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
Nov 30, 2021	2021_886630_0035	013364-21, 013637-21, 014149-21, 014383-21, 015039-21, 017004-21	Complaint

Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue Wallaceburg ON N8A 4M2

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

Fairfield Park
1934 Dufferin Avenue Wallaceburg ON N8A 4M2

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

AMIE GIBBS-WARD (630)

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): Onsite November 1, 2, 3, 5, 8, 9 and 10, 2021. Offsite November 4, 2021.

The following Complaint intakes were completed within this inspection:

Related to staffing levels and resident care:
Log #014149-21
Log #015039-21
Log #014383-21
Log #013637-21
Log #017004-21

Related to responsive behaviours and alleged sexual abuse:
Log #013364-21

This inspection was conducted concurrently with Critical Incident (CI) Inspection #2021_886630_0034 and an Infection Prevention and Control (IPAC) inspection was completed within that inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the interim Director of Care (DOC), the interim Assistant Director of Care (ADOC), the Resident Care Plan Co-ordinator (RCC), the Director of Activation, the Administrative Assistant, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the BSO/Restorative Care Personal Support Worker (PSW), RPNs, PSWs, a Housekeeper, a Resident Aide (RA), family members and residents.

The inspector also observed resident rooms and common areas, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home, reviewed Residents' Council meeting minutes, reviewed written records of program evaluations and also reviewed the home’s Daily Staffing Assignment sheets.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Personal Support Services
Responsive Behaviours
Sufficient Staffing

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

- **6 WN(s)**
- **4 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provided direct care to residents, were kept aware of the contents of each residents' plan of care and had convenient and immediate access to it.

The home's staffing plan included Resident Aides (RAs) who worked under the direction of nursing staff in the home. Their duties and responsibilities included providing personal care, physical assistance as well as one to one support to residents, especially at times when there was not a full compliment of Personal Support Worker (PSW) staff available in the home. Residents' care needs and interventions were communicated to the staff primarily through the electronic plan of care. The RAs in the home did not have access to the plan of care or POC and had not received training on resident care plans. This placed residents at risk for not receiving the care they required.

Sources: Observations November 5, 8 and 9, 2021; Residents' care plan and other clinical records; Resident Aide Job Description March 2020; interview with a RA and other staff. [s. 6. (8)]

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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure written approaches to care, including the identification of behavioural triggers that may result in responsive behaviours, were developed to meet the needs of the resident.

The written approaches included in the care plan for a resident with specific responsive behaviours, did not include the identification of triggers for those behaviours. The home had a variety of agency staff working with the resident who were not familiar with their care needs. The lack of the identification of the triggers in their written interventions placed the resident at risk for not receiving the care they required.

Sources: Interview with a family member; the resident's care plan and other clinical records; interview with a Registered Practical Nurse (RPN) and other staff. [s. 53. (1) 1.]

2. The licensee has failed to ensure written strategies were developed to meet the needs of a resident, including techniques and interventions, to prevent, minimize or respond to their responsive behaviours.

During the inspection on multiple occasions a resident was observed to have specific responsive behaviours. Their behaviour monitoring documentation and progress notes also showed they were having responsive behaviours on a daily basis. Multiple staff said the resident required a specific intervention, as it was the only thing that was effective to help respond to their behaviours. The resident's written care plan did not include this specific intervention. The lack of this as a written strategy placed the resident at risk for not receiving the care they required.

Sources: Observations November 1, 2, 3, 5, 8 and 9, 2021; the resident's progress note and other clinical records; the home's Daily Staffing Assignment sheets September and October 2021; the home's written staffing plan; interviews with a RPN and other staff. [s. 53. (1) 2.]

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 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 :

1. The licensee has failed to ensure the care provided to a specific resident under the personal support services program, including interventions and the resident's responses to interventions, were documented.

The expectation in the home was that the personal care provided to the residents would be documented in the computer. Staff and management said documentation of the personal care provided to residents was not always being completed due to time constraints.

A specific resident's Documentation Survey Reports for a two month period, showed there was no documented evidence to demonstrate that staff had provided personal hygiene care to the resident on five out of 61 day shifts and 15 out of 61 evening shifts. There was no harm associated with the missing documentation, however it posed a risk as it effected staff's ability to determine whether the personal care had been provided or refused.

Sources: The resident's Documentation Survey Reports; and interviews with the Administrator and other staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written staffing plan promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident.

Multiple anonymous complaints were received by the Ministry of Long-Term Care

(MLTC) regarding staffing levels in the home and the continuity of resident care.

Observations in the home identified there were staff from multiple agencies and a variety of RAs and Housekeeping Aides assisting with residents' personal care. There were times during the inspection when the majority of nursing and personal support staff in a home area on a shift were from agencies.

Residents and families expressed concerns to Inspector #630 regarding the continuity of care in the home for nursing and personal support services.

Staff and management in the home reported that, due to decreased availability of the home's PSWs and registered nursing staff, a variety of strategies had been implemented to care for the residents. This included utilizing RAs, Housekeeping Aides, Laundry Aides, management staff as well as PSWs, RPNs and Registered Nurses (RNs) from external agencies to provide care to residents in August, September and October 2021.

Staff told Inspector #630 that they felt the RAs and staff from agencies were doing their best to assist with resident care, but were often not familiar with the residents or the processes in the home which they felt impacted on resident care. In addition, the management in the home reported there had been a high turnover of RA staff since the position had been started during the COVID-19 pandemic.

The management described the home as having a staffing crisis related to the COVID-19 pandemic. They said they had been reaching out to external agencies and community partners for support. The Administrator said they had been working on a long-term plan to hire and train more PSW and registered nursing staff, but in the meantime they were doing everything they could to provide residents with care including utilizing RAs and staff from five different agencies.

Sources: Daily Staff Assignment sheets September 1 to November 3, 2021; interview with residents; observations November 1, 2, 3, 5, 8, 9 and 10, 2021; Chatham-Kent Ontario Health Team Briefing Notes October 29, 2021; Job Description Resident Aide March 2020; interviews with the Administrator and other staff. [s. 31. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the staffing plan promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed, at a minimum twice a week by the method their choice, unless contraindicated by a medical condition.

Staff and management acknowledged there were times when residents were not receiving their preferred bathing care twice per week as scheduled, due to not having a full compliment of PSW staff working in the home. They said PSWs were the staff members primarily responsible for bathing care. The staff said when a tub bath or shower was missed due to staffing levels it was difficult to make them up on other shifts. The home did not have a process implemented to make up missed baths or showers or to follow-up with staff to determine if the missed documentation meant the care was not provided.

The care plans for two residents showed they preferred a shower twice per week and required specific levels of care from the staff with their bathing care. Their "Documentation Survey Report" for a two month period, showed there was no documented evidence that they had received a shower twice per week. For one resident there was no documented care for six out 17 scheduled showers. For the other resident there was no documented care for nine out of 18 scheduled showers.

Management said residents were thoroughly washed daily by staff as part of their routine morning care and therefore were being kept clean even if bathing care was not being provided twice weekly in a tub or shower. This personal care reduced the risk related to missed bathing care, however these residents were at risk for not receiving the personal bathing care they preferred and required.

Sources: Documentation Survey Reports and other clinical records for residents; an interview with a family member; and interviews with the Resident Care Plan Coordinator and other staff. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, 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 :

1. The licensee has failed to ensure that residents, who required continence care products as part of their toileting plan of care, had sufficient changes to remain clean and dry.

Staff and management said there were times when residents were not receiving timely continence care in the home due to not having a full compliment of PSW staff available for personal care.

i) A family member expressed concerns related to a resident's continence care needs not being met in the home. The resident's "Documentation Survey Report" for a two month period showed there was no documented evidence that staff had provided continence care on 22 out of 61 day shifts, 17 out of 61 evening shifts, and 17 out of 61 night shifts.

ii) Staff reported concerns that a resident was not consistently receiving the continence care they required in the home due to not having a full compliment of PSW staff available for personal care. The resident's "Documentation Survey Report" for a two month period, showed there was no documented evidence that staff had provided continence care on 18 out of 61 day shifts, 17 out of 61 evening shifts, and 17 out of 61 night shifts.

Sources: Documentation Survey Reports and other clinical records for two residents; an interview with a family member; and interviews with a PSW and other staff. [s. 51. (2) (g)]

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 who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

Issued on this 3rd day of December, 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) :	AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2021_886630_0035
Log No. / No de registre :	013364-21, 013637-21, 014149-21, 014383-21, 015039-21, 017004-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 30, 2021
Licensee / Titulaire de permis :	LaPointe-Fisher Nursing Home, Limited 1934 Dufferin Avenue, Wallaceburg, ON, N8A-4M2
LTC Home / Foyer de SLD :	Fairfield Park 1934 Dufferin Avenue, Wallaceburg, ON, N8A-4M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Maxim

To LaPointe-Fisher Nursing Home, 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. 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).

Order / Ordre :

The licensee must be compliant with s. 6 (8) of the LTCHA.

Specifically, develop and implement a process in the home to ensure that Resident Aides (RAs), and any other staff who provide direct care to residents, are kept aware of the contents of each resident's plan of care and have convenient and immediate access to it.

Provide training to RAs, and any other staff who are involved in direct care to residents, regarding the process for accessing and understanding resident plans of care. A documented record of this training must be kept in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others who provided direct care to residents, were kept aware of the contents of each residents' plan of care and had convenient and immediate access to it.

The home's staffing plan included Resident Aides (RAs) who worked under the direction of nursing staff in the home. Their duties and responsibilities included providing personal care, physical assistance as well as one to one support to residents, especially at times when there was not a full compliment of Personal Support Worker (PSW) staff available in the home. Residents' care needs and interventions were communicated to the staff primarily through the electronic plan of care. The RAs in the home did not have access to the plan of care or POC and had not received training on resident care plans. This placed residents at risk for not receiving the care they required.

Sources: Observations November 5, 8 and 9, 2021; Residents' care plan and other clinical records; Resident Aide Job Description March 2020; interview with a RA and other staff. [s. 6. (8)].

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

Severity: The RAs in the home not having access to the plan of care placed three specific residents at risk for not receiving the care they required.

Scope: Three of the three residents reviewed had non-compliance with this legislation, demonstrating a widespread issue.

Compliance History: One written notifications (WN) and 11 voluntary plans of correction (VPCs) were issued to the home related to different sections of the legislation in the past 36 months. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 14, 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. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

O. Reg. 79/10, s. 53 (1).

Order / Ordre :

The licensee must be compliant with subsection 53 (1) of O. Reg. 79/10.

Specifically, the licensee must:

i) Assess a resident's individual needs for one to one staffing related to their responsive behaviours. This assessment must be documented, including the names of the persons completing the assessment.

ii) Based on the assessment of the resident's individual need for one to one staffing, develop and implement written strategies to meet their care needs. These strategies must be documented in the resident's plan of care and the home's written staffing plan.

Grounds / Motifs :

1. The licensee has failed to ensure written strategies were developed to meet the needs of a resident, including techniques and interventions, to prevent, minimize or respond to their responsive behaviours.

During the inspection on multiple occasions a resident was observed to have specific responsive behaviours. Their behaviour monitoring documentation and progress notes also showed they were having responsive behaviours on a daily basis. Multiple staff said the resident required a specific intervention, as it was the only thing that was effective to help respond to their behaviours. The resident's written care plan did not include this specific intervention. The lack of this as a written strategy placed the resident at risk for not receiving the care they required.

Sources: Observations November 1, 2, 3, 5, 8 and 9, 2021; the resident's progress note and other clinical records; the home's Daily Staffing Assignment sheets September and October 2021; the home's written staffing plan; interviews with a RPN and other staff. [s. 53. (1) 2.]

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

Severity: The lack of written strategies for one to one care placed the resident at risk for not receiving the care they required for responsive behaviours.

Scope: Two of the three residents reviewed had non-compliance with the written strategies for responsive behaviours, demonstrating a pattern.

Compliance History: One written notifications (WN) and 11 voluntary plans of correction (VPCs) were issued to the home related to different sections of the legislation in the past 36 months. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 14, 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
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 30th day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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