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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 23, 2022	2022_820130_0001	007295-21, 009960-21, 011889-21, 011894-21, 012064-21, 013247-21, 014099-21, 014216-21, 016828-21, 001353-22, 001520-22, 001591-22, 001594-22	Critical Incident System

Licensee/Titulaire de permis

Henley House Limited
200 Ronson Drive Suite 305 Toronto ON M9W 5Z9

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

The Henley House
20 Ernest Street St Catherines ON L2N 7T2

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

GILLIAN HUNTER (130), CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)

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): January 12, 13, 19, 21, 25, 26, 27, 28, 31, and February 1, 2, 3, 4, 7, 8, 9, 14, 2022.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, meal service, infection prevention and control (IPAC) practices, and reviewed clinical records, internal investigation notes, relevant policies and procedures and other pertinent documents.

Please note this critical incident inspection was conducted concurrently with the following complaint inspection: 2022_820130_0002.

The following intakes were completed during this complaint inspection:

Log #007295-21 (CI 2909-000012-21), #009960-21 (CI 2909-000015-21), #011889-21 (CI 2909-000018-21), #011894-21 (CI 2909-000019-21), #012064-21 (CI 2909-000021-21), #012064-21 (CI 2909-000021-21), #013247-21 (CI 2909-000024-21), #014099-21 (CI 2909-000025-21), #014216-21 (CI 2909-000026-21), 001353-22 (CI 2909-000005-22) related to falls, Log # 016828-21 (CI 2909-000034-21), #001591-22 (CI 2909-000009-22) and #001594-22 (CI 2909-000010-22) related to abuse and neglect and Log #001520-22 (CI 2909-000008-22) related to medication administration.

Please Note: A Written Notification and Compliance Order related to Ontario Regulation 79/10 s. 36 was identified in concurrent inspection # 2022_820130_0002 (log #000495-22) and was issued in this inspection report. A Written Notification and Voluntary Plan of Correction (VPC) related to Ontario Regulation 79/10 s. 30 (2) was identified in concurrent inspection # 2022_820130_0002 (log #000495-22) and was issued in this inspection report. A Written Notification and Voluntary Plan of Correction (VPC) related to Long Term Care Homes Act, s. 6 (1) c and s. 6 (10) b was identified in concurrent inspection # 2022_820130_0002 (log #000495-22) and was issued in this inspection report. A Written Notification and Compliance Order related to Ontario Regulation 79/10 s. 33 was identified in this inspection and has been issued in the concurrent inspection # 2022_820130_0002 (log #001299-22) report. A Written Notification and Voluntary Plan of Correction (VPC) related to Long Term Care Homes Act, s. 6 (7) was identified in this inspection and has been issued in the concurrent inspection # 2022_820130_0002 (log #009960-21) report.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Associate Director of Care (ADOC),

Resident Assessment Instrument (RAI) Coordinator, Environmental Manager, Business Manager, Physiotherapist (PT) Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. 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 :

The licensee failed to ensure that staff used safe techniques when transporting residents.

A) In October 2021, a non weight bearing resident was portered from their room to the

shower room on a commode chair. While in the shower and upon return to their room, the device broke. There was no injury to the resident. Staff confirmed that using the commode chair to porter a resident to and from the shower room was not a safe transferring technique.

B) In August 2021, a second resident was transported by staff from their bedroom to the shower room using a wheeled commode chair, instead of their wheelchair. During the transport, the resident's feet touched the floor and they slid from their left side out of the commode chair onto the floor, resulting in an injury.

The PSW indicated prior to the shower, the resident needed care and requested a commode chair. The staff member indicated they were new and had not provided care to the resident prior and that it was the resident's choice to be transported to the shower room in the commode chair instead of their wheelchair. The staff member indicated they had received training regarding equipment and devices that were safe to transport a resident. They confirmed using the commode chair to transport a resident was not a safe technique.

Documentation indicated a falls committee meeting had occurred the day following the incident with recommendations the resident was to be transferred to the commode chair, when in the tub room.

The Acting DOC, ADOC and PT confirmed a commode chair was not to be used to transport a resident as it had not been designed for this purpose. The Acting DOC confirmed the home did not have a policy, procedure or training program that identified safe transporting techniques for residents; however, the home was scheduled for upcoming training sessions and would request the vendor to include safe transporting techniques in these sessions.

The absence of a policy and/or procedure identifying equipment or devices that should or should not be used to safely transport a resident, including implementation through training, impacted on the resident sustaining actual harm.

There was actual risk of harm to the first resident and actual harm to the second resident, when staff used unsafe techniques to transfer the residents.

Sources: CI reports, resident and staff interviews and clinical records.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to provide a resident the right to be properly clothed and cared for in a manner consistent with their needs.

Upon entering a resident's room in January 2022, staff found the resident in an unacceptable state. The day before, morning staff told the evening staff at shift change that they did not have time to make the residents bed, and requested the next shift make the bed. The resident was found wearing the same clothes as the previous day and the bedding was still sitting folded beside the resident's bed.

Staff interviews confirmed the resident required assistance with the task of dressing and the plan of care directed staff to check the resident hourly and document for "intentional comfort rounds". There was no documentation that the resident was resistive to care during this incident.

The Acting DOC acknowledged that resident was not properly clothed, or cared for when their bed was not made up for the night. It was unknown why this was not identified during the evening or night shift and why action wasn't taken.

Sources: CI report, clinical records, resident observation and staff interviews.

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 to ensure residents are properly clothed and cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee failed to ensure that the written plan of care for residents, related to locomotion, transfers and toileting, set out clear directions to staff and others who provided direct care to the residents.

A)The Point Click Care (PCC) care plan for a resident provided conflicting statements regarding the use of equipment and the level of assistance required for toileting and transfers.

Staff interviewed confirmed the resident's actual needs of the resident and acknowledged

that direction in the plan of care did not provide clear direction related to these tasks.

Conflicting direction in the plan of care related to transfers and toileting put the resident at risk of harm and injury, if staff did not provide the necessary support or use the required equipment to transfer the resident.

B) In August 2021, another resident sustained an injury resulting from an improper transfer. Their electronic care plan following the incident provided conflicting direction related to locomotion.

Staff interviewed confirmed the resident's actual needs and acknowledged the care plan did not provide clear direction to staff related to locomotion.

When the written plan of care does not set out clear directions to staff and others who provide direct care, there is a potential for risk of harm to the resident as care may not be provided in a manner that meets their assessed needs and preferences.

Sources: Clinical records, care plans, progress notes, assessments and interviews with staff.

2. The licensee failed to ensure that residents' plans of care related to dressing and transfers were reviewed and revised when their care needs changed.

A) The electronic plan of care for a resident stated they had specific needs and preferences related to activities of daily living, including, sleep and rest, toileting and transfers.

The resident was observed in February 2022, and during an interview, stated they were no longer able to have their preferences met because there had been a change in their condition and the home lacked specific equipment to meet their individual needs. Staff interviewed confirmed the plan of care was not updated when the resident's care needs changed.

There was a risk of harm and potential for injury to the resident when the care plan was not updated to reflect the actual care needs of the resident and the level of assistance required by staff for transfers, dressing and toileting.

B) In January 2022, a resident was found in an unacceptable state in bed. The care plan

stated the resident did not require assistance and could dress themselves safely and appropriately. Staff interviewed confirmed the resident could not independently complete the task.

The Acting DOC acknowledged the care plan had not been revised and that the resident required more assistance with care.

Sources: CI report, clinical record, interview with Acting DOC and other staff.

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 to ensure that there is a written plan of care for residents that sets out clear directions to staff and others who provide direct care to the residents and that the plan of care is reviewed and revised when the residents' care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that a suspected incident of neglect of three residents by the licensee or staff was immediately investigated and that appropriate action was taken in response to the incidents.

A) In January 2022, a PSW reported an incident of alleged neglect to the Acting DOC. When entering a resident's room, staff found the resident in an unacceptable condition. The PSW reported they had showered and dressed the resident 48 hours (hrs) earlier and that the resident was found wearing the same clothing.

Interviews with staff and the care plan identified the resident required extensive assistance for specific care tasks.

B) In January 2022, the same PSW reported a second incident of alleged neglect to the Acting DOC, whereby they observed the resident in bed, shivering with no bed linens. The previous morning, the staff had informed evening staff at shift change that they did not have time to make the resident's bed, and requested staff to complete the task and that bedding was left at the resident's bedside.

During the inspection Inspector #583 requested the home’s investigation notes on several occasions. It was confirmed by the ADOC and Acting DOC that the home had not begun their investigation. It was acknowledged that appropriate action had not been taken. Staffing levels were not reviewed, staff who worked at the time of the alleged neglect were not identified and no interviews were completed. No information related to the two incidents was documented in the residents' plan of care and it was acknowledged they did not know what led to the residents being found in a compromised circumstance.

C) In February 2022, while completing separate interviews related to critical incidents submitted by the home, two PSWs shared an allegation of neglect. They reported that on a date in January 2022, morning care was provided later in the morning for some residents due to short staffing. They observed a resident in an unacceptable condition and shared the resident appeared uncomfortable. The RN was summoned to assess and treat the resident. Staffing records revealed there was no PSW on the unit the night prior.

Inspector #583 shared the information with the Acting DOC; who indicated they were not aware of the incident and that there was no documentation that the incident had occurred in the resident’s records. In an interview with the Acting DOC and ADOC, it was shared

they had not been able to initiate the investigation and immediate action had not been taken.

All suspected allegations of neglect occurred on the same unit in January 2022. The Acting DOC acknowledged that not investigating the allegations of abuse and neglect put the residents at risk, because immediate action had not been taken to prevent recurrence and a long-term action plan was not in place to correct the situation.

Sources: CI reports; Zero Tolerance of Resident Abuse/Neglect Policy (Revised September 2021); clinical records; interviews with Acting DOC and other staff.

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 to ensure that a suspected incident of neglect of residents, by the licensee or staff is immediately investigated and that appropriate action is taken in response to the incidents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that interventions for residents and the residents' responses to the interventions, under the nursing and personal support services program were documented.

A) According to a resident's progress notes, recorded in October 2021, an incident occurred as a result of an improper transfer. There was no further information recorded regarding follow-up after the incident, whether a resident assessment was performed; if there was injury to the resident, nor the resident's response to the incident. Staff interviewed confirmed the progress note was incomplete and did not reflect all actions taken with respect to the resident.

B) In January 2022, there was another incident whereby a resident was found to have not received care in a manner that was consistent with their needs. A review of their plan of care showed that there was no documentation of the incident, action taken or of the resident's responses to the interventions provided. Skin assessments completed in December 2021 and January 2022, were incomplete and it was not known if the resident's impaired skin integrity worsened after the incident. The Acting DOC acknowledged documentation was not completed as required.

Sources: Clinical records; interviews with RN #127, RPN #137, and other staff.

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 to ensure that interventions for residents and the residents' responses to the interventions, under the nursing and personal support services program are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that residents, who required continence care products, had sufficient changes to remain clean, dry and comfortable.

On a date in January 2022, a PSW entered a resident's room to provide morning care and found the resident in an unacceptable state. Progress notes during this time did not contain any documentation of the incident or events leading up to the incident.

The resident's care plan identified they required assistance for specific tasks and had specific needs and goals related to continence care.

In an interview with the Acting DOC it was acknowledged that the resident was not kept clean, dry and comfortable.

Sources: CI report; clinical record; interview with Acting DOC and other staff.

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 to ensure that residents requiring continence care products has sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

Issued on this 29th day of March, 2022

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) :	GILLIAN HUNTER (130), CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2022_820130_0001
Log No. / No de registre :	007295-21, 009960-21, 011889-21, 011894-21, 012064-21, 013247-21, 014099-21, 014216-21, 016828-21, 001353-22, 001520-22, 001591-22, 001594-22
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 23, 2022
Licensee / Titulaire de permis :	Henley House Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	The Henley House 20 Ernest Street, St Catherines, ON, L2N-7T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Bosco

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 Henley House Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 O. Reg. 79/10.

Specifically, the licensee must:

1) Develop an interdisciplinary policy, procedure, or protocol regarding safe techniques to transport residents who are unable to physically ambulate and require the use of equipment or devices to do so.

2) Implement the developed policy, procedure, or protocol through training of all staff who are responsible for transporting residents, including new staff on orientation. This training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

3) Audits shall be conducted to ensure the policy is understood and complied with. Records of audits shall be retained.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe techniques when transporting residents.

A) In October 2021, a non weight bearing resident was portered from their room to the shower room on a commode chair. While in the shower and upon return to their room the device broke. There was no injury to the resident. Staff confirmed that using the commode chair to porter a resident to and from the shower room was not a safe transferring technique.

B) In August 2021, a second resident transported by staff from their bedroom to

the shower room using a wheeled commode chair, instead of their wheelchair. During the transport, the resident's feet touched the floor and they slid from their left side out of the commode chair onto the floor, resulting in an injury.

The PSW indicated prior to the shower, the resident required toileting and requested a commode chair. The staff member indicated they were new and had not provided care to the resident prior and that it was the resident's choice to be transported to the shower room in the commode chair instead of their wheelchair. The staff member indicated they had received training regarding equipment and devices that were safe to transport a resident. They confirmed using the commode chair to transport a resident was not a safe technique.

Documentation indicated a falls committee meeting had occurred the day following the incident with recommendations the resident was to be transferred to the commode chair, when in the tub room.

The Acting DOC, ADOC and PT confirmed a commode chair was not to be used to transport a resident as it had not been designed for this purpose. The interim DOC confirmed the home did not have a policy, procedure or training program that identified safe transporting techniques for residents; however, the home was scheduled for upcoming training sessions and would request the vendor to include safe transporting techniques in these sessions.

The absence of a policy and/or procedure identifying equipment or devices that should or should not be used to safely transport a resident, including implementation through training, impacted on the resident sustaining actual harm.

There was actual risk of harm to the first resident and actual harm to the second resident, when staff used unsafe techniques to transfer the residents.

Sources: CI reports, resident and staff interviews and clinical records.

An order was made by taking the following factors into account:
Severity: There was actual risk and harm to both residents reviewed.
Scope: The was a pattern as at least two residents were affected.
Compliance History: In the last 36 months, a Voluntary Plan of Corrective Action

(VPC) was issued on April 19, 2021 to the same section.
(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 04, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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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 23rd day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Hunter

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