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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Amended Public Copy/Copie modifiée 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
Jun 23, 2020	2020_543561_0005 (A1)	002593-20, 002899-20, 003294-20, 005400-20, 006966-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Burloak
5959 New Street BURLINGTON ON L7L 6W5

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

Amended by DARIA TRZOS (561) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Error in compliance due date. Revision made.

Issued on this 23rd day of June, 2020 (A1)

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

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

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Long-Term Care Inspections Branch

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

Burloak
5959 New Street BURLINGTON ON L7L 6W5

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

Amended by DARIA TRZOS (561) - (A1)

Amended 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): May 20, 28, 29, 2020, and June 2, 3, 4, 5, 8, 9, 10, 11, 12, 2020.

The following Critical Incident System (CIS) inspections were completed during this off-site inspection:

log #003294-20, CI #2857-000012-20 - related to alleged abuse,

log #002593-20, CI #2857-000006-20 - related to alleged abuse,

log #005400-20, CI #2857-000013-20 - related to resident neglect,

log #002899-20, CI #2857-000009-20 - related to a fall with injury,

log #006966-20, CI #2857-000017-20 - related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (ED), Director of Care (DOC), registered staff, and personal support workers (PSWs).

The following Inspection Protocols were used during this inspection:

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

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

4 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	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. 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 failed to ensure that residents were protected from abuse by anyone.

The Long Term Care Homes Act, 2007, O. Reg, 79/10, includes definitions of different types of abuse.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2020, indicating that resident #004 had an incident towards resident #003.
The CIS report indicated that resident #004 had a history of an identified responsive behaviour, some towards resident #003 in the past.

The plan of care for resident #004 identified that they exhibited identified behaviours towards residents and the goal was to prevent this behaviour affecting others. The plan of care also identified triggers that were to be avoided. Additionally, the resident had an intervention in place to prevent the identified responsive behaviour.

In an interview with the DOC they stated that resident #004 had the identified responsive behaviours towards other residents and they were being monitored. On an identified date in 2020, the staff failed to monitor the resident and the intervention was not in place for the behaviour when the incident occurred. The DOC stated that resident #003 was not able to recall the incident and did not understand what had happened.

The licensee failed to ensure that resident #003, who was cognitively impaired was protected from abuse. [s. 19. (1)]

2. The licensee failed to ensure that residents were protected from neglect by the licensee or staff in the home.

The Long Term Care Homes Act, 2007, O. Reg, 79/10, includes definitions of different types of abuse and neglect.

A CIS report was submitted to the Director related to neglect of resident #005 that resulted in harm.
The CIS report indicated that on an identified date in 2020, resident #005 was

discovered unattended during a specific activity of daily living by a staff member from an oncoming shift. They were not made aware that the care was not completed by the staff on the outgoing shift. The resident sustained an altered skin integrity as a result of the incident. The CIS report also indicated that upon the conclusion of the investigation, it was identified that neglect of this resident was substantiated by the home.

The plan of care of resident #005 identified that they were assessed to be at high risk for falls and had an intervention in place to prevent falls. The resident also required an identified level of assistance for transfers, which was not followed. The progress note on an identified date in 2020, indicated that the resident sustained an altered skin integrity as a result.

The investigation notes were reviewed by Inspector #561 and indicated that resident #005 was left unattended for an identified period of time.

In an interview with the DOC they stated that PSW #103 completed an improper transfer and failed to follow the plan of care related to care during an activity of daily living. The PSW also failed to complete a safety check prior to ending their shift. The DOC stated that actions of the PSW were neglectful and placed the resident at risk.

The licensee failed to ensure that resident #005 was protected from neglect by the licensee or staff in the home. [s. 19. (1)]

3. The licensee failed to ensure that the resident was protected from physical abuse by anyone.

The Long Term Care Homes Act, 2007, O. Reg, 79/10, includes definitions of different types of abuse.

A CIS report was submitted to the Director indicating that on an identified date in 2020, PSW #105 had an incident towards resident #002 that resulted in altered skin integrity.
The CIS report indicated that resident #002’s Substitute Decision Maker (SDM) approached the management staff and reported the incident. The SDM stated that resident #002 alleged that an identified PSW had an incident towards them during care.

The home's investigation notes indicated that the resident was able to recall the incident on the day of the interview with the home.
The investigation notes included an interview with PSW #105 conducted by Interim ED, and they were not able to give a reasonable explanation of how the injury occurred.
The investigation notes indicated that the home was able to substantiate abuse towards resident #002.

Clinical record review identified that the staff completed a skin assessment on the date of the reported incident and identified that resident #002 had a new skin alteration.

The home's investigation notes and the interview with the DOC confirmed that resident #002 was abused by PSW #105.

The licensee failed to ensure that resident #002 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with section 8(1)(b), of The Long Term Care Homes Act, 2007, every licensee of a long-term care home shall ensure that there is, an organized program of personal support services for the home to meet the assessed needs of the residents.

The home's policy titled "LTC-Safety Rounds", Index: CARE10-010.05, revised March 31, 2019, indicated that resident safety will be enhanced through the provision of safety rounds. Safety Rounds may include the following:
1) Observing the Resident
2) Checking for breathing
3) Checking for the need to toilet or checking for incontinence
4) Ensuring for comfortable positioning
5) Assistance in obtaining person items
6) Checking to ensure safety devices are in place, (e.g. call bell)

The DOC stated that the homes procedure for PSW staff was to complete safety rounds at the end of their shift.

A CIS report was submitted to the Director related to alleged neglect of a resident that resulted in harm or a risk of harm to the resident.
The CIS report indicated that the home commenced an investigation into the incident.

The investigation notes stated that PSW #104 assisted resident #006 with care

and did not go back to check on the resident. The oncoming shift PSW found the resident at a specified time and the care was not completed by the outgoing PSW. PSW #104 was interviewed by the home and confirmed the events that occurred and stated that they forgot to do the last safety check prior to leaving their shift.

The DOC was interviewed and stated that PSW #104 assisted the resident with their care and later forgot about the resident and failed to do the last check prior to the end of their shift which was contrary to the home's procedure for safety rounds.

B) A CIS report was submitted to the Director related to neglect of resident #005 which resulted in harm.
The CIS report indicated that on an identified date in 2020, resident #005 was discovered unattended by the oncoming shift. The night staff were not made aware at shift exchange that the resident still required assistance with care.

Through their investigation the home determined that resident #005 was left unattended for a number of hours.

The PSW acknowledged in the interview with the home that they did not do the last safety round to check on the resident prior to the end of their shift.

In an interview with the DOC they confirmed that the PSW failed to follow the home's policy and failed to complete the last safety round to check on the resident.

The licensee failed to ensure that the homes procedure for PSW staff to complete safety rounds at the end of their shift was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was submitted to the Director related to neglect of resident #005 that resulted in harm.
The CIS report indicated that on an identified date in 2020, resident #005 was discovered unattended by the oncoming shift. The night staff were not made aware at shift exchange that the resident still required assistance with care.

The investigation notes were reviewed by Inspector #561 and indicated that resident #005 was left unattended for several hours.

The resident's plan of care identified that resident #005 was assessed to be at high risk for falls and the staff were not to leave the resident unattended during a specified activity of daily living.

In an interview with the DOC they stated that PSW #103 left the resident

unattended for several hours.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

A CIS report was submitted to the Director on an identified date in 2020, related to a fall that resulted in injury.
The CIS report indicated that resident #001 sustained a fall and initially no injury was observed; however, next day the resident was complaining of pain on the left knee and the physician had ordered a test. The results of the test were positive for an identified injury and the resident was sent to the hospital for further treatment.

Clinical records were reviewed and identified that the resident had an intervention in place as an intervention for falls. The interview with registered staff #101 indicated that the PSW staff were to document application of the intervention in Point of Care (POC). POC documentation was reviewed and the identified intervention was not being documented.

The DOC confirmed that the identified intervention was not being documented in POC.

The licensee failed to ensure that the application of the intervention for falls set out in the plan of care was being documented. [s. 6. (9) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director related to neglect of resident #005 on an identified date in 2020 that resulted in harm.
The CIS report indicated that the home commenced an investigation and upon the conclusion of it, they identified that the staff member completed an improper transfer of the resident during care.

The investigation notes were reviewed by Inspector #561 which concluded that an improper transfer was performed by the identified staff member.

The resident’s plan of care identified that resident #005 required a device for all transfers. Clinical record review indicated that PSW #103 transferred the resident using the device by themselves.

The home’s policy titled "Operation of Mechanical Lifting/Transferring and Repositioning Devices", index: CARE6-O10.07 - LTC, revised March 31, 2019, stated that two staff were required to be present while the mechanical device was in operation.

In an interview with the DOC they stated that PSW #103 transferred resident #005 by themselves using a device.

The licensee failed to ensure the staff used safe transferring and positioning devices or techniques when assisting resident #005. [s. 36.]

Issued on this 23rd day of June, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DARIA TRZOS (561) - (A1)
Inspection No. / No de l'inspection :	2020_543561_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002593-20, 002899-20, 003294-20, 005400-20, 006966-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 23, 2020(A1)
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Burloak 5959 New Street, BURLINGTON, ON, L7L-6W5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elora Luymes

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 AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 :

(A1)
The licensee must be compliant with Long Term Care Homes Act, 2007, s. 19(1).

Specifically the licensee must:
1. Ensure resident #005 and all other residents are not neglected by staff.
2. Ensure resident #005's plan of care is followed in relation to safe transfer and assistance with care.
3. Ensure safety rounds are completed on all residents prior to the end of shift.
4. Ensure resident #002 and any other resident are protected from abuse by staff.

Grounds / Motifs :

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

1. The licensee failed to ensure that residents were protected from neglect by the licensee or staff in the home.

The Long Term Care Homes Act, 2007, O. Reg, 79/10, includes definitions of different types of abuse and neglect.

A CIS report was submitted to the Director related to neglect of resident #005 that resulted in harm.
The CIS report indicated that on an identified date in 2020, resident #005 was discovered unattended during a specific activity of daily living by a staff member from an oncoming shift. They were not made aware that the care was not completed by the staff on the outgoing shift. The resident sustained an altered skin integrity as a result of the incident. The CIS report also indicated that upon the conclusion of the investigation, it was identified that neglect of this resident was substantiated by the home.

The plan of care of resident #005 identified that they were assessed to be at high risk for falls and had an intervention in place to prevent falls. The resident also required an identified level of assistance for transfers, which was not followed. The progress note on an identified date in 2020, indicated that the resident sustained an altered skin integrity as a result.

The investigation notes were reviewed by Inspector #561 and indicated that resident #005 was left unattended for an identified period of time.

In an interview with the DOC they stated that PSW #103 completed an improper transfer and failed to follow the plan of care related to care during an activity of daily living. The PSW also failed to complete a safety check prior to ending their shift. The DOC stated that actions of the PSW were neglectful and placed the resident at risk.

The licensee failed to ensure that resident #005 was protected from neglect by the licensee or staff in the home. (561)

2. The licensee failed to ensure that the resident was protected from abuse by anyone.

The Long Term Care Homes Act, 2007, O. Reg, 79/10, includes definitions of different types of abuse.

A CIS report was submitted to the Director indicating that on an identified date in 2020, PSW #105 had an incident towards resident #002 that resulted in altered skin integrity.
The CIS report indicated that resident #002's Substitute Decision Maker (SDM) approached the management staff and reported the incident. The SDM stated that resident #002 alleged that an identified PSW had an incident towards them during care.

The home's investigation notes indicated that the resident was able to recall the incident on the day of the interview with the home.
The investigation notes included an interview with PSW #105 conducted by Interim ED, and they were not able to give a reasonable explanation of how the injury occurred.
The investigation notes indicated that the home was able to substantiate abuse towards resident #002.

Clinical record review identified that the staff completed a skin assessment on the date of the reported incident and identified that resident #002 had a new skin alteration.

The home's investigation notes and the interview with the DOC confirmed that resident #002 was abused by PSW #105.

The licensee failed to ensure that resident #002 was protected from abuse by anyone.

The severity of this issue was a level 3 as there was actual harm to residents #002 and #005.
The scope was level 2 as two of the four residents were reviewed related to neglect and abuse. Compliance history was a level 3 as there was previous non-compliance with the same subsection that included:
- A Written notification (WN) issued February 3, 2020 (2020_820130_0004),
- A Voluntary Plan of Correction (VPC) issued December 28, 2018 (2018_689586_0027) (561)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 22, 2020(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

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

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

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

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

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

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

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

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

Issued on this 23rd day of June, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DARIA TRZOS (561) - (A1)

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

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