diet. As per their plan of care they were to have two specific adaptive devices. The resident was observed at lunch on three occasions. During lunch on the three observed occasions, the resident did not receive one of their adaptive devices. Interview with the FESS on an identified date in 2017, identified that the resident sometimes refused one of their adaptive devices.

On an identified date in 2017, the Director of Nursing acknowledged that residents #002, #008 and #009 sometimes refused a specific adaptive device, and there were no interventions in place for when the residents refused their adaptive devices.

The licensee did not ensure that residents #002, #008 and #009 were reassessed and their plans of care reviewed and revised when the care set out in the plan was not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

Issued on this 23 day of October 2017 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA BOS (683) - (A1)

Inspection No. / No de l'inspection : 2017_661683_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 015099-17, 018907-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Oct 23, 2017;(A1)

Licensee / Titulaire de permis : DELHI NURSING HOME LTD
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

LTC Home / Foyer de SLD : DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jeremy Zinger

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 DELHI NURSING HOME LTD, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall prepare, implement and submit a plan for achieving compliance with O. Reg. 79/10 s. 33 (1) to ensure that residents #002, #005 and #006 are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee shall also conduct and document auditing activities, at regular intervals, to ensure that all residents are bathed, at a minimum, twice a week. The plan must identify who will be responsible for the auditing activities.

Please submit the written plan to Lisa Bos, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, via email by October 31, 2017, to Lisa.Bos@ontario.ca.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (1), scope (3) and compliance history (3), in keeping with s. 33 (1) of the Regulation, in respect of the minimal risk for residents #002, #005 and #006, the scope of the issue was

widespread, and the Licensee's history of related non-compliance.

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

i) Resident #002 was to receive a bath or shower on two specific days each week. A review of their Point of Care (POC) bathing records from August 2017, identified that there were three occasions where they did not receive their scheduled baths, and these baths were not made up.

PSW #106 identified that the home was short staffed on two identified dates in August 2017, which was why the resident did not receive their bath.

ii) Resident #005 was to receive a bath or shower on two specific days each week. A review of their POC bathing records from August 2017, identified that there was one occasion where the resident did not receive their scheduled bath, and the bath was not made up.

iii) Resident #006 was to receive a bath or shower on two specific days each week. A review of their POC bathing records from August 2017, identified that there was one occasion where the resident did not receive their scheduled bath, and the bath was not made up.

PSW #106 acknowledged that when the home was working short staffed, the bathing shift was pulled, and in some cases, the baths were not completed. This reassignment of staff, at times, resulted in residents not being bathed twice a week. They identified that when they were not able to complete a bathing activity as per the bathing schedule, they would record "not applicable" in their POC records for the affected residents.

PSWs #106, #107, #110 and #112 identified that baths were sometimes missed when they were short staffed. PSW #105 identified that they worked short staffed often.

Interview with the Office Manager on an identified date in 2017, identified that the home had been working short staffed a "fair amount lately," and that it was more

prominent over the past three months.

Interview with the Director of Nursing on an identified date in 2017, identified that they had recently been working short staffed, but that it had not been happening for long. They also identified strategies currently in place in an attempt to "make up" missed bathing, to fill vacant shifts and vacant positions to reduce working below the desired staffing compliment. They confirmed that residents #002, #005 and #006 were not bathed, at a minimum, twice a week by the method of their choice during the month of August 2017. [s. 33. (1)] (683)

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

Oct 31, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for falls prevention are provided to all residents as specified in the plan.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s. 6 (7) of the Act, in respect of the actual harm that resident #001 experienced, the scope of one isolated incident, and the Licensee's history of ongoing non-compliance.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of the home's critical incident report and staff interviews identified that resident #001 had unwitnessed falls on identified dates in 2017. The falls occurred in a specific area of the home and resulted in altered skin integrity. On an identified date, the resident was taken to hospital and diagnosed with a condition which resulted in a significant change in their health status.

Resident #001 was identified as a high risk for falls and had interventions in place to minimize the risk for falls. As per their plan of care, the resident was to have a specific falls intervention in place.

Review of the home's internal incident report identified that the specific falls intervention was not in place when the resident fell.

Interview with the Director of Nursing on an identified date in 2017, confirmed that as per their internal investigation, resident #001's falls intervention was not in place on the date of their most recent fall, as specified in their plan of care. [s. 6. (7)] (683)

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

Oct 31, 2017

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall assess resident #002, #008 and #009 related to their use of adaptive devices and review and revise the care plan when the care set out in the plan has not been effective.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (3) and compliance history (4), in keeping with s. 6 (10)(c) of the Act, in respect of the actual harm that resident #002 experienced, the scope of the issue was widespread, and the Licensee's history of ongoing non-compliance.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

i) Review of complaint log #018907-17, progress notes and staff interviews identified that on an identified date in 2017, resident #002 had an incident that resulted in an alteration in skin to a specified body part. A progress note from 2017, identified that when the incident occurred, the resident did not have an identified adaptive device in place as it was refused by the resident.

Resident #002 had an identified diagnosis. As per their plan of care, they were to have specific adaptive devices in place.

A progress note from an identified date in 2017, included a comment which suggested an intervention be added to the resident's care plan, in the event that they refused their adaptive device. The note requested that the resident be assessed and their plan of care updated. Review of the resident's care plan did not identify the suggested intervention from the progress note.

The resident was observed at lunch on three occasions in August 2017. The resident received one of their adaptive devices on all days, however did not receive the other adaptive device on two of the three occasions.

Interview with the FESS on an identified date in 2017, acknowledged that the plan of care identified the specific adaptive device and that the expectation was the staff would provide the resident with the adaptive device, unless otherwise specified. They identified that resident #002 would often refuse a specific adaptive device. As a result of the incident on the identified date in 2017, the home made changes to identified equipment in the home, which the FESS believed reduced the risk of injury. The FESS also identified that staff were encouraged to provide specific interventions to residents to reduce the risk of injury.

Interview with the Director of Nursing on an identified date in 2017, identified that the resident was cognitive and able to make their own decisions, and that they sometimes refused a specific adaptive device. They believed the risk of residents injuring themselves was reduced with the adjustments made to the equipment. They acknowledged that updates could have been added to the residents care plan to reflect the risk of injury if they refused their adaptive device.

ii) Resident #008 was on an identified diet. As per their plan of care, they were to have a specific adaptive device. The resident was observed at lunch on three occasions in August 2017. During lunch on one of the identified dates, the resident did not receive their adaptive device. Interview with the FESS on an identified date in 2017, identified that the resident sometimes refused their adaptive device and sometimes did not.

iii) Resident #009 was on an identified diet. As per their plan of care they were to

have two specific adaptive devices. The resident was observed at lunch on three occasions. During lunch on the three observed occasions, the resident did not receive one of their adaptive devices. Interview with the FESS on an identified date in 2017, identified that the resident sometimes refused one of their adaptive devices.

On an identified date in 2017, the Director of Nursing acknowledged that residents #002, #008 and #009 sometimes refused a specific adaptive device, and there were no interventions in place for when the residents refused their adaptive devices.

The licensee did not ensure that residents #002, #008 and #009 were reassessed and their plans of care reviewed and revised when the care set out in the plan was not effective. [s. 6. (10) (c)] (683)

(A1)
Ground #2 has been removed.

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

Oct 31, 2017

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 23 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA BOS

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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