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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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
Oct 27, 2021	2021_868561_0009	024565-20, 005763-21, 007238-21, 010105-21, 012176-21, 012822-21, 015301-21, 015591-21	Critical Incident System

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue London ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North Paris ON N3L 2N9

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

DARIA TRZOS (561), FARAH_ KHAN (695)

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): September 23, 24, 27, 28, 29, 2021 and October 1, 4, 5, 6, 7, 8, 12, 13, 14, 2021.

The following Critical Incident (CI) intakes were inspected during this inspection:
log #024565-20 - related to improper treatment of a resident,
log #005763-21 - related to alleged resident to resident abuse,
log #007238-21 - related to alleged resident to resident abuse,
log #010105-21 - related to improper treatment of a resident,
log #012176-21 - related to falls,
log #012822-21 - related to alleged staff to resident abuse,
log #015301-21 - related to unplanned evacuation,
log #015591-21 - related to unplanned evacuation.

A Complaint inspection was also conducted concurrently with this inspection with an inspection number 2021_868561_0010.

Inspector number 720920 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Clinical Services (DOCS), Director of Culinary Services, Associate Director of Clinical Services (ADOCS), Infection Prevention and Control (IPAC) Lead, Facilities Manager, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), housekeeping staff, recreation staff, dietary aide, Behaviour Supports Ontario (BSO), Operations Manager at Pinkerton Agency, security agency staff, Refrigeration Formen, personal support workers (PSWs), and residents.

During the course of the inspection, the inspector(s): toured the home, completed an Infection Prevention and Control (IPAC) checklist, observed provision of care, reviewed clinical records, investigation notes, policies and procedures and program evaluations.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **7 WN(s)**
- **3 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 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 has failed to ensure that a resident was protected from abuse by another

resident.

Ontario Regulation 79/10, section 2(1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On an identified date there was an incident between two residents that resulted in an injury. Staff observed the incident and confirmed the same details. It was reported that the resident who was injured was fearful as a result of the incident. A contract worker was present during the incident; however, they were distracted which led to the contract worker not intervening in time to prevent further altercations between the residents. Staff members expressed concerns regarding the training and knowledge of contract workers. The Director of Clinical Services (DOCS) stated that the contract service worker should not be distracted while providing services to residents. The DOCS acknowledged that this incident was considered abuse.

Sources: The Critical Incident System (CIS) report; interviews with staff. [s. 19. (1)]

2. The licensee has failed to ensure that a resident was not neglected by the licensee or staff in the home.

Ontario Regulation 79/10 section 2(1) defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A registered staff performed a task for a resident and failed to communicate this to the oncoming shift and failed to document the task completed. The PSW staff who provided direct care to the resident, failed to report to registered staff a change in the resident’s condition, and as a result, the registered staff did not assess the resident. The registered staff on the oncoming shift also failed to assess the resident when they had a change in condition. The next day, the registered staff that initially performed the undocumented task failed to call the on-call physician to report the change in the resident’s condition. Subsequently, the resident was sent to the hospital and required treatment. This pattern of an inaction jeopardized the health and well being of the resident.

Sources: CI report; home’s investigation notes; resident’s clinical records; interviews with staff. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee failed to ensure that security staff who provided direct care to residents, in regards to the prevention and management of their responsive behaviours, had convenient and easy access to their plans of care.

Three residents were reviewed related to responsive behaviours. Their written plans of care were reviewed and identified interventions to deal with those behaviours. Security staff that were in the home monitoring those residents were interviewed and indicated that they did not have access to the written plans of care for these residents. They were not aware of residents' triggers or interventions implemented to assist these residents with their behaviours. Registered staff confirmed that the security staff did not have access to residents' written plans of care; however, they were expected to provide an individualized plan of care for responsive behaviours.
When security staff were providing care without access to the individualized plans of care for residents with responsive behaviours, there was an increased chance they would not know the strategies to prevent physical aggression, and therefore, a resident may be at increased risk for harm.

Sources: residents’ care plans; contract staff binder; interviews with staff. [s. 6. (8)]

2. The licensee has failed to ensure that a resident’s written plan of care was revised when the resident's care needs changed post fall.

A resident sustained an injury as a result of a fall. The resident required interventions after the fall which was confirmed by staff. The written plan of care was not updated with interventions. Two other residents' written plans of care were reviewed related to falls and they were not revised with the new interventions.

There may be an increased risk to residents when the written plans of care are not revised.

Sources: CIS report; Post fall Management policy; resident’s written plan of care; interviews with staff. [s. 6. (10) (b)]

3. The licensee has failed to ensure that a plan of care for a resident was revised when their care needs changed.

A resident had a change in condition when they returned from the hospital on different occasions. Their plan of care was not revised to include a new intervention after re-admissions. The process for re-admission was reviewed with registered staff and DOCS and it was confirmed that the plan of care was not revised for this resident.

Not revising the plan of care with intervention and treatments when there was a change in the resident's condition, increased the risk of staff not being aware of the plan and increased the risk of providing incorrect treatment.

Sources: Resident's plan of care; home’s policy Bladder - Indwelling Catheter Care & Maintenance policy; interviews staff. [s. 6. (10) (b)]

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 the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that interventions were implemented to assist a resident in order to minimize the risk of altercations between residents.

An incident occurred between two resident that resulted in an injury to one of those residents. A previous altercation occurred between the same residents and was witnessed. At the time of the incident, a contract worker was present; however, they were distracted. As a result the staff member did not intervene in time to prevent further altercation between the residents. Staff members expressed concerns regarding training and knowledge of contract workers.
The DOCS stated that contract service worker was not to be distracted while providing services to residents.
If the contract worker had intervened immediately and had not been distracted the resident may not have been harmed in an altercation.

Sources: The CIS reports; interviews with staff. [s. 55. (a)]

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 ensure that, procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, “Just Clean Your Hands” (JCYH) related to staff assisting residents with HH before and after meals.

The home’s HH program did not include a process for staff to assist residents to clean their hands before and after a meal. On one of the units in the home, residents’ hands were not cleaned before and after the lunch meal. On another unit observed, residents’ hands were not cleaned before the snack service.
According to JCYH program, staff are required to assist residents to clean their hands before and after meals.
The failure to have a hand hygiene program in place in accordance with EBPs presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of lunch service and snack service; interviews with stafff; “Just Clean Your Hands” program resources. [s. 229. (9)]

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 in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #5: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's right to be treated with courtesy and respect and dignity was respected and promoted.

There was an incident in the home where the manner in which a staff member interacted with a resident did not respect the resident's rights to be treated with courtesy and respect. The investigation notes and video surveillance footage showed the incident and confirmed that the resident's rights were not respected. The DOCS confirmed the incident occurred and action was taken.

Sources: CIS report; home's investigation notes; video surveillance; progress notes; interview with staff. [s. 3. (1) 1.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Bladder - Indwelling Catheter Care & Maintenance policy in the required Continence Care and Bowel Management Program was complied with, for resident #014.

O. Reg. 79/10, s. 30(1) requires that the home complies with each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48.

O. Reg. 79/10, s. 48(1)3. And s. 48(2) requires that the program is developed and implemented in the home relate to continence care and that the program provides for assessments and reassessment instruments.

Specifically, staff did not comply with the home’s policy Bladder - Indwelling Catheter Care & Maintenance.

The home’s Bladder - Indwelling Catheter Care & Maintenance policy indicated that registered staff member responsible for the resident's care shall ensure that there is a documented plan of care for each resident with an indwelling catheter. The registered staff member who is responsible for the treatments shall complete a Treatment Administration Record (TAR). The registered staff member responsible for the resident's care shall ensure that irrigation of and changing of the indwelling catheter is completed as per policy and procedure and with a physician's order.

A resident was readmitted to the home from a hospital with a medical device. The physician's note indicated to keep the device in until the resident had a specialist appointment. The register staff did not follow through with the order and did not add it to electronic medication administration record (EMAR) or ETAR. There was no schedule for monitoring and changing of the device completed as the home’s policy indicated. This was confirmed by the DOCS.

Sources: resident’s plan of care; home’s policy Bladder - Indwelling Catheter Care & Maintenance; interviews with staff. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who demonstrated responsive behaviours, strategies were implemented for those behaviours.

An incident occurred between two residents during a meal time. The resident's plan of care had interventions in place related to their responsive behaviours. The resident was observed during this inspection and an intervention was not implemented as per the plan of care. The Director of Culinary Services stated that staff were supposed to follow the plan of care.

Sources: The CIS report; resident's care plan; interviews with staff. [s. 53. (4) (b)]

Issued on this 4th day of November, 2021

[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) :	DARIA TRZOS (561), FARAH_ KHAN (695)
Inspection No. / No de l’inspection :	2021_868561_0009
Log No. / No de registre :	024565-20, 005763-21, 007238-21, 010105-21, 012176-21, 012822-21, 015301-21, 015591-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 27, 2021
Licensee / Titulaire de permis :	Park Lane Terrace Limited 284 Central Avenue, London, ON, N6B-2C8
LTC Home / Foyer de SLD :	Park Lane Terrace 295 Grand River Street North, Paris, ON, N3L-2N9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Carol Bradley

To Park Lane Terrace Limited, 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 :

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 comply with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

1. Ensure that residents are protected from abuse by anyone.
2. Ensure that roles and responsibilities for contract workers are reviewed and revised as necessary to ensure that there is a clear outline of the roles and responsibilities when monitoring residents.
3. Train existing and any new contract staff on their written roles and responsibilities. A written record of the training provided must be kept.
4. Ensure that identified staff reviews the process/policy for communicating and documenting when there is a change in a resident's condition or treatment. A written record of this review must be kept.
5. Ensure that all PSW and registered staff on the identified unit are trained on the home's "Bladder-Indwelling Catheter Care and Maintenance Policy" and a written record of the training is kept.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from abuse by another resident.

Ontario Regulation 79/10, section 2(1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On an identified date there was an incident between two residents that resulted in an injury. Staff observed the incident and confirmed the same details. It was reported that the resident who was injured was fearful as a result of the incident.

A contract worker was present during the incident; however, they were distracted which led to the contract worker not intervening in time to prevent further altercations between the residents.

Staff members expressed concerns regarding the training and knowledge of contract workers. The Director of Clinical Services (DOCS) stated that the contract service workers should not be distracted while providing services to residents. The DOCS acknowledged that this incident was considered abuse.

Sources: The Critical Incident System (CIS) report; interviews with staff. (695)

2. The licensee has failed to ensure that a resident was not neglected by the licensee or staff in the home.

Ontario Regulation 79/10 section 2(1) defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A registered staff performed a task for a resident and failed to communicate this to the oncoming shift and failed to document the task completed. The PSW staff who provided direct care to the resident, failed to report to registered staff a change in the resident's condition, and as a result, the registered staff did not assess the resident. The registered staff on the oncoming shift also failed to assess the resident when they had a change in condition. The next day, the registered staff that initially performed the undocumented task failed to call the on-call physician to report the change in the resident's condition. Subsequently, the resident was sent to the hospital and required treatment. This pattern of an inaction jeopardized the health and well being of the resident.

Sources: CI report; home's investigation notes; resident's clinical records; interviews with staff.

Severity: Two residents were harmed as a result of the incidents.

Scope: The scope of this non-compliance was isolated because two residents

out of six reviewed were abused and neglected.

Compliance History: In the last 36 months, the licensee was found to be in non compliance with s. 19(1); a written notification (WN) was issued on January 24, 2019 (2018_556168_0011), and a compliance order was issued on November 21, 2019 (2019_549107_0013). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 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

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

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 27th day of October, 2021

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