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
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Public Copy/Copie 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
Sep 1, 2020	2020_845585_0006	002605-20, 003826-20, 003941-20, 010220-20, 010813-20, 013143-20, 014800-20, 014996-20	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Wentworth Lodge
41 South Street West DUNDAS ON L9H 4C4

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

LEAH CURLE (585), LESLEY EDWARDS (506), YULIYA FEDOTOVA (632)

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): July 24, 27, 28, 29, 30, 31, August 4, 5, 6, 7 and 10, 2020.

The following seven Critical Incident System (CIS) inspections were conducted:

log #003826-20 - abuse
log #003941-20 - unexpected death
log #010220-20 - abuse
log #010813-20 - abuse and responsive behaviours
log #013143-20 - abuse and responsive behaviours
log #014800-20 - abuse
log #014996-20 - abuse and responsive behaviours

One follow-up inspection (log #002605-20) to Compliance Order (CO) #001 related to s.19(1), issued in inspection #2020_543561_0001, was also conducted.

Note: a complaint inspection #2020_560632_0009 (log #002471-20) was also conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Housekeeping staff, the Nursing Clerk, Resident Assessment Instrument Minimum Data Set (RAI-MDS) and Restorative Care Coordinator, the Director of Building Services, Nurse Managers and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed provision of care, reviewed clinical records, investigation notes, policies and procedures, training records and program evaluations.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

4 WN(s)
3 VPC(s)
1 CO(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

Long Term Care Homes Act, (LTCHA), 2007, O. Reg. 79/10, includes types of abuse and their definitions.

A) A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2020. The report described an incident where resident #008's actions caused injury to resident #005.

Resident #005's clinical record noted they had a specified diagnosis and an identified Cognitive Performance Scale (CPS) score.

Resident #008's clinical record noted they had a specified diagnosis, an identified CPS score, and responsive behaviours.

The Critical Incident Report and progress notes review confirmed that on an identified date in 2020, resident #008 demonstrated responsive behaviours which caused injury to resident #005.

The noted injury was confirmed by Personal Support Worker (PSW) #112 and Registered Practical Nurse (RPN) #113.

During the inspection, the Administrator acknowledged that on the identified date in 2020, resident #005 was not protected from abuse by resident #008.

Note: This finding is further evidence to support the compliance order issued on February 10, 2020, during CIS inspection # 2020_543561_0001 with a compliance due date of

April 30, 2020.

B) A CIS report was submitted to the Director on an identified date in 2020. The report described an incident where resident #008's actions caused injury to resident #017.

Resident #017's clinical record noted they had a specified diagnosis and an identified CPS score.

Resident #008's clinical record noted they had a specified diagnosis, an identified CPS score, and responsive behaviours.

Critical Incident Report and progress notes review confirmed that on an identified date in 2020, resident #008 demonstrated responsive behaviours which caused injury to resident #017.

The noted injury was confirmed by PSW #112 and RPN #113.

During the inspection, the Administrator acknowledged that on the identified date in 2020, resident #017 was not protected from abuse by resident #008.

The licensee failed to ensure that resident #005 and resident #017 were protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

On multiple identified dates in 2020, resident #009 demonstrated specified responsive behaviours toward co-residents.

On an identified date in 2020, resident #009 demonstrated responsive behaviours toward resident #004. Following the incident, Nurse Manager (NM) #121 documented in a progress note that a specified intervention was implemented to respond to resident #009's needs. There was no record to show that the intervention was added into resident #009's written plan of care.

On a later date in 2020, NM #121 documented the specified intervention into the resident's written plan of care. NM #121 confirmed in an interview that the intervention was not part of the written plan of care until several days after it was implemented.

The licensee failed to ensure that there was a written plan of care that set out the planned care for resident #009 in relation to interventions to respond to the needs of their behaviours. [s. 6. (1) (a)]

2. 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.

On multiple identified dates in 2020, resident #009 demonstrated specified responsive

behaviours toward co-residents.

On an identified date in 2020, resident #009 demonstrated responsive behaviours toward resident #004. Following the incident, as per nursing notes, a specified intervention was implemented. RN #108 was interviewed and confirmed that the incident occurred and that the specified intervention had been implemented to respond to the needs of the resident.

On an identified date in 2020, over an identified period of time, observations made showed that the specified intervention was not being implemented. RPN #125 was interviewed and stated the intervention was to be in effect during the time of the observation.

Interview with NM #121 confirmed the resident's plan of care stated they were to receive the specified intervention. NM #121 confirmed the care set out in the plan of care was not provided to the resident as specified in the plan in relation to responsive behaviour management. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that there is a written plan of care for each resident that sets out the planned care for the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with s. 24. (1) 2 in that a person, who had reasonable grounds to suspect abuse of a resident failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the Long-Term Care Homes Act (LTCHA). Pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1).

On an identified date in 2020, a CIS report was submitted to the Director regarding suspected abuse of resident #004 by resident #009.

The home’s Policy NO: AM-06-06, “Prevention, Reporting & Elimination of Abuse of Residents of LTC Homes” (date reviewed: April 30, 2020), was reviewed. The policy stated: "abuse of a resident by anyone resulted in a risk of harm was to be immediately reported upon becoming aware of the incident and immediately notify MLTC by phoning Service Ontario After Hours line phone number and submit the CIS report the next business day". The home's policy also directed, "If any team member witnesses an incident or has any knowledge of an incident that has constituted resident abuse or neglect, they are responsible to immediately take these steps: 3) Immediately inform the Administrator or any Supervisor (including any Manager or Registered Nurse in the Lodge)."

Investigation records were reviewed and revealed that on an identified date in 2020, staff #129 observed resident #009 interact with resident #004 in a manner that would constitute as grounds to immediately report the matter to the Director.

NM #121 confirmed the incident was not immediately reported to the Director until a later identified date in 2020, as staff #129 did not immediately inform a Registered Nurse about the incident, as per the home's process.

The home failed to ensure that any person who had reasonable grounds to suspect abuse of resident #004, failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the LTCHA. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of the residents with responsive behaviours: 2. Written strategies, including technique and interventions, to minimize or respond to the responsive behaviours.

NM #121 reported that in late July 2020, the home implemented a new term to describe a specified intervention intended for use as a strategy to respond to the needs of residents with behaviours. The specified intervention was noted in resident #008 and resident #009's plans of care.

RPN # 113, PSW #127 and PSW #128 were interviewed. The staff were not aware of what the specified intervention meant.

NM #121 provided a description of what the specified intervention meant; however, confirmed there was no written direction to define what the intervention meant nor had instruction been provided to all staff on what was expected of them to ensure the intervention would be implemented correctly.

The Administrator confirmed the home had identified a gap their in written strategies and interventions used for staff to follow when monitoring of residents with responsive behaviours.

The licensee failed to ensure that written strategies, including techniques and interventions were developed to meet the needs of the residents with responsive behaviours to minimize or respond to the responsive behaviours. [s. 53. (1) 2.]

2. The licensee failed to ensure that a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The home's written record of their 2018 program evaluation for responsive behaviours provided was reviewed. The record did not include the date of the evaluation, a summary of the changes made and the date those changes were implemented. The Administrator confirmed the written record of the program evaluation did not include the above noted items. [s. 53. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the following are developed to meet the needs of the residents with responsive behaviours: 2. Written strategies, including technique and interventions, to minimize or respond to the responsive behaviours, to be implemented voluntarily.

Issued on this 14th day of September, 2020

[redacted]

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LEAH CURLE (585), LESLEY EDWARDS (506), YULIYA FEDOTOVA (632)
Inspection No. / No de l’inspection :	2020_845585_0006
Log No. / No de registre :	002605-20, 003826-20, 003941-20, 010220-20, 010813-20, 013143-20, 014800-20, 014996-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 1, 2020
Licensee / Titulaire de permis :	City of Hamilton 28 James Street North, 4th Floor, HAMILTON, ON, L8R-2K1
LTC Home / Foyer de SLD :	Wentworth Lodge 41 South Street West, DUNDAS, ON, L9H-4C4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Karen Allcroft

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 City of Hamilton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_543561_0001, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with Long Term Care Homes Act (LTCHA), 2007, s. 19. (1).

Specifically, the licensee shall ensure that:
1. Resident #017 and any other resident in the home are protected from abuse by resident #008.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order follow up (COFU) #001 from inspection #2020_543561_0001 issued on February 10, 2020, with a compliance due date of April 30, 2020.

The licensee must be compliant with Long Term Care Homes Act, 2007, s. 19 (1).

Specifically, the licensee shall ensure that:
1. Resident #019 and any other resident in the home are protected from abuse by staff or anyone.
2. Resident #002, #014, #015, #016 and any other resident in the home are protected from abuse by resident #003 and #013.

The licensee completed step 1 and 2 in COFU #001.

The licensee has failed to ensure that they have complied with section 19. (1) of the LTCHA related to duty to protect.

The licensee failed to ensure that residents were protected from abuse by anyone.

Section 19. (1) of the LTCHA states "every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff." 2007, c. 8, s. 19 (1).

Long Term Care Homes Act, (LTCHA), 2007, O. Reg. 79/10, includes types of abuse and their definitions.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2020. The report described an incident where resident #008's actions caused injury to resident #017.

Resident #017's clinical record noted they had a specified diagnosis and an identified Cognitive Performance Scale (CPS) score.

Resident #008's clinical record noted they had a specified diagnosis, an identified CPS score, and responsive behaviours.

Critical Incident Report and progress notes review confirmed that on an identified date in 2020, resident #008 demonstrated responsive behaviours which caused injury to resident #017.

The noted injury was confirmed by Personal Support Worker (PSW) #112 and Registered Practical Nurse (RPN) #113.

During the inspection, the Administrator acknowledged that on the identified date in 2020, resident #017 was not protected from abuse by resident #008.

The licensee failed to ensure that resident #017 was protected from abuse by anyone. [s. 19. (1)]

The order was made up on the application of the factors for severity, scope and compliance history. The severity of this issue was determined to be a level 2 as there was minimal harm to the resident. The scope of the issue was a level 2 as

it related to 1 of 2 residents reviewed.

The home had a level 4 history of on-going non-compliance with this subsection of the Act that included:
• Written Notification (WN) issued September 5, 2017 (2017_556168_0024).
• Director Order (DO) served December 7, 2018 (2018_689586_0022 (A1), which was found in compliance on March 25, 2019.
• Two Compliance Orders (CO): one served on July 12, 2019 (2019_573581_0005), then re-issued on February 10, 2020 (2020_543561_0001)

The LTCH has no history of other Compliance Orders issued in the last 36 months. (632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 10, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 1st day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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