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
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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
Dec 17, 2019	2019_543561_0026	020683-19	Complaint

Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

DARIA TRZOS (561), LISA BOS (683)

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): November 22, 25, 26, 27, 28, 2019 and December 3, 4, 5, 6, 9, 2019.

This complaint inspection with a log #020683-19 was related to nursing and personal support services.

A Critical Incident System (CIS) inspection number 2019_543561_0025 was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing and Personal Care (DONPC), Associate Director of Nursing (ADON), Manager of Program and Support Services, Director of Dietary Services, Nursing Secretary, Registered staff including Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, Dietary staff, Maintenance staff, Recreation staff, Restorative staff, and residents.

During the course of the inspection, the inspector(s): observed provision of care, observed meal services, reviewed clinical records, relevant polices and procedures, staff schedules, training records, and investigation notes.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that each resident of the home was 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.

A complaint was submitted to the Director regarding residents not receiving baths due to the home working with fewer staff than the scheduled staffing complement.

In an interview with staff #123, they identified that during the day shift, each floor had a staff member scheduled to complete baths for residents. If the home was working with fewer staff than the scheduled staffing complement, the PSW working the bath shift was pulled to the home area that was short and the staff on the affected home areas were expected to complete the baths that were scheduled for the bath shift to complete.

A) A review of the schedules for identified dates in 2019, indicated that the home was working with fewer staff than their scheduled staffing complement on an identified floor.

i) A review of the Point of Care (POC) documentation for an identified time period in 2019, did not include documentation that resident #010 had their scheduled baths on two of the identified dates, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being “short staffed.” A review of the missed baths binder, identified that resident #010 did not receive their baths on two of the identified dates in 2019, due to the home being “short staffed.”

In interviews with PSWs #124 and #125, they identified that the baths were not done on one of the identified dates in 2019, due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

Resident #010 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

ii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #011 had their scheduled bath on one of the days reviewed, nor was there documentation that the resident refused their bath or that their bath was made up. A review of the missed baths binder and a progress note, indicated that resident #011 did not receive their bath on one of the dates identified in 2019, due to

the home being “short staffed.”

Resident #011 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

iii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #012 had their scheduled baths on two of the dates reviewed in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being “short staffed.” A review of the missed baths binder identified that resident #012 did not receive their bath on two of the dates identified during the identified time period in 2019, due to the home being “short staffed.”

In interviews with PSWs #124 and #125, they identified that the baths were not done due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

Resident #012 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

iv) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #013 had their scheduled bath on one of the days identified in 2019, nor was there documentation that the resident refused their bath or that their bath was made up. A review of the missed baths binder and a progress note, indicated that resident #013 did not receive their bath on one of the days identified in 2019, due to the home being “short staffed.”

Resident #013 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

v) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #014 had their scheduled baths on two of the dates identified in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being “short staffed.” A review of the missed baths binder identified that resident #014 did not receive their baths on two of the dates identified in 2019, due to the home being “short staffed.”

In interviews with PSWs #124 and #125, they identified that the baths were not done due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

Resident #014 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

vi) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #015 had their scheduled bath on one of the dates identified in 2019, nor was there documentation that the resident refused their bath or that their bath was made up. A review of the missed baths binder identified that resident #015 did not receive their bath on the identified date in 2019, due to the home being "short staffed."

In interviews with PSWs #124 and #125, they identified that the baths were not done due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

In an interview with the Director of Nursing and Personal Care (DONPC), they reviewed the electronic records for residents #010, #011, #12, #013, #014 and #015, and acknowledged that there was no documentation that the residents received their baths on the identified dates.

Review of bathing records, resident progress notes and staff interviews confirmed that all residents were not bathed, at a minimum, twice a week by the method of their choice.

B) A review of the schedules for the identified time period in 2019, indicated that the home was working with fewer staff than their scheduled staffing complement on an identified floor.

i) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #016 had their scheduled bath on one of the dates identified in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being "short staffed."

Resident #016 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

ii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #017 had their scheduled bath on one of the dates identified in 2019, nor was there documentation that the resident refused their baths or that their baths were made up.

In an interview with resident #017, they indicated that they have missed baths due to the home being "short staffed."

Resident #017 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

iii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident # 018 had their scheduled bath on two of the identified dates in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being “short staffed.”

In an interview with resident #018, they indicated that they have missed baths due to the home being "short staffed." They indicated that when the home was "short staffed" they were able to give themselves a sponge bath, but that they preferred a tub bath.

Resident #018 did not receive two consecutive baths, by the method of their choice, in a week due to the home working with fewer staff than the scheduled staffing complement.

In an interview with the DONPC, they reviewed the electronic records for residents #016, #017 and #018, and acknowledged that there was no documentation that the residents received their baths on the identified dates.

Review of bathing records, resident progress notes and staff and resident interviews confirmed that all residents were not bathed, at a minimum, twice a week by the method of their choice. (683) [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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, and summary of the changes made and the date those changes were implemented.

A complaint was submitted to the Director regarding staffing. A review of the home's "Staffing Contingency Plan," number N-5.6, indicated that it was last reviewed on February 27, 2019.

In an interview with the Chief Executive Officer (CEO), they acknowledged that the home had a written staffing plan for the organized program of nursing and personal support services, and that the plan was discussed regularly in meetings. They acknowledged that the home did not have a written record of the annual evaluation of the staffing plan which included the date of the evaluation, the names of the persons who participated in the evaluation, and a summary of the changes made and the date those changes were implemented.

The home did not ensure that there was a written record of the annual evaluation of the staffing plan. [s. 31. (4)]

Issued on this 10th day of January, 2020

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) :	DARIA TRZOS (561), LISA BOS (683)
Inspection No. / No de l’inspection :	2019_543561_0026
Log No. / No de registre :	020683-19
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 17, 2019
Licensee / Titulaire de permis :	Albright Gardens Homes, Incorporated 5050 Hillside Drive, Beamsville, ON, L0R-1B2
LTC Home / Foyer de SLD :	Albright Gardens Homes, Incorporated 5050 Hillside Drive, Beamsville, ON, L0R-1B2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	William ter Harmsel

To Albright Gardens Homes, Incorporated, 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)

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 must be compliant with O. Reg. 79/10 s. 33 (1).

Specifically, the licensee must:

1. Ensure residents #010, #011, #12, #013, #014, #015, #016, #017, #018, and all other residents are 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.

2. Develop a written plan, that is communicated to all direct care staff, to ensure that when a resident misses a scheduled bath or shower, that the missed bath or shower is documented and made up the same week. The plan must identify the roles of PSW staff and registered staff when residents miss their scheduled bath or shower and it must identify strategies that could be used to make up for missed baths. The home is to develop a sign off sheet for all direct care staff to identify that they read and understand the home's process for missed baths. The sign off sheet is to include the staff member's full name, their position, and the date in which they reviewed the document. The home is to maintain these records.

3. Develop an auditing tool to determine, at a minimum, if residents #010, #011, #12, #013, #014, #015, #016, #017 and #018 are bathed twice a week by the method of his or her choice, unless contraindicated by a medical condition. The audit must include a review of Point of Care (POC) records and a review of the missed bath binders located at the nursing station. The audit must indicate if the resident missed their scheduled bath or shower and if it was made up within the same week. Records are to be maintained of the audits, which are to be completed, at a minimum, monthly. The home is to assign one individual to be responsible for reviewing the audits to ensure compliance with the Regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was 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.

A complaint was submitted to the Director regarding residents not receiving

baths due to the home working with fewer staff than the scheduled staffing complement.

In an interview with staff #123, they identified that during the day shift, each floor had a staff member scheduled to complete baths for residents. If the home was working with fewer staff than the scheduled staffing complement, the PSW working the bath shift was pulled to the home area that was short and the staff on the affected home areas were expected to complete the baths that were scheduled for the bath shift to complete.

A) A review of the schedules for identified dates in 2019, indicated that the home was working with fewer staff than their scheduled staffing complement on an identified floor.

i) A review of the Point of Care (POC) documentation for an identified time period in 2019, did not include documentation that resident #010 had their scheduled baths on two of the identified dates, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being "short staffed." A review of the missed baths binder, identified that resident #010 did not receive their baths on two of the identified dates in 2019, due to the home being "short staffed."

In interviews with PSWs #124 and #125, they identified that the baths were not done on one of the identified dates in 2019, due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

Resident #010 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

ii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #011 had their scheduled bath on one of the days reviewed, nor was there documentation that the resident refused their bath or that their bath was made up. A review of the missed baths binder and a progress note, indicated that resident #011 did not receive their bath on one of

the dates identified in 2019, due to the home being "short staffed."

Resident #011 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

iii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #012 had their scheduled baths on two of the dates reviewed in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being "short staffed." A review of the missed baths binder identified that resident #012 did not receive their bath on two of the dates identified during the identified time period in 2019, due to the home being "short staffed."

In interviews with PSWs #124 and #125, they identified that the baths were not done due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

Resident #012 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

iv) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #013 had their scheduled bath on one of the days identified in 2019, nor was there documentation that the resident refused their bath or that their bath was made up. A review of the missed baths binder and a progress note, indicated that resident #013 did not receive their bath on one of the days identified in 2019, due to the home being "short staffed."

Resident #013 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

v) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #014 had their scheduled baths on two of the dates identified in 2019, nor was there documentation that the resident

refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being "short staffed." A review of the missed baths binder identified that resident #014 did not receive their baths on two of the dates identified in 2019, due to the home being "short staffed."

In interviews with PSWs #124 and #125, they identified that the baths were not done due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

Resident #014 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

vi) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #015 had their scheduled bath on one of the dates identified in 2019, nor was there documentation that the resident refused their bath or that their bath was made up. A review of the missed baths binder identified that resident #015 did not receive their bath on the identified date in 2019, due to the home being "short staffed."

In interviews with PSWs #124 and #125, they identified that the baths were not done due to the home working with fewer staff than the scheduled staffing complement. They indicated that the registered staff were notified that they were unable to complete the baths and the affected residents were documented in the missed baths binder.

In an interview with the Director of Nursing and Personal Care (DONPC), they reviewed the electronic records for residents #010, #011, #12, #013, #014 and #015, and acknowledged that there was no documentation that the residents received their baths on the identified dates.

Review of bathing records, resident progress notes and staff interviews confirmed that all residents were not bathed, at a minimum, twice a week by the method of their choice.

B) A review of the schedules for the identified time period in 2019, indicated that the home was working with fewer staff than their scheduled staffing complement on an identified floor.

i) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #016 had their scheduled bath on one of the dates identified in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being "short staffed."

Resident #016 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

ii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident #017 had their scheduled bath on one of the dates identified in 2019, nor was there documentation that the resident refused their baths or that their baths were made up.

In an interview with resident #017, they indicated that they have missed baths due to the home being "short staffed."

Resident #017 did not receive two consecutive baths in a week due to the home working with fewer staff than the scheduled staffing complement.

iii) A review of the POC documentation for an identified time period in 2019, did not include documentation that resident # 018 had their scheduled bath on two of the identified dates in 2019, nor was there documentation that the resident refused their baths or that their baths were made up. A progress note indicated that the resident did not have their scheduled bath due to the home being "short staffed."

In an interview with resident #018, they indicated that they have missed baths due to the home being "short staffed." They indicated that when the home was "short staffed" they were able to give themselves a sponge bath, but that they preferred a tub bath.

Resident #018 did not receive two consecutive baths, by the method of their choice, in a week due to the home working with fewer staff than the scheduled staffing complement.

In an interview with the DONPC, they reviewed the electronic records for residents #016, #017 and #018, and acknowledged that there was no documentation that the residents received their baths on the identified dates.

Review of bathing records, resident progress notes and staff and resident interviews confirmed that all residents were not bathed, at a minimum, twice a week by the method of their choice. (683)

The severity of this issue was determined to be a level 1 as there was no risk to the residents. The scope of the issue was a level 2 as it was related to two of three home areas reviewed. The home had a level 3 compliance history that included:
• Written notification (WN) issued December 3, 2019 (2018_569508_0022);
• Compliance order (CO) #005 issued December 19, 2018, with a compliance due date of March 30, 2019 (2018_720130_0010);
• CO #001 issued September 28, 2017, with a compliance due date of January 5, 2018 (2017_560632_0013);
• Voluntary plan of correction (VPC) issued February 23, 2017 (2017_569508_0002). (561)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 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 17th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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