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
Mar 29, 2022	2022_820130_0002	010610-21, 000130-22, 000329-22, 000495-22, 001299-22	Complaint

Licensee/Titulaire de permis

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

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

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

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

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

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 12, 13, 19, 21, 25, 26, 27, 28, 31, and February 1, 2, 3, 4, 7, 8, 9, 14, 2022.

Please note this complaint inspection was conducted concurrently with the following CI inspection: 2022_820130_0001.

NOTE: A Written Notification and Compliance Order related to Ontario Regulation

79/10 s. 36 was identified in this inspection and has been issued in concurrent inspection # 2022_820130_0001 (log #000495-22). A Written Notification and Voluntary Plan of Correction (VPC) related to Ontario Regulation 79/10 s. 30 (2) was identified in this inspection and has been issued in the concurrent inspection # 2022_820130_0001 (log #000495-22). A Written Notification and Voluntary Plan of Correction (VPC) related to Long Term Care Homes Act, s. 6 (1) c and s. 6 (10) b was identified in this inspection and has been issued in concurrent inspection # 2022_820130_0001 (log #000495-22). A Written Notification and Compliance Order related to Ontario Regulation 79/10 s. 33 was identified in concurrent inspection # 2022_820130_0002 (log #001299-22) and was issued in this report. A Written Notification and Voluntary Plan of Correction (VPC) related to Long Term Care Homes Act, s. 6 (7) was identified in concurrent inspection # 2022_820130_0002 (log #009960-21) and was issued in this report.

During this inspection the following was inspected:
Log #: 010610-21 related to medication administration,
Log #: 000130-22 related to sufficient staffing and provision of care,
Log #: 000329-22, #001299-22 and #000495-22, related to sufficient staffing, abuse and neglect, bathing and dining.

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

During the course of the inspection, the inspector(s) spoke with The Acting Administrator, Acting Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Environmental Manager, Business Manager, Physiotherapist (PT) Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, residents and families.

The following Inspection Protocols were used during this inspection:

Dining Observation
Infection Prevention and Control
Medication
Personal Support Services
Responsive Behaviours
Sufficient Staffing

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

- **6 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 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 :

The licensee failed to ensure that multiple residents received a shower, which was their

method of choice, at a minimum, two times a week.

A) According to a complaint received from a resident's Substitute Decision Maker (SDM) and bathing records, the resident had not received a shower, which was their preference, for a number of weeks from October 2021 - February 2022. Staff interviewed and progress notes stated that staff were not able to shower the resident because they lacked specific equipment, necessary to complete the task and because the plan of care did not provide clear direction regarding transfers.

B) A complaint was received from another resident’s family member that showers were not being completed. Bathing records were reviewed for three additional residents that lived on the same unit for January 2022. The three residents were required to have a minimum of nine showers that month. It was documented that the first resident missed four showers, the second resident missed five showers and the third resident missed seven showers. If it was documented that a resident demonstrated a responsive behaviour, refused their shower or were required to be in isolation, Inspector #583 did not include their missed shower in the summary above.

PSW staff confirmed that not all residents were bathed two times per week by a method of their choice on the identified unit in January 2022. Staff shared short staffing and staff not using resident specific techniques and interventions to respond to responsive behaviours as factors that contributed to showers not being completed. Bathing records were reviewed in February 2022, to see who received a shower on the previous day for the specific unit. It was documented that two out of eight scheduled residents received a shower and that one resident refused. Staff who worked during this time period confirmed that not all scheduled showers were completed. No staffing shortages were identified on the unit on those days, but two PSW staff were on modified duties. In interviews with PSW staff that regularly worked on the unit it was shared that there was no process in place to make up missed showers and that once they are missed they were not rescheduled.

C) During an interview in February 2022, a resident stated it was their preference to have a shower twice a week; however, due to short staffing they had not received a shower for one month. Their plan of care stated they required total dependence of one staff for bathing and that they preferred showers twice a week. According to the progress notes, the resident had received two out of 11 showers during a specific time period. PSWs interviewed during this inspection shared that the home had been routinely short staffed requiring agency staff and that not all showers on the unit were being completed. PSWs

on other units shared that there was no process in place to make up missed showers and that once they were missed they were not rescheduled.

Sources: Plan of care, POC, Bathing Task Care Records; Bath Day Skin/Oral Assessments; progress notes and bathing care plans. Resident observation, interviews STM, residents, ADOC and other staff.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that care set out in the plan of care for residents related to hygiene, grooming and mobility was provided to the resident as specified in the plan.

A) A resident's plan of care stated the resident's needs related to activities of daily living and what was required of staff on specific days.

The resident was observed on two separate dates during this inspection and observed to have an unkept appearance. During the observation, they stated their preferences for specific tasks and their need for assistance.

Staff interviewed confirmed they had performed a specific task prior to the observation, but had not provided all of the care set out in the plan of care.

B) During an interview another resident, complained they had recently been left in bed all day because they were told the home was short staffed.

The plan of care indicated that the resident was totally dependent on staff for most aspects of care, including bed mobility and transfers; they had a history of pain due to their diagnosis.

A progress note recorded by staff in January 2022, confirmed that the resident had expressed they were uncomfortable and requested to get out of bed; however, due to a staffing shortage, the resident and all other residents on the unit were left in bed all day.

Staff interviewed and the daily staffing schedule confirmed the home was short staffed on all shifts on a date in January 2022.

There was a risk of increased pain to the resident when care was not provided to them as specified in their plan of care.

Sources: Observations and Interviews with residents. Clinical record reviews and interviews with nursing and office staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

WN #3: 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 :

The licensee failed to ensure that triggers were identified and strategies were developed and implemented to respond to residents' with responsive behaviours.

A) It was documented in February 2022, that a resident refused to have their scheduled shower. In January 2022 the resident did not receive seven of their scheduled showers, there was no documentation as to why they were missed. In interviews with staff it was shared the resident sometimes refused care.

In January 2022, the resident was found sleeping in their bed in an unacceptable state. The resident required one staff to provide extensive assistance with their care. Progress notes were reviewed over a six week period prior and did not identify any incidents of refusal of care, triggers or any strategies staff used to respond. Their plan of care did not identify the responsive behaviour and did not include any strategies to use when providing care. It was acknowledged by the Acting DOC that triggers and strategies were not developed to help ensure the resident's care needs were met.

B) A second resident's care plan stated they had a responsive behaviour that required specific interventions and actions by staff related to those behaviours and the goal for care. In January 2022 the resident did not receive six of their scheduled showers. In interviews with staff it was shared it was often related to the responsive behaviour.

In January 2022, PSW staff assigned to morning care, observed the resident in unacceptable condition. There was malodour in the room and the resident was wearing the same outfit that the same PSW had dressed them in two days prior. In an interview nursing staff shared that due to responsive behaviours it was not uncommon to observe the resident in this state. Progress notes in January 2022, did not contain any documentation of the responsive behaviour, actions taken when the responsive behaviour was demonstrated and the resident's response to the interventions. This was acknowledged by the Acting DOC.

Sources: CI Reports; bathing schedules; bathing records; Bath Day Skin/Oral Assessment; clinical records and interviews with Acting DOC and other staff.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that triggers are identified and strategies are developed and implemented to respond to residents' responsive behaviours, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee failed to ensure that no drugs were administered to residents unless the drugs had been prescribed to that resident.

In July 2021, agency nursing staff reported that while administering medications, they did not confirm the identity of a resident. They assumed it was another resident, as they resided in the same room and administered the resident the incorrect medication.

This medication included drugs that the resident was allergic to. As a result, the resident experienced an adverse reaction.

Failure to ensure the identity of the resident receiving the medication resulted in a resident receiving the wrong medications which caused harm to the resident when they experienced side effects.

Sources: Plan of care, incident report, interview with ADOC #118.

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 no drugs are administered to residents unless the drugs have been prescribed to that resident, to be implemented voluntarily.

WN #5: 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 :

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, was in compliance with and was implemented, in accordance with applicable requirements under the Act and in accordance with r. 48 (2) which requires every long term care home to ensure there is a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

In accordance with the home's policy, residents were to have their skin examined twice a week by the PSW on their bath and shower day. Staff were to document their findings, sign and date the appropriate form.

Over a five month period in 2021 and 2022, staff documented that a resident's skin was examined on eight of 32 bath/shower days.

Staff interviewed confirmed it was the expectation that the resident's skin was to be examined on bath days and that the form be completed. Staff acknowledged that the Bath Day Skin/Oral assessments forms were not consistently completed.

Sources: Then home's Skin and Wound Policy, 10-03, version: August 2019, titled Bath Day Skin /Oral Assessment, interview with staff.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee failed to ensure that a verbal complaint made to the licensee or a staff member by resident, concerning their care, was dealt with.

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

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

According to the plan of care, the resident required specific equipment for care. In October 2021, a device used by the resident broke and was not replaced until December 2021. The new devices that were ordered by the home were assessed to be unsuitable for the resident. The plan of care identified the resident had not received their preferred choice of shower for approximately 18 weeks from October 2021 to February 2022. The resident and staff interviewed indicated the reason for not receiving a shower was directly related to the lack of equipment.

A progress note recorded in January 2022, indicated the resident had complained to staff that they were not getting the care they needed. The same staff recorded and confirmed in an interview that they had reported the complaint to the ADOC, but were not aware that any action had been taken by the ADOC.

There was no documentation to indicate the ADOC had followed up with the resident. The ADOC confirmed in an interview that they were not aware that the resident had not been receiving their shower for the reasons specified by staff.

There was an ongoing risk that the resident's care needs were not being met when their complaint was not dealt with.

Sources: Plan of care, care plan, progress notes, interviews with the resident, ADOC and other staff.

Issued on this 29th day of March, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	GILLIAN HUNTER (130), CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l’inspection :	2022_820130_0002
Log No. / No de registre :	010610-21, 000130-22, 000329-22, 000495-22, 001299-22
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 29, 2022
Licensee / Titulaire de permis :	Henley House Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	The Henley House 20 Ernest Street, St Catherines, ON, L2N-7T2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Nancy Bosco

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must:

a) Ensure all residents receive two baths/showers per week or more frequently as determined by the resident's hygiene requirements.

b) Ensure all residents are bathed by the method of their choice.

c) Develop a contingency plan that includes how missed scheduled baths/showers will be made up when missed due to staffing shortages.

d) Ensure all relevant staff are aware of the contingency plan.

e) Routine audits shall be completed and a record kept until staff are compliant with the contingency plan.

Grounds / Motifs :

1. The licensee failed to ensure that multiple residents received a shower, which was their method of choice, at a minimum, two times a week.

A) According to a complaint received from a resident's Substitute Decision Maker (SDM) and bathing records, the resident had not received a shower, which was their preference, for a number of weeks from October 2021 - February 2022. Staff interviewed and progress notes stated that staff were not

able to shower the resident because they lacked specific equipment, necessary to complete the task and because the plan of care did not provide clear direction regarding transfers.

B) A complaint was received from another resident's family member that showers were not being completed. Bathing records were reviewed for three additional residents that lived on the same unit for January 2022. The three residents were required to have a minimum of nine showers that month. It was documented that the first resident missed four showers, the second resident missed five showers and the third resident missed seven showers. If it was documented that a resident demonstrated a responsive behaviour, refused their shower or were required to be in isolation, Inspector #583 did not include their missed shower in the summary above.

PSW staff confirmed that not all residents were bathed two times per week by a method of their choice on the identified unit in January 2022. Staff shared short staffing and staff not using resident specific techniques and interventions to respond to responsive behaviours as factors that contributed to showers not being completed. Bathing records were reviewed in February 2022, to see who received a shower on the previous day for the specific unit. It was documented that two out of eight scheduled residents received a shower and that one resident refused. Staff who worked during this time period confirmed that not all scheduled showers were completed. No staffing shortages were identified on the unit on those days, but two PSW staff were on modified duties. In interviews with PSW staff that regularly worked on the unit it was shared that there was no process in place to make up missed showers and that once they are missed they were not rescheduled.

C) During an interview in February 2022, a resident stated it was their preference to have a shower twice a week; however, due to short staffing they had not received a shower for one month. Their plan of care stated they required total dependence of one staff for bathing and that they preferred showers twice a week. According to the progress notes, the resident had received two out of 11 showers during a specific time period. PSWs interviewed during this inspection shared that the home had been routinely short staffed requiring agency staff and that not all showers on the unit were being completed. PSWs on other units shared that there was no process in place to make up missed showers and that

once they were missed they were not rescheduled.

Sources: Plan of care, POC, Bathing Task Care Records; Bath Day Skin/Oral Assessments; progress notes and bathing care plans. Resident observation, interviews STM, residents, ADOC and other staff.

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

Severity: There was no identified risk to the residents.
Scope: The scope was widespread as greater than three residents were affected.
Compliance History: In the last 36 months, there was no non compliance issued to the same section.
(583)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 29, 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 29th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

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

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