Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2017	2016_413500_0014	032053-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

NITAL SHETH (500), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 8, 9, 10, 11, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, December 1, 2, 7, 2016.

The following intakes were inspected concurrently during this RQI:

Critical Incident (CI) Intakes related to staff to resident abuse #002164-15, resident to resident abuse #028890-16, and complaints intakes related to Residents' Bill of Rights #000984-15, #007507-15, #029793-16, duty to protect #030847-16, continence care and management #009374-15, #034325-15, and falls incident injury #032351-16.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Unit Directors, Assessment Instrument (RAI) Coordinator, Social Workers (SW), Meditech Educator, Health Record Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), President of the Residents' Council, President of the Family Council, Residents, and Family Members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection prevention and control practices, reviewed clinical health records, staffing schedules/assignments, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

5 WN(s)
1 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from physical abuse by anyone.

For the purposes of the definition of “abuse” in subsection 2 (1) of the O. Reg. 79/10, “physical abuse” means, the use of physical force by a resident that causes physical injury to another resident.

A review of the Critical Incident System (CIS) report revealed that in 2016, PSW #120 found resident #007 sitting in resident #006's room. Resident #007 exhibited a responsive behaviour when PSW #120 attempted to redirect and move him/her from resident #006's room. PSW #120 stepped outside the room to get assistance; meanwhile resident #006 returned to his/her room. PSW #120 returned to the room, found resident #006 dragging resident #007 on the floor out his/her room. Resident #007 was screaming. Resident #007 was hospitalized and sustained an injury.

A review of resident #006's written plan of care revealed that staff were required to redirect him/her upon exhibition of responsive behaviour.

Interview with PSW #120 revealed that resident #006 had responsive behaviour, and confusion, and if someone went into his/her premises he/she would exhibit responsive behaviours. On an identified day in 2016, when PSW #120 stepped out of the room to get assistance to remove resident #007 from resident #006's room, he/she found resident #006 dragging resident #007 across the floor by the hand out of his/her room. Resident #007 was crying and was agitated because of pain. Resident #007 was sent out to the hospital. Resident #006 used physical force towards resident #007, and resident #007 sustained an injury.

Interview with RN #106 was not completed because the inspector attempted to contact the staff member, however RN #106 was unavailable for interview and did not return call.

A review of progress notes, documented by RN #106 confirmed the above mentioned incident.

A review of the home's investigation record revealed that resident #007 sustained an injury as a result of the use of physical force by resident #006.

Interview with Unit Director #105 revealed that resident #007 sustained an injury due to physical abuse by resident #006. [s. 19. (1)]

2. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

For the purposes of the definition of “neglect” in subsection 2 (1) of the O. Reg. 79/10, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of the CIS revealed that in 2016, resident #009 had a fall when PSW #108 was preparing to transfer the resident. The resident sustained an injury. The resident was transferred to the hospital for treatment and returned to the home on the same day. Eight days later, the resident was noted unresponsive and transferred to the hospital. The resident returned from the hospital with a new identified diagnosis.

A review of the resident’s clinical record revealed that the resident passed away on the following day.

An interview with PSW #108 revealed that he/she was preparing the resident for a transfer and safety measures were not applied to the bed. He/she was waiting for another PSW to help for a transfer. Meanwhile, he/she turned his/her back to grab something and the resident rolled over and fell on the floor. PSW #108 asked PSW #121 to transfer the resident and they both transferred the resident from the floor to the bed. PSW #108 stated that it was a mistake and he/she was very upset with the incident and apologized for what happened with the resident.

Interview with PSW #121 revealed that he/she helped PSW #108 to transfer the resident from the floor to the bed assuming that the nurse had already completed an assessment of the resident.

A review of the home’s policy entitled “Elder Abuse and Neglect: Zero Tolerance”, revised July 2015, indicated that the residents of the home are protected from Abuse and Neglect by reinforcing that such abuse and neglect are not tolerated in the home. The policy indicated a definition of neglect, means the failure to provide a client with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more clients.

Interview with the Unit Director #111, revealed that it was an accident and both PSWs were counselled for neglecting the home’s falls prevention and safety protocols. PSW #108 should have followed safety protocols, while turning back to grab something in

order to ensure the resident's safety in the bed.

Interview with the DOC revealed that as per the definition of neglect, it was neglect. It was an unintentional neglect which turned into an accident and injury to the resident.

The severity of the non-compliance and the severity of the harm were actual harm.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed that Compliance Order (CO) was issued during inspection #2014_405189_0003, dated November 14, 2016, related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On November 16, 2016, around 0900 hours the inspector observed 13 resident rooms had signs posted on the entrance. These signs indicated residents' transferring and positioning requirement and were visible to anyone walking in the hallway.

Interviews with PSWs #108, #119, #121, RPNs #103, #109, #113, RNs #107, and #110 revealed that the above mentioned information represents the residents' personal health information and it should be protected.

Interview with Unit Director #111, and the DOC revealed that the above mentioned information is residents' personal health information and should be protected from anyone. It should not be posted outside the room. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy put in place is complied with.

A review of the home's policy entitled "Weighing Clients/ Weight Changes", revised June 2015, indicated, each resident's height should be measured in centimeters within 24 hours of admission and annually after.

A review of resident #002, #003, #010, #014, #015, #016, #017, #018, #019, #020, and #021's height record revealed that their heights were not measured annually.

Interviews with RPNs #103, #112, #113, #114, #115, #116, #117 revealed that they are measuring residents' heights on admission.

Interview with Unit Director #111 revealed that resident' heights are measured on admission, and should also be done annually as per the home's policy. [s. 8. (1) (b)]

2. A review of the home's policy entitled "Falls Risk Management", revised April 20, 2015, revealed that initial response for all staff after a witnessed or unwitnessed fall is "do not move client".

A review of the CIS revealed that in 2016, resident #009 had a fall when PSW #108 was preparing to transfer the resident. The resident sustained an injury. The resident was transferred to the hospital and returned to the home on the same day. Eight days later, the resident was noted unresponsive and transferred to the hospital. The resident returned from the hospital with a new identified diagnosis.

Interviews with PSWs #108 and #121 revealed that they made a mistake that they moved resident #009 without notifying to the nurse.

Interview with RN #109, Unit Director #111, and the DOC revealed that as per the home's policy staff should not move the resident after a fall without first reporting to the nurse. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, contained an explanation of the duty under section 24 to make mandatory reports.

A review of the home’s policy entitled “Elder/Client Abuse and Neglect: Zero Tolerance”, revised July 2015, indicated that staff are to report any suspected, witnessed or allegation of abuse by anyone or neglect by the staff to the management, and the Unit Director or Director of Care will contact the Ministry of Health. The policy does not indicate a clear description for a person to report the suspicion to the Director of the Ministry of Health and Long-term Care.

Interview with DOC revealed that the policy does not have a clear explanation of the duty under section 24 to make mandatory reports and the policy requires a revision. [s. 20. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A review of the CIS report revealed that in 2016, PSW #120 found resident #007 sitting in resident #006's room. Resident #007 became exhibited responsive behaviour when PSW #120 attempted to redirect and move him/her from resident #006's room. PSW #120 stepped outside the room to get assistance; meanwhile resident #006 returned to his/her room. PSW #120 returned to the room, found resident #006 dragging resident #007 on the floor out his/her room. Resident #007 was screaming. Resident #007 was hospitalized and sustained an injury.

Interview with Unit Director #105 confirmed that the above mentioned CI should have been reported immediately. [s. 24. (1)]

Issued on this 24th day of January, 2017

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), DEREGE GEDA (645)
Inspection No. / No de l'inspection :	2016_413500_0014
Log No. / Registre no:	032053-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 23, 2017
Licensee / Titulaire de permis :	THE JEWISH HOME FOR THE AGED 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
LTC Home / Foyer de SLD :	THE JEWISH HOME FOR THE AGED (2824) 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dr. William Reichman

To THE JEWISH HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

1.The licensee shall develop, implement and submit a plan that the home will ensure:

-the home will prevent incidents of staff to resident neglect which can jeopardize residents' health and safety.

- all residents residing on third floor RF home area are protected from physical abuse elicited by residents' physically responsive behaviour.

The plan is to include the required tasks, the person responsible for completing tasks and the time lines for completion. The plan is to be submitted to nital.sheth@ontario.ca by February 3, 2017.

2. Within a week of receipt of this order the home will conduct meetings between management and direct care staff related to:

a). Neglect. Ensure the meeting includes a review of the definition of neglect, and a discussion on the types of actions from staff during a care may jeopardize residents' health and safety.

b). Resident to resident physical abuse. The meeting shall allow direct care staff opportunities to collaborate in the development and implementation of written strategies, including techniques and interventions to meet the needs of residents' physically responsive behaviours.

Meetings shall include techniques and interventions, to prevent, risks associated with,
-actions taken by staff during transferring and providing care which can constitute in neglect and
- resident to resident physical abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

For the purposes of the definition of "neglect" in subsection 2 (1) of the O. Reg. 79/10, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being

of one or more residents.

A review of the CIS revealed that in 2016, resident #009 had a fall when PSW #108 was preparing to transfer the resident. The resident sustained an injury. The resident was transferred to the hospital for treatment and returned to the home on the same day. Eight days later, the resident was noted unresponsive and transferred to the hospital. The resident returned from the hospital with a new identified diagnosis.

A review of the resident's clinical record revealed that the resident passed away on the following day.

An interview with PSW #108 revealed that he/she was preparing the resident for a transfer and safety measures were not applied to the bed. He/she was waiting for another PSW to help for a transfer. Meanwhile, he/she turned his/her back to grab something and the resident rolled over and fell on the floor. PSW #108 asked PSW #121 to transfer the resident and they both transferred the resident from the floor to the bed. PSW #108 stated that it was a mistake and he/she was very upset with the incident and apologized for what happened with the resident.

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Interview with the Unit Director #111, revealed that it was an accident and both PSWs were counselled for neglecting the home's falls prevention and safety protocols. PSW #108 should have followed safety protocols, while turning back to grab something in order to ensure the resident's safety in the bed.

Interview with the DOC revealed that as per the definition of neglect, it was

neglect. It was an unintentional neglect which turned into an accident and injury to the resident. (500)

2. The licensee has failed to protect residents from physical abuse by anyone.

For the purposes of the definition of “abuse” in subsection 2 (1) of the O. Reg. 79/10, “physical abuse” means, the use of physical force by a resident that causes physical injury to another resident.

A review of the Critical Incident System (CIS) report revealed that in 2016, PSW #120 found resident #007 sitting in resident #006’s room. Resident #007 exhibited a responsive behaviour when PSW #120 attempted to redirect and move him/her from resident #006’s room. PSW #120 stepped outside the room to get assistance; meanwhile resident #006 returned to his/her room. PSW #120 returned to the room, found resident #006 dragging resident #007 on the floor out his/her room. Resident #007 was screaming. Resident #007 was hospitalized and sustained an injury.

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Interview with PSW #120 revealed that resident #006 had responsive behaviour, and confusion, and if someone went into his/her premises he/she would exhibit responsive behaviours. On an identified day in 2016, when PSW #120 stepped out of the room to get assistance to remove resident #007 from resident #006’s room, he/she found resident #006 dragging resident #007 across the floor by the hand out of his/her room. Resident #007 was crying and was agitated because of pain. Resident #007 was sent out to the hospital. Resident #006 used physical force towards resident #007, and resident #007 sustained an injury.

Interview with RN #106 was not completed because the inspector attempted to contact the staff member, however RN #106 was unavailable for interview and did not return call.

A review of progress notes, documented by RN #106 confirmed the above mentioned incident.

A review of the home’s investigation record revealed that resident #007 sustained an injury as a result of the use of physical force by resident #006.

Interview with Unit Director #105 revealed that resident #007 sustained an injury due to physical abuse by resident #006. [s. 19. (1)]

The severity of the non-compliance and the severity of the harm were actual harm.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed that Compliance Order (CO) was issued during inspection #2014_405189_0003, dated November 14, 2016, related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)] (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Inspection de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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