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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 17, 2021	2021_790730_0004	026032-20, 001065-21, 001305-21, 001722-21	Complaint

Licensee/Titulaire de permis

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

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

Henley Place
1961 Cedarhollow Boulevard London ON N5X 0K2

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

CHRISTINA LEGOUFFE (730), KRISTEN MURRAY (731)

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): February 1, 2, 3, 4, 5, 8, 9, and 10, 2021.

The following intakes were completed in this complaint inspection:

Log #001305-21 was related to prevention of abuse and neglect and food quality;

Log #026032-20 and related CIS Log #001065-21, CIS #3045-000002-21 were related to incompetent care of a resident;

and Log #001722-21 was related to medication management.

NOTE: A Compliance Order related to LTCHA, s. 20 (1) was identified in a concurrent inspection 2021_790730_0003 (Log #025705-20, CIS #3045-000048-20 and Log #025856-20, CIS #3045-000050-20) and issued in this report.

Inspector #523 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Dietary Consultant, the Environmental Supervisor, Dietary Aides (DAs), the Director of Behaviour Supports, the Business Manager, Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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

- **6 WN(s)**
- **3 VPC(s)**
- **2 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. 20. Policy to promote zero tolerance

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s policy to promote zero tolerance of abuse and neglect of residents was complied with for three residents.

The licensee’s policy titled “Zero Tolerance of Resident Abuse/Neglect” (2-17) stated that employees must immediately report any case of suspected abuse to their department manager, immediate supervisor, or during off hours the most senior supervisor available.

A. A staff member brought forward concerns to the home related to an incident that occurred five days before. The staff member reported concerns related to incompetent care of a resident. The Director of Care said that the staff member did not immediately report their concerns to management in the home, which would be the home's expectation. [s. 20.]

2. A resident showed an inappropriately behaviour towards another resident. A Registered Nurse (RN) said that they discovered a progress note related to the incident, written by the RPN, when they were reviewing the 24 hour report the following day. They also said that the RPN who had been on duty at the time of the incident, should have reported the incident to management immediately. Disciplinary action was taken against the RPN by the home related to their policy of reporting allegations of resident to resident abuse. [s. 20.]

3. One resident acted inappropriately towards another resident. An RN told the home during their investigation that they had been informed by the RPN on the unit about the incident but had failed to follow the home’s procedure and report the incident to management. Disciplinary action was taken against the RN by the home related to their policy of reporting allegations of resident to resident abuse.

There was increased risk of harm to three residents as a result of staff not immediately reporting allegations of abuse or incompetent care to management as per the home's policy.

Sources: Critical Incident System Reports; Clinical records reviewed included: progress notes, care plans, assessments, the home’s investigation notes, the licensee’s policy titled "Zero Tolerance of Resident Abuse/Neglect” (2-17, revised September 2013); and interviews with an RN and other staff. [s. 20.]

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administered drugs to residents in the home unless that person was a physician, dentist, registered nurse or registered practical nurse.

On multiple occasions Registered Nurse (RN) #103 asked personal support workers (PSWs) to assist with administering medications to residents on one home area. RN #103 said an Associate Director of Care and the Director of Care (DOC) told them they could ask PSWs to assist with medication administration.

A PSW identified that previously on another home area, RN #103 prepared medications for the residents and placed them on the residents' meal trays for the PSWs to administer to the residents. The home's Medication Pass policy indicated that medication passes were to be completed by registered staff, and medication administration included staying with the resident while the resident took the medications. As a result of RN #103 not administering the medications to the residents, there was increased risk to residents.

Sources: Medication Pass policy (#3-6-1, last revised November 2013); video surveillance footage; and interviews with the DOC and other staff. [s. 131. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for a resident provided clear direction for the use of restraints.

A resident had physician's orders for a restraint. The resident's plan of care included an intervention which said to use the restraint at a specified time. The most recent Quarterly Restraint Reassessment indicated that the resident used the restraint differently than what was indicated in the care plan. A Registered Practical Nurse (RPN) said that the resident's plan of care did not provide clear direction for staff with regards to the use of restraints.

There was increased risk of harm to the resident as their plan of care did not provide clear direction related to the use of restraints.

Sources: Clinical records reviewed for the resident included orders, the Documentation Survey Report V2 for December 2020, PLS Quarterly Restraints Reassessment, care plan; and interviews with a PSW, RPN, and other staff. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident plans of care provide clear direction for the use of restraints, to be implemented voluntarily.

WN #4: 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 Food Temperatures – Point of Service policy and procedure included in the Dietary Services program were complied with.

LTCHA s. 11 (1) (a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O. Reg. 79/10, s. 68 (1) (a) and s. 68 (2) requires that the program includes the development and implementation of policies and procedures related to nutrition care and dietary services.

Specifically, staff did not comply with the home's policy and procedure "Food Temperatures – Point of Service", dated October 2013.

A complaint was received by the Ministry of Long Term Care, which included concerns related to food temperatures.

During the lunch meal service, the food temperatures were not recorded by a Dietary Aide prior to meal service. The home's "Food Temperatures – Point of Service" policy indicated that food temperatures were to be taken and recorded by the dietary aide, for all foods prior to meal service. As a result of the food temperatures not being recorded, there was increased risk to the residents that foods would be served at unsafe temperatures.

Sources: Food Temperatures – Point of Service policy (#05-06, last revised October 2013); the food temperature records binder; and interviews with a Dietary Aide and other staff. [s. 8. (1) (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 food temperatures are taken and recorded as per the home's policy, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's policy titled "Restraints- Program Overview" was complied with for two residents.

The licensee's policy stated under the procedure section that residents who used a restraint would be evaluated quarterly by registered nursing staff using the electronic Quarterly Restraint Reassessment in Point Click Care (PCC).

Resident #001 required a restraint. Their care plan also indicated that registered staff would complete a Quarterly Restraint Reassessment on PCC and evaluate the effectiveness of restraint used under the Restraint Resident Assessment Protocol (RAP) every three months. No Quarterly Restraint Reassessment was completed for resident #001 for the one quarter of 2020. [s. 29. (1)]

2. A Registered Practical Nurse identified resident #010 as a resident who required a restraint. No Quarterly Restraint Reassessments were completed for resident #010 for three quarters of 2020.

The Director of Care said that the Quarterly Restraint Reassessments should have been completed by registered staff in PCC. They said that the home had identified some missing assessments during an audit and that these assessments should have been completed for the two residents.

There was increased risk of harm to both residents as the home did not complete the Quarterly Restraint Reassessments as specified in the home's policy.

Sources: Clinical records reviewed for residents #001 and #010 included orders, care plans, PLS Quarterly Restraints Reassessment; the licensee's policy titled 'Restraints-Program Overview' (08-17, updated January 2020) and an interview with the DOC. [s. 29. (1) (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 Quarterly Restraint Reassessments are completed as per the home's policy, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of allegations of incompetent treatment of a resident.

A staff member brought forward concerns to the home related to incompetent care of a resident. The home did not immediately submit a Critical Incident Systems (CIS) report to the Ministry of Long-Term Care (MLTC) related to the allegations.

Sources: Critical Incident System (CIS) report; the home’s investigation notes; and interviews with the Administrator and Director of Care. [s. 24.]

Issued on this 17th day of February, 2021

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) :	CHRISTINA LEGOUFFE (730), KRISTEN MURRAY (731)
Inspection No. / No de l'inspection :	2021_790730_0004
Log No. / No de registre :	026032-20, 001065-21, 001305-21, 001722-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 17, 2021
Licensee / Titulaire de permis :	Henley Place Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Henley Place 1961 Cedarhollow Boulevard, London, ON, N5X-0K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Kummerfield

To Henley Place 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Order / Ordre :

The licensee must comply with s. 20 (1) of the LTCHA, 2007.

Specifically, the licensee must:
a) Ensure that staff immediately report any incident of suspected resident abuse or incompetent care in accordance with the licensee's policy titled "Zero Tolerance of Resident Abuse/Neglect."

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with for three residents.

The licensee's policy titled "Zero Tolerance of Resident Abuse/Neglect" (2-17) stated that employees must immediately report any case of suspected abuse to their department manager, immediate supervisor, or during off hours the most senior supervisor available.

A. A staff member brought forward concerns to the home related to an incident that occurred five days before. The staff member reported concerns related to incompetent care of a resident. The Director of Care said that the staff member did not immediately report their concerns to management in the home, which would be the home's expectation. [s. 20.]

2. A resident showed an inappropriately behaviour towards another resident. A Registered Nurse (RN) said that they discovered a progress note related to the incident, written by the RPN, when they were reviewing the 24 hour report the following day. They also said that the RPN who had been on duty at the time of the incident, should have reported the incident to management immediately. Disciplinary action was taken against the RPN by the home related to their policy

of reporting allegations of resident to resident abuse. [s. 20.]

3. One resident acted inappropriately towards another resident. An RN told the home during their investigation that they had been informed by the RPN on the unit about the incident but had failed to follow the home's procedure and report the incident to management. Disciplinary action was taken against the RN by the home related to their policy of reporting allegations of resident to resident abuse.

There was increased risk of harm to three residents as a result of staff not immediately reporting allegations of abuse or incompetent care to management as per the home's policy.

Sources: Critical Incident System Reports; Clinical records reviewed included: progress notes, care plans, assessments, the home's investigation notes, the licensee's policy titled "Zero Tolerance of Resident Abuse/Neglect" (2-17, revised September 2013); and interviews with an RN and other staff. [s. 20.]

An order was made by taking the following factors into account:

Severity: There was a risk of harm to residents #001, #004, and #006 as staff did not immediately report allegations of abuse or incompetent care to management.

Scope: The scope of this non-compliance was widespread, three of three residents were affected.

Compliance History: One Written Notification (WN) was issued to the home related to the same section of legislation in the past 36 months. (730)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2021

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must comply with s. 131 (3) of O. Reg 79/10.

Specifically, the licensee must:

a) Ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse, unless specified under CMOH Directive #3.

b) Re-educate RN #103 on the home's policy related to medication administration. The licensee must document the education, including the date, and the staff member who provided the education.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that no person administered drugs to residents in the home unless that person was a physician, dentist, registered nurse or registered practical nurse.

On multiple occasions Registered Nurse (RN) #103 asked personal support workers (PSWs) to assist with administering medications to residents on one home area. RN #103 said an Associate Director of Care and the Director of Care (DOC) told them they could ask PSWs to assist with medication administration.

A PSW identified that previously on another home area, RN #103 prepared medications for the residents and placed them on the residents' meal trays for the PSWs to administer to the residents. The home's Medication Pass policy indicated that medication passes were to be completed by registered staff, and medication administration included staying with the resident while the resident took the medications. As a result of RN #103 not administering the medications to the residents, there was increased risk to residents.

Sources: Medication Pass policy (#3-6-1, last revised November 2013); video surveillance footage; and interviews with the DOC and other staff. [s. 131. (3)]

An order was made by taking the following factors into account:

Severity: Medications were administered to residents on multiple dates by PSWs. There was actual risk of harm to residents.

Scope: The scope of this non-compliance was a pattern because it affected every resident on two home areas reviewed.

Compliance History: This section of the regulation under O. Reg 79/10 s. 131 (3) has not been issued to the licensee in the past 36 months.
(731)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2021

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 February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christina Legouffe

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