Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2019	2019_641665_0019	026143-18, 011242-19, 011243-19, 011244-19, 011904-19, 013468-19, 015467-19, 017393-19, 017678-19, 018129-19	Critical Incident System

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

JOY IERACI (665), NITAL SHETH (500), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 7-11, 15-18, 22, 24 and 25, 2019.

The following intake logs were inspected:
Follow Up Logs:
- #011242-19 related to abuse and neglect
- #011243-19 related to safe use of transferring and positioning devices or techniques
- #011244-19 related to bathing

Critical Incident System (CIS) Logs:
Logs related to abuse and neglect:
- #026143-18/CIS #2824-000038-18
- #013468-19/CIS #2824-000033-19

Logs related to falls prevention:
- #011904-19/CIS #2824-000024-19
- #015467-19/ CIS #2824-000039-19
- #017393-19/ CIS #2824-000043-19
- #017678-19/CIS #2824-000044-19
- #018129-19/ CIS #2824-000048-19

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7), identified in a concurrent complaint inspection #2097_641665_0020 (Log #019263-19 and Log #019420-19, CIS #2824-000051-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Long Term Care Managers (LTC Manager), Director of Development and Facilities (DDF), Assistant to the ED (AED), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Lead (BSL), Personal Support Workers (PSWs), residents and family members.

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

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_751649_0005	535
O.Reg 79/10 s. 33. (1)	CO #001	2019_751649_0007	535
O.Reg 79/10 s. 36.	CO #002	2019_751649_0005	535

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. (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 :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #031, #032 and #004 as specified in the plan.

A review of the Critical Incident System (CIS) report, indicated that resident #031 sustained areas of altered skin integrity on an identified date and time in 2019. The resident was placed on an identified object to assist with an identified activity of daily living by PSW #110 on an identified time. Family found the resident on the floor in a specified area 10 minutes later. The resident had a change in status an hour and a half later and was sent to the hospital. The resident passed away in the hospital the following day.

A review of the minimum data set (MDS) assessment completed 12 days prior to the CIS report, indicated that the resident required an identified number of people for assistance for the identified activity of daily living mentioned above.

A review of the resident's written care plan did not indicate that family can help with the resident for the identified activity of daily living.

In an interview, PSW #110 indicated that the resident was transferred on an identified object to provide the identified activity of daily living by the family and PSW #110. The family was with the resident and PSW #110 left the room. Usually, when family was there, the family helps with care.

In interviews, PSW #110 and RPN #109 confirmed that they were expected to follow the resident's care plan.

A review of the home's policy entitled, "Minimal Lift and Client/Resident Handling Policy", revised February 6, 2012, indicated that all staff involved in resident handling are required to adhere to the designated transfer status as identified on each of the client/resident's care plan except in emergency or exceptional circumstances.

In an interview, LTC Manager #111 indicated that staff were expected to follow the residents' care plan. The LTC Manager indicated that when a resident's plan of care required an identified number of staff for assistance, that the identified number of staff members were to provide the care. Families and companions were not allowed to provide care to residents unless it was specified in their plan of care. The LTC Manager stated that the identified number of staff members should have helped the resident for care and PSW #110 should have stayed with the resident.

This non-compliance was issued as a result of PSW #110's failure to follow resident

#031's plan of care. [s. 6. (7)]

2. A review of a CIS report, indicated that on an identified date and time in 2019, resident #032 sustained areas of altered skin integrity post transfer into an identified mobility device. Diagnositic testing indicated that the resident sustained an identified injury. The home investigated and identified that staff did not follow the plan of care as a specified mechanical device was not used for the transfer.

A review of the resident's written care plan indicated that the resident required a specified mechanical device for transfers.

In an interview, PSW #102 indicated that they were providing an identified activity of daily living with the resident and transferred the resident on their own. The PSW stated they were not aware about the change in the care plan for the resident which directed staff to use the specified mechanical device for transfers. PSW #102 confirmed that they were expected to follow the resident's care plan.

In an interview, RPN #103 confirmed that the resident required an identified number of people for assistance for transfers and staff were required to implement the resident's care plan.

In an interview LTC Manager #111 indicated that staff were expected to follow the residents' care plan. The LTC Manager indicated that staff should have used the specified mechanical device with the identified number of staff members when they transferred the resident to maintain the resident's safety.

This non-compliance was issued as a result of PSW #102's failure to follow resident #032's plan of care.

3. The Ministry of Long-Term Care received a complaint from the ACTIONLine on an identified date in 2019, related to plan of care concerns and an allegation of abuse towards resident #004. The home submitted a critical incident system (CIS) report the same day related to the same concern.

In an interview, the complainant indicated that an identified number of staff members were to provide care to resident #004. The complainant stated that on an identified date in 2019, the plan of care was not followed as RN #132 provided an identified personal care to the resident on their own.

A review of resident #004's written plan of care indicated care must be provided by an identified number of PSW staff on an identified shift and a different number of PSW staff on another identified shift. The written plan of care did not have documentation regarding the number of PSW staff for care during a different identified shift (A).

In an interview, PSW #133 who worked on an identified shift (A), stated that they knew resident #004 very well and their knowledge of the resident's plan of care was that an identified number of PSW staff were to provide care at all times. When the resident required personal care during the identified shift (A), the identified number of PSW staff must always provide the care. PSW #133 further stated that the number of PSW staff had been in place for years, as it was communicated to the PSW by the unit's registered staff.

A record review of the progress notes in point click care (PCC) on an identified date and time in 2019, by RN #132, indicated that RN #132 provided an identified personal care to the resident, and documented that the identified number of PSW staff were busy.

In an interview, RN #132 indicated they had worked on resident #004's resident home area since 2018, and was aware that the resident's plan of care indicated that an identified number of PSW staff were to provide care. The RN stated that this information was provided to them during shift reports by the registered staff working on an identified shift. The RN acknowledged that they provided personal care to the resident on their own, even though they were aware that the plan of care required an identified number of staff for care.

In an interview, LTC Manager #111 indicated it was an expectation for the staff to follow the residents' plan of care. The LTC Manager acknowledged that RN #132 did not provide care to resident #004 as specified in the plan of care, as the RN provided care to the resident on their own.

This non-compliance was issued as a result of RN #132's failure to follow resident #004's plan of care.

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a).

The home submitted a CIS report to the Director on an identified date in 2018, for an allegation of resident to resident physical abuse between residents #070 and #071.

A review of the CIS report indicated that the home conducted an investigation, but the report did not have documentation of the results of the investigation.

In an interview, LTC Manager #123 indicated they had submitted the CIS report on the identified date in 2018. The LTC Manager reviewed the amended CIS report submitted 14 days later, and confirmed that the results of the home's investigation for the allegation of abuse was not reported to the Director. [s. 23. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: a description of the individuals involved in the incident, including, names of any residents involved in the incident.

A review of a CIS report on an identified date in 2019, indicated that the home submitted an incident causing injury to a resident which resulted in a significant change in the resident's health status. The home did not include the resident's name who was involved in the incident. There was a request made by the Centralized Intake and Triage Team (CIATT) to the home to amend the CIS by an identified date and time to include the full name of the resident. Three voicemails were left by CIATT to the home to amend the CIS on three identified dates. The CIS was not amended until 36 days after the last voicemail CIATT left with the home.

In an interview, LTC Manager #111 indicated that the home should have amended the CIS based on the request made by CIATT. [s. 107. (4) 2.]

2. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

A review of the same CIS report noted above , indicated that the home did not include the information about the long-term actions and prevention plan to prevent recurrence of the incident. There was a request made by CIATT to the home to amend the CIS by an identified date and time to include the above mentioned information. Three voicemails were left by CIATT to the home to amend the CIS on three identified dates. The CIS was not amended until 36 days after the last voicemail CIATT left with the home.

In an interview with LTC Manager #111 indicated that the home should have amended the CIS based on the request made by CIATT. [s. 107. (4) 4.]

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 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) :	JOY IERACI (665), NITAL SHETH (500), VERON ASH (535)
Inspection No. / No de l'inspection :	2019_641665_0019
Log No. / No de registre :	026143-18, 011242-19, 011243-19, 011244-19, 011904-19, 013468-19, 015467-19, 017393-19, 017678-19, 018129-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 15, 2019
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, TORONTO, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Simon Akinsulie

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 The Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 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. (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).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the Long Term Care Home Act (LTCHA), 2007.

Specifically the licensee must:

1. Ensure residents #004, #032 and any other resident, are provided care by an identified number of staff when required as per the plan of care.

2. Ensure resident #032 and any other resident are transferred with the appropriate mechanical device as specified in the plan of care.

3. Ensure Personal Support Workers (PSWs) #102 and #110 receive re-training on the home's policy titled "Minimal Lift and Client/Resident Handling Policy". The re-training should be documented with the date and who provided the re-training.

4. Develop and implement an auditing tool that documents when the registered staff and PSWs are made aware of the change in the plan of care for resident #032 and any other resident, related to transfers.

5. Ensure audits are conducted to ensure resident #004 receives care during an identified shift by the identified number of staff when required as per the plan of care.

6. Ensure audits are conducted to ensure PSWs #102 and #110 provide care to resident #032 and any other resident with the assistance of the long term care home staff, not family and or companions, when required as per the plan of care.

7. Maintain a written record of the audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit, the outcome of the audits, actions taken to address any concerns and an evaluation of the results.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #031, #032 and #004 as specified in the plan.

A review of the Critical Incident System (CIS) report, indicated that resident #031 sustained areas of altered skin integrity on an identified date and time in 2019. The resident was placed on an identified object to assist with an identified activity of daily living by PSW #110 on an identified time. Family found the resident on the floor in a specified area 10 minutes later. The resident had a change in status an hour and a half later and was sent to the hospital. The resident passed away in the hospital the following day.

A review of the minimum data set (MDS) assessment completed 12 days prior to the CIS report, indicated that the resident required an identified number of people for assistance for the identified activity of daily living mentioned above.

A review of the resident's written care plan did not indicate that family can help with the resident for the identified activity of daily living.

In an interview, PSW #110 indicated that the resident was transferred on an identified object to provide the identified activity of daily living by the family and PSW #110. The family was with the resident and PSW #110 left the room. Usually, when family was there, the family helps with care.

In interviews, PSW #110 and RPN #109 confirmed that they were expected to follow the resident's care plan.

A review of the home's policy entitled, "Minimal Lift and Client/Resident Handling Policy", revised February 6, 2012, indicated that all staff involved in resident handling are required to adhere to the designated transfer status as identified on each of the client/resident's care plan except in emergency or exceptional circumstances.

In an interview, LTC Manager #111 indicated that staff were expected to follow the residents' care plan. The LTC Manager indicated that when a resident's plan of care required an identified number of staff for assistance, that the identified number of staff members were to provide the care. Families and companions were not allowed to provide care to residents unless it was specified in their plan of care. The LTC Manager stated that the identified number of staff members should have helped the resident for care and PSW #110 should have stayed

with the resident.

This non-compliance was issued as a result of PSW #110's failure to follow resident #031's plan of care. (500)

2. A review of a CIS report, indicated that on an identified date and time in 2019, resident #032 sustained areas of altered skin integrity post transfer into an identified mobility device. Diagnositic testing indicated that the resident sustained an identified injury. The home investigated and identified that staff did not follow the plan of care as a specified mechanical device was not used for the transfer.

A review of the resident's written care plan indicated that the resident required a specified mechanical device for transfers.

In an interview, PSW #102 indicated that they were providing an identified activity of daily living with the resident and transferred the resident on their own. The PSW stated they were not aware about the change in the care plan for the resident which directed staff to use the specified mechanical device for transfers. PSW #102 confirmed that they were expected to follow the resident's care plan.

In an interview, RPN #103 confirmed that the resident required an identified number of people for assistance for transfers and staff were required to implement the resident's care plan.

In an interview LTC Manager #111 indicated that staff were expected to follow the residents' care plan. The LTC Manager indicated that staff should have used the specified mechanical device with the identified number of staff members when they transferred the resident to maintain the resident's safety.

This non-compliance was issued as a result of PSW #102's failure to follow resident #032's plan of care. (665)

3. The Ministry of Long-Term Care received a complaint from the ACTIONLine on an identified date in 2019, related to plan of care concerns and an allegation of abuse towards resident #004. The home submitted a critical incident system (CIS) report the same day related to the same concern.

In an interview, the complainant indicated that an identified number of staff members were to provide care to resident #004. The complainant stated that on an identified date in 2019, the plan of care was not followed as RN #132 provided an identified personal care to the resident on their own.

A review of resident #004's written plan of care indicated care must be provided by an identified number of PSW staff on an identified shift and a different number of PSW staff on another identified shift. The written plan of care did not have documentation regarding the number of PSW staff for care during a different identified shift (A).

In an interview, PSW #133 who worked on an identified shift (A), stated that they knew resident #004 very well and their knowledge of the resident's plan of care was that an identified number of PSW staff were to provide care at all times. When the resident required personal care during the identified shift (A), the identified number of PSW staff must always provide the care. PSW #133 further stated that the number of PSW staff had been in place for years, as it was communicated to the PSW by the unit's registered staff.

A record review of the progress notes in point click care (PCC) on an identified date and time in 2019, by RN #132, indicated that RN #132 provided an identified personal care to the resident, and documented that the identified number of PSW staff were busy.

In an interview, RN #132 indicated they had worked on resident #004's resident home area since 2018, and was aware that the resident's plan of care indicated that an identified number of PSW staff were to provide care. The RN stated that this information was provided to them during shift reports by the registered staff working on an identified shift. The RN acknowledged that they provided personal care to the resident on their own, even though they were aware that the plan of care required an identified number of staff for care.

In an interview, LTC Manager #111 indicated it was an expectation for the staff to follow the residents' plan of care. The LTC Manager acknowledged that RN #132 did not provide care to resident #004 as specified in the plan of care, as the RN provided care to the resident on their own.

This non-compliance was issued as a result of RN #132's failure to follow resident #004's plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to residents #031 and #032. The scope of the issue was a level 2 as it related to three of six residents reviewed. The home had a level 5 compliance history as they had re-issued compliance orders (CO) to the same subsection and four or more COs of the LTCHA that included:

- CO #001 issued July 27, 2017 (2017_486653_0012), complied November 21, 2017
- Voluntary plan of correction (VPC) issued December 3, 2018 (2018_766500_0017)
- VPC issued May 14, 2019 (2019_751649_0007)
- written notification (WN) issued October 10, 2019 (2019_817652_0019);

Additionally, the LTCH has a history of eight other compliance orders in the last 36 months. (665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2020

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 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, 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 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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

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