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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2018	2018_760527_0021	026101-18, 026209-18	Complaint

Licensee/Titulaire de permis

King Nursing Home Limited
49 Sterne Street Bolton ON L7E 1B9

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

King Nursing Home
49 Sterne Street Bolton ON L7E 1B9

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

KATHLEEN MILLAR (527), AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 1, 2, 3, 4, 5, 9, 10, 11 and 12, 2018.

Complaint Log #026209-18 related to an allegation of abuse and neglect and falls prevention management.

Critical Incident Log #026101-18 related to a resident fall resulting in an injury was conducted in conjunction with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), the Director of Resident and Family Services, the physiotherapist (PT), the physiotherapist aid (PTA), activation staff, the Resident Assessment Instrument (RAI) Coordinator, and residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed resident care, reviewed clinical records, reviewed the home's policy and procedures, reviewed training records, and reviewed annual program evaluations of related programs.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's care plan and had convenient and immediate access to it.

Resident #001 was admitted and an assessment was conducted,which identified the resident was high risk for falls and used a mobility device.

The licensee's policy related to Falls Prevention identified that all newly admitted residents were considered high falls risk.

The clinical record was reviewed, which revealed that the physiotherapist #110 assessed the resident for mobility and recommended the staff use a specific mechanical device and provided a loaner mobility aide.

Registered Nurse (RN) #108 was interviewed and said that the resident was high risk for falls based on the information provided by the substitute decision maker (SDM) and was using a specific device provided by the family when admitted. The RN said the physiotherapist provided a loaner mobility device for the resident and changed the resident's transfer status.

Registered Practical Nurse (RPN) #112 was interviewed and also confirmed the resident was high risk for falls and was in a specific device when admitted. They said that the physiotherapist assessed the resident and provided a loaner mobility device and changed the resident's transfer status. The RPN acknowledged that this information was added to the resident's 24 hour admission care plan by RN #116.

RN #105, RPN #106, RPN #107, Personal Support Worker (PSW) #100, and PSW #113, were interviewed and each of the staff were not aware of what was on the resident's care plan related to the mobility device that the resident should be placed in as recommended by the physiotherapist and they were not aware that the resident was a high risk for falls. Each of the staff said that there was no communication to them that the resident was assessed for the use of a specific mobility device and they were not told the resident was high risk for falls. The staff acknowledged that they had access to the resident's 24 hour admission care plan, knew where to find the information and had convenient access to the care plan; however they did not check the resident's 24 hour admission care plan and were not aware of what was on the resident's admission care plan, related to mobility

and transfers.

The licensee failed to ensure that the staff and others who provided direct care to resident #001 were kept aware of the contents of the resident's care plan.

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 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) Long Term Care Home (LTCH) Inspector #694 observed a female resident positioned in a mechanical lift and one PSW operating the lift.

PSW #121 acknowledged that resident #006 was being transferred using a mechanical lift and they used the lift without another staff member present. PSW #121 acknowledged that the expectation was that two staff were to be present at all times during a transfer using a mechanical lift.

The clinical record of resident #006 was reviewed and stated that the resident required a mechanical lift with two person physical assist for all transfers.

The licensee's policy related to resident transfer and lift procedures directed staff to have a second staff member in attendance throughout the entire procedure.

PSW #130 was interviewed and they said that staff were to complete a pre-inspection checklist to ensure the equipment was in working order and the last point on the list stated, ensure two qualified employees were present at all times when operating lift equipment.

In separate interviews with RPN #124 and the Administrator, they both acknowledged that safe transferring devices and techniques were not used by staff while they were transferring resident #006. (694)

B) Resident #001 had a fall on a specific date and time and the home submitted a critical incident to the Ministry of Health and Long Term Care (MOHLTC). Based on this information, the home's investigation notes and interviews with staff, the resident was seated in a specific mobility device, which was not the correct device as recommended by the physiotherapist. Also, there were no brakes applied after the resident was positioned in the mobility device.

At the time of the fall, the resident was bent over in their mobility device and tried to pick an item off the floor. After the fall, the resident was transferred to the hospital and was diagnosed with an injury.

The clinical record was reviewed, which identified the resident had been recently admitted, was high risk for falls and required a mobility device.

The home's video surveillance identified that RN #105, did not apply the brakes on the mobility device.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001 and #006.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

Resident #001 had a fall, sustained an injury and was transferred to hospital.

The clinical record was reviewed and it was identified that when the resident was admitted to the home, the resident had a history of falls prior to admission and the family provided information related to the resident's fall history. The resident was assessed as high risk for falls; the resident required assistance. The resident's transfer status subsequently changed after the initial assessment by the physiotherapist #110 and the PT confirmed in their assessment that the resident was high risk for falls.

The licensee's policy related to Falls Prevention, directed staff to select the appropriate mobility device to reduce the risk of falling and to utilize the Falls Prevention Kit.

PSW #100 was interviewed and acknowledged that the resident was high risk for falls. The PSW also acknowledged that the resident was in a specific mobility device, which

was not the heavier mobility device that residents were usually positioned in.

RPN #105 was interviewed and acknowledged that the home did not utilize the Falls Prevention Kit to determine the appropriate fall prevention measure for the resident. The RPN also acknowledged that the resident was in a specific mobility device and it was not the device that the PT had provided.

RPN #107 was interviewed and acknowledged that the resident was not in the mobility device recommended by the PT to help prevent falls and for the resident's comfort. Also, they had not implemented the bed and chair alarms for the resident and these were interventions available in the Falls Prevention Kit that would have been implemented for residents that were high risk for falls.

The licensee failed to ensure that staff complied with the Falls Prevention policy in order to prevent resident #001 from falling.

Additional Required Actions:

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

Issued on this 10th day of December, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2018_760527_0021
Log No. / No de registre :	026101-18, 026209-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 7, 2018
Licensee / Titulaire de permis :	King Nursing Home Limited 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home / Foyer de SLD :	King Nursing Home 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janice King

To King Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Order / Ordre :

The licensee must be compliant with s. 24 (7) of the O. Reg 79/10.

Specifically the licensee must:

1) Ensure that all staff are kept aware of the contents of the newly admitted residents' care plan and have convenient and immediate access to the care plans.

Grounds / Motifs :

1. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's care plan and had convenient and immediate access to it.

Resident #001 was admitted and an assessment was conducted,which identified the resident was high risk for falls and used a mobility device.

The licensee's policy related to Falls Prevention identified that all newly admitted residents were considered high falls risk.

The clinical record was reviewed, which revealed that the physiotherapist #110 assessed the resident for mobility and recommended the staff use a specific mechanical device and provided a loaner mobility aide.

Registered Nurse (RN) #108 was interviewed and said that the resident was high risk for falls based on the information provided by the substitute decision maker (SDM) and was using a specific device provided by the family when

admitted. The RN said the physiotherapist provided a loaner mobility device for the resident and changed the resident's transfer status.

Registered Practical Nurse (RPN) #112 was interviewed and also confirmed the resident was high risk for falls and was in a specific device when admitted. They said that the physiotherapist assessed the resident and provided a loaner mobility device and changed the resident's transfer status. The RPN acknowledged that this information was added to the resident's 24 hour admission care plan by RN #116.

RN #105, RPN #106, RPN #107, Personal Support Worker (PSW) #100, and PSW #113, were interviewed and each of the staff were not aware of what was on the resident's care plan related to the mobility device that the resident should be placed in as recommended by the physiotherapist and they were not aware that the resident was a high risk for falls. Each of the staff said that there was no communication to them that the resident was assessed for the use of a specific mobility device and they were not told the resident was high risk for falls. The staff acknowledged that they had access to the resident's 24 hour admission care plan, knew where to find the information and had convenient access to the care plan; however they did not check the resident's 24 hour admission care plan and were not aware of what was on the resident's admission care plan, related to mobility and transfers.

The licensee failed to ensure that the staff and others who provided direct care to resident #001 were kept aware of the contents of the resident's care plan.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it was isolated. The home had a level 3 history of one or more related non-compliance in the last 36 months.
(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Order # / Ordre no : 002

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

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 the O. Reg. 79/10.

Specifically, the licensee shall ensure that:

1) Staff shall provide safe positioning devices or techniques when assisting resident #001 and any other residents as directed in their plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #001 had a fall on a specific date and time and the home submitted a critical incident to the Ministry of Health and Long Term Care (MOHLTC). Based on this information, the home's investigation notes and interviews with staff, the resident was seated in a specific mobility device, which was not the correct device as recommended by the physiotherapist. Also, there were no brakes applied after the resident was positioned in the mobility device.

At the time of the fall, the resident was bent over in their mobility device and tried to pick an item off the floor. After the fall, the resident was transferred to the hospital and was diagnosed with an injury.

The clinical record was reviewed, which identified the resident had been recently admitted, was high risk for falls and required a mobility device.

The home's video surveillance identified that RN #105, did not apply the brakes on the mobility device.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 2 history of on-going non-compliance with one or more unrelated non-compliance in the last 36 months.

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s.8 (1)(b) of the LTCHA.

Specifically the licensee must:

1) Ensure direct care providers are compliant with the licensee's Fall Prevention policy and procedures.

2) Develop and implement an audit process to ensure that the appropriate interventions are implemented for residents that are high risk for falls.

3) Educate direct care staff related to the falls prevention policy and procedures.

Grounds / Motifs :

1. The licensee failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a

written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

Resident #001 had a fall, sustained an injury and was transferred to hospital.

The clinical record was reviewed and it was identified that when the resident was admitted to the home, the resident had a history of falls prior to admission and the family provided information related to the resident's fall history. The resident was assessed as high risk for falls; the resident required assistance. The resident's transfer status subsequently changed after the initial assessment by the physiotherapist #110 and the PT confirmed in their assessment that the resident was high risk for falls.

The licensee's policy related to Falls Prevention, directed staff to select the appropriate mobility device to reduce the risk of falling and to utilize the Falls Prevention Kit.

PSW #100 was interviewed and acknowledged that the resident was high risk for falls. The PSW also acknowledged that the resident was in a specific mobility device, which was not the heavier mobility device that residents were usually positioned in.

RPN #105 was interviewed and acknowledged that the home did not utilize the Falls Prevention Kit to determine the appropriate fall prevention measure for the resident. The RPN also acknowledged that the resident was in a specific mobility device and it was not the device that the PT had provided.

RPN #107 was interviewed and acknowledged that the resident was not in the mobility device recommended by the PT to help prevent falls and for the resident's comfort. Also, they had not implemented the bed and chair alarms for the resident and these were interventions available in the Falls Prevention Kit that would have been implemented for residents that were high risk for falls.

The licensee failed to ensure that staff complied with the Falls Prevention policy in order to prevent resident #001 from falling.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level as it was isolated to one of three residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Written notification (WN) and Voluntary Plan of Correction (VPC) issued September 26, 2018, (2018_737640_0020),
- WN and Compliance Order (CO) issued January 29, 2018 (2017_482640_0025),
- WN and Compliance Order (CO) issued December 29, 2017 (2017_482640_024),
- WN and VPC issued January 23, 2017 (2016_544527_0020) and (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

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
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 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)
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 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 7th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Central West Service Area Office