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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2020	2020_598570_0004	024410-19, 024429-19, 000286-20, 005069-20, 005120-20, 015842-20, 016475-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

SAMI JAROUR (570), ANGIEM KING (644)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 09, 10, 11, 12, 13, August 05, 06, 10, 11, 12, 13, 17, 18, 19, 20 and 21, 2020.

**The following intakes were inspected:
A log #024429-19 related to care concerns.
A log #015842-20, related to a fall incident.
A log #016475-20, related to fall incident and care concerns.
Four logs #000286-20, #024410-19, #005120-20 and #005069-20 related to allegations of abuse.**

**PLEASE NOTE:
- Written Notifications and Compliance Orders (CO) related to LTCHA, 2007, c.8, s. 6 (7), identified in a concurrent CIS inspection #2020_598570_0003, were issued in this report.**

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Environmental Services Manager (ESM), Registered Dietitian (RD), Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Physiotherapist (PT), Occupational Therapist (OT), Physiotherapy Assistant (PTA), families and residents.

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

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

3 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to concerns specific to nutrition and hydration for resident #018.

A review of electronic health records on Point Click Care (PCC) for resident #018, indicated that the resident had significant weight changes. The registered dietitian (RD) prescribed a nutritional supplement for weight maintenance. The record's review did not indicate that the SDM was notified of the new nutritional supplement order or the resident's significant weight changes.

In separate interviews, RD #112, RN #113 and DOC, they indicated that resident #018's SDM was not notified of the significant weight change and of the nutritional supplement order.

The licensee failed to ensure that resident #018's SDM was notified of the resident's significant weight change and the new nutritional supplement order. [s. 6. (5)]

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

A complaint was received by the Ministry of Long Term Care (MLTC), related to a fall incident involving resident #018. A related Critical Incident Report (CIR) was submitted to the MLTC, related to an allegation of neglect involving resident #018 resulting in a fall incident of the resident.

In an interview, the complainant indicated that the resident sustained a fall when staff did not use an intervention to maintain safe positioning of the resident.

A review of the CIR and progress notes related to the fall incident indicated that resident #018 sustained a fall when the resident was not repositioned as required in the plan of care. The plan of care for resident #018, directed staff to reposition the resident for safety when seated in their mobility device.

During separate interviews, PSWs #125, #132 and RPN #126 indicated that resident #018 should be repositioned as required in the plan of care for safety.

In an interview, PSW #132 indicated that they did not reposition the resident’s mobility device as required and the resident would not have fallen if their mobility device was repositioned as required.

In an interview, the DOC acknowledged that the plan of care for resident #018 specific to falls prevention interventions was not followed when PSW #132 did not reposition resident #018’s mobility device causing the resident to sustain a fall.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #018 as specified in the plan, specific to falls prevention interventions. [s. 6. (7)]

3. A Critical Incident Report (CIR) was submitted to the Director, regarding a fall incident involving resident #017. The resident was found on the floor and was sent to hospital and diagnosed with an injury. PSW #120 had left resident #017 to continue walking without assistance.

The plan of care for resident #017 was reviewed and indicated staff to provide assistance with ambulation.

In an interview, PSW #123 indicated that resident #017 required assistance by staff when walking.

In an interview, RPN #124, indicated that PSW #120 left resident #017 walking unassisted leading to the resident falling. The PSW did not follow directions and did not follow the plan of care for the resident.

In an interview, RPN #115 lead of the falls prevention and management program confirmed that the resident was not assisted by staff while walking as directed in the plan of care at the time of the fall.

In an interview, the DOC acknowledged that the plan of care for resident #017 specific to falls prevention interventions was not followed, when PSW #120 left the resident to walk unsupervised.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #017 as specified in the plan, specific to falls prevention interventions. [s. 6. (7)]

4. A Critical Incident Report (CIR) was submitted to the Director, regarding a fall incident involving resident #001. The resident was transferred to hospital and diagnosed with an injury.

The plan of care for resident #001 was reviewed and indicated the resident required the use of a device for falls prevention.

During separate interviews, PSW #100, PSW #102 and RPN #101 indicated that indicated that the resident did not have the device for falls prevention in place as directed in the plan of care.

In an interview, RPN #104, confirmed that the resident did not have the device for falls prevention in place as directed in the plan of care.

In an interview, the DOC acknowledged that the plan of care for resident #001 was not followed when a device for falls prevention was not in place as directed in the plan of care.

The licensee failed to ensure that the plan of care was provided to resident #001 as directed in the plan specific to falls prevention interventions. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

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 has failed to ensure that where the Act or the Regulation required that licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident at admission and monthly thereafter.

Specifically, staff did not comply with the licensee's policy regarding Height and Weight Monitoring, RC-18-01-06, last updated on November 2019, which is part of the licensee's nutrition care and dietary service program. The policy identified that any weight with a 2.5

kilogram (kg) difference from the previous month required a re-weigh to ensure accuracy. The identified policy also indicated that staff were to ensure the current, accurate weight of individual residents, including re-weigh if applicable, was recorded by the 10th day of each month either on paper or electronically and entered in the resident's health care record.

A complaint was received by the MLTC, related to concerns specific to nutrition and hydration for resident #018.

A review of the electronic health record on Point ClickCare (PCC), did not indicate that a re-weigh was completed for resident #018 when significant weight change was identified on three identified dates.

In an interview, PSW #136 indicated that residents' weights are taken during the first week of the month and documented on point of care (POC). PSW #136 indicated that a re-weigh would be done if there was a big change of resident's weight which would be reported to the registered staff.

In an interview, RPN #137 indicated that residents' weights are done at the beginning of every month on bath days and documented on POC by PSW staff. RPN #137 indicated that registered staff would review residents' weights for any significant change and request a re-weigh.

In an interview, RN #133 indicated that registered staff on each unit review residents' weights on PCC and if the weight was up by 2.2 kg or or down by 2.2 kg, a re-weigh would be done to ensure the weight was accurate.

In an interview, RD #112 reviewed resident #018's weight on PCC and indicated that the resident required a re-weigh when significant weight change was identified.

In an interview, the DOC acknowledged that the home did not comply with their Height and Weight Monitoring policy when resident #018 was not re-weighed before the 10th day of the month after a significant weight change was identified.

The licensee failed to ensure that the Height and Weight Monitoring policy was complied with when resident #018 was not re-weighed when significant weight change was identified.

Due to non-compliance identified related to resident #018, scope was expanded to three residents including residents #019 and #020.

2. A review of the electronic health record including weights documentation on PCC for resident #019 did not indicate a re-weigh was completed when significant weight change was identified on two identified dates.

In an interview, RD #112 reviewed resident #019's weight on PCC and indicated that the resident required a re-weigh for the significant weight change identified as per the home's policy.

The licensee failed to ensure that the Height and Weight Monitoring policy was complied with when resident #019 was not re-weighed when significant weight change was identified.

3. A review of the electronic health record including weights documentation on PCC for resident #020 did not indicate that a re-weigh was completed when significant weight change was identified on an identified date.

In an interview, RD #112 reviewed resident #020's weight on PCC and indicated that the resident required a re-weigh to confirm the weight change as per the home's policy.

The licensee failed to ensure that the Height and Weight Monitoring policy was complied with when resident #020 was not re-weighed when significant weight change was identified. [s. 8. (1) (a),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 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the MLTC, which stated that baths were not provided to residents in two residents' home areas due to short staffing.

A review of the bathing schedule of an identified month indicated that residents #010, #012, #013, #014 and #015 did not receive their scheduled baths. The review did not indicate that the missed baths for those residents were provided on the following shift or at a later date.

A review of the staff communication tab on PCC indicated that day baths were not given to eleven residents from two residents' home areas.

In an interview the Executive Director (ED) acknowledged that on an identified date, one residents' home area was short one PSW staff on the day and evening shifts; another residents' home area was short two PSW staff on the day shift and one PSW on the evening shift on the identified date.

In an interview, resident #015 indicated that sometimes they go for four or five days without a bath as there was not enough people to do the bath. The resident also indicated that not all missed baths were provided on an alternate day.

In an interview, PSW #121 indicated that when short staffed, baths that require two-person assist won't be given.

In an interview, RPN #101 indicated that when short staffed by two PSWs, showers and baths could not be provided to all residents. The RPN indicated that bed bath would be provided and easy showers can be moved to the following shift.

In an interview, RPN #124 indicated that there were times when only two PSWs instead of four PSWs would be working in a residents' home area. RPN #124 reviewed the note on communication tab on PCC and confirmed that residents #010 and #012 did not receive their bath on an identified date, due to short staffing.

In an interview, RN #133 indicated that there was a period during an identified month when residents did not get two bath a week due to short staffing. The RN indicated that there was no documentation to indicate that missed baths from an identified date were given.

In an interview, the DOC indicated that residents should have a minimum of two bath a week. The DOC indicated that the expectation is that any missed bath should be provided on the following shifts. The DOC was unable to confirm if the missed baths on an identified date, were provided on an alternate day to the residents.

The licensee failed to ensure that residents #010, #012, #013, #014 and #015 received, at a minimum, two baths during an identified week. [s. 33. (1)]

Additional Required Actions:

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

Issued on this 23rd day of September, 2020

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SAMI JAROUR (570), ANGIEM KING (644)

Inspection No. / No de l'inspection : 2020_598570_0004

Log No. / No de registre : 024410-19, 024429-19, 000286-20, 005069-20, 005120-20, 015842-20, 016475-20

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 14, 2020

Licensee / Titulaire de permis : CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Port Perry Place
15941 Simcoe Street, Port Perry, ON, L9L-1N5

Laura Powell

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur :

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 Homes Act (LTCHA).

Specifically, the licensee must:

1. Review the current falls prevention interventions for resident #018 with Personal Support Workers (PSW) involved in providing care to the resident to ensure the resident is positioned as required in the mobility device.

2. Review the current falls prevention interventions for resident #001 with Personal Support Workers (PSW) involved in providing care to the resident to ensure the PSW staff implement the falls prevention interventions, including the application of a device for falls prevention, in accordance with the plan of care for resident #001.

3. Develop and implement a process to ensure that PSW staff who provide care to residents #018 and #001 follow and implement the falls prevention interventions in accordance to each resident's plan of care.

4. Maintain a record of the above-mentioned reviews, including the content, facilitator, attendees, dates, and times. This record shall be made available to the Inspector upon request.

Grounds / Motifs :

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

A complaint was received by the Ministry of Long Term Care (MLTC), related to a fall incident involving resident #018. A related Critical Incident Report (CIR) was submitted to the MLTC, related to an allegation of neglect involving resident #018 resulting in a fall incident of the resident.

In an interview, the complainant indicated that the resident sustained a fall when staff did not use an intervention to maintain safe positioning of the resident.

A review of the CIR and progress notes related to the fall incident indicated that resident #018 sustained a fall when the resident was not repositioned as required in the plan of care. The plan of care for resident #018, directed staff to reposition the resident for safety when seated in their mobility device.

During separate interviews, PSWs #125, #132 and RPN #126 indicated that resident #018 should be repositioned as required in the plan of care for safety.

In an interview, PSW #132 indicated that they did not reposition the resident's mobility device as required and the resident would not have fallen their mobility device was repositioned as required.

In an interview, the DOC acknowledged that the plan of care for resident #018 specific to falls prevention interventions was not followed when PSW #132 did not reposition resident #018's mobility device causing the resident to sustain a fall.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #018 as specified in the plan, specific to falls prevention interventions. (570)

2. A Critical Incident Report (CIR) was submitted to the Director, regarding a fall incident involving resident #017. The resident was found on the floor and was sent to hospital and diagnosed with an injury. PSW #120 had had left resident #017 to continue walking without assistance.

The plan of care for resident #017 was reviewed and indicated staff to provide assistance with ambulation.

In an interview, PSW #123 indicated that resident #017 required assistance by staff when walking.

In an interview, RPN #124, indicated that PSW #120 left resident #017 walking unassisted leading to the resident falling. The PSW did not follow directions and did not follow the plan of care for the resident.

In an interview, RPN #115 lead of the falls prevention and management program confirmed that the resident was not assisted by staff while walking as directed in the plan of care at the time of the fall.

In an interview, the DOC acknowledged that the plan of care for resident #017 specific to falls prevention interventions was not followed, when PSW #120 left the resident to walk unsupervised.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #017 as specified in the plan, specific to falls prevention interventions. (570)

3. A Critical Incident Report (CIR) was submitted to the Director, regarding a fall incident involving resident #001. The resident was transferred to hospital and diagnosed with an injury.

The plan of care for resident #001 was reviewed and indicated the resident required the use of a device for falls prevention.

During separate interviews, PSW #100, PSW #102 and RPN #101 indicated that indicated that the resident did not have the device for falls prevention in place as directed in the plan of care.

In an interview, RPN #104, confirmed that the resident did not have the device for falls prevention in place as directed in the plan of care.

In an interview, the DOC acknowledged that the plan of care for resident #001 was not followed when a device for falls prevention was not in place as directed in the plan of care.

The licensee failed to ensure that the plan of care was provided to resident #001 as directed in the plan specific to falls prevention interventions. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm and actual risk of harm to residents. The scope of the issue was a level 2 as it related to three out of five residents reviewed. The home had a level 4 compliance history as the LTCH had on-going non-compliance with this section of the LTCHA that included:
- WN and VPC issued on December 11, 2019 (2019_716554_0007)
- WN and VPC issued on June 03, 2019 (2019_591623_0005)
- WN issued on September 12, 2017 (2017_623626_0014) (570)

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

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 14th day of September, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sami Jarour

Service Area Office / Bureau régional de services : Central East Service Area Office