Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
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Téléphone: (416) 325-9660
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Amended Public Copy/Copie modifiée 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
May 01, 2019	2019_634513_0006 (A2)	003269-18, 004396-18, 004928-18, 005725-18, 012396-18, 024844-18, 032955-18, 032956-18, 000078-19, 004607-19	Critical Incident System

Licensee/Titulaire de permis

The Kensington Health Centre
25 Brunswick Avenue TORONTO ON M5S 2L9

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

The Kensington Gardens
25 Brunswick Avenue TORONTO ON M5S 2L9

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

Amended by JUDITH HART (513) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Changes:
1. Revision 6(7) Licensee Report Findings and Order Report Grounds see paragraph #3; replace 'hip fracture' with 'an injury' see paragraph #6;
2. Revision 8(1) Licensee Report Findings replace 'admitted' with 'transferred' paragraph #4; and
3. Revision to Order Due Date from June 7, 2019 to June 21, 2019.

Issued on this 1 st day of May, 2019 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

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

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

The Kensington Gardens
25 Brunswick Avenue TORONTO ON M5S 2L9

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

Amended by JUDITH HART (513) - (A2)

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): March 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, and 25, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected: 003269-18, related to unsafe transfer, 004396-18, related to a fracture, 004928-18, related to an influenza outbreak, 005725-18, related to a fracture, 012396-18, related to a fall, 024844-18, related to alleged sexual abuse, 032955-18, related to order #001, 032956-18, related to order #002, 000078-19, and 004607-19, related to a fall.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Assistant Director of Resident Care (ADOC), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Care Attendant, Registered Dietitian, Residents, Family Members, and Power of Attorney (POA) .

During the course of the inspection, the inspectors observed staff and resident interactions, the provision of resident care, reviewed health records and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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	2018_324535_0013	513
O.Reg 79/10 s. 54.	CO #002	2018_324535_0013	513

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 the resident as specified in the plan.

The Ministry of Health and Long Term Care (MOHLTC) received a Critical Incident System (CIS) report regarding an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The resident sustained an alteration in mobility that resulted in an injury.

A review of the data for resident #005 indicated moderate cognitive impairment, required one-person extensive assistance for activities of daily living (ADL) with two-person assistance for mobility and was at an identified risk for alterations in mobility. A review of the progress notes for specific dates in 2018 and 2019, indicated the resident had several incidents of alterations in mobility without injury. On a specific date in 2019, resident #005 had an alteration in mobility while with one personal care attendant (PCA), sustained an injury, was investigated in hospital on a specific date and returned to the home with treatments.

A review of resident #005's care plan on a specific date in 2019, indicated the resident required two-person side-by-side physical assistance for mobility.

An interview with PCA #120 indicated that on a specific date in 2019, resident #005 was assisted to a specific location by one person physical assistance, without the assistance of a second staff. PCA #120 indicated they did not review resident #005's plan of care regarding their need for assistance with mobility, but was aware where the information could be found. The PCA further stated being directed by another PCA to assist the resident to a specific location without the assistance of a second staff.

An interview with nurse manager #121 confirmed resident #005 required two-person physical assistance, however on the specific date in 2019, resident #005 received physical assistance by one staff. The staff was disciplined. In this instance the PCA did not provide care to resident #005 as stipulated in the plan. [s. 6. (7)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: 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 :

(A2)
1. The licensee has failed to ensure that any policy instituted or otherwise put in place is complied with.

According to O.Reg. 79/10, s. 48(1)1 the licensee is required to ensure that a falls prevention and management program to reduce the incident of falls and risk of injury is developed and implemented in the home.

The home's policy titled, Head Injury Routine (HIR), specified HIR be completed every 15 minutes for an hour, then every 30 minutes for two hours, hourly times four and every four hours times 48hours for unwitnessed falls, unless ordered

otherwise.

A CIS report was submitted to the MOHLTC on a specific date in 2019, with regard to an incident for which resident #005 had been mobilizing in the hallway with one-person assist and experienced an alteration in mobility without any apparent injury. They were assessed by the physiotherapist with no apparent abnormalities noted. On a specific date 2019, they were transferred to hospital for a specific medical diagnosis.

A review of the data for resident #005 indicated moderate cognitive impairment, required one-person extensive assistance for activities of daily living (ADL) with two-person assistance for mobility and was at an identified risk for alterations in mobility. A review of the progress notes for specific dates in 2018 and 2019, indicated the resident had several incidents of alterations in mobility without injury. On a specific date in 2019, resident #005 had an alteration in mobility while with one PCA, sustained an injury, was investigated in hospital on a specific date and returned to the home with treatments.

A review of the HIR for resident #005's unwitnessed alterations in mobility, on 12 identified dates at specific times in 2018, and 2019, indicated HIR was not obtained and recorded.

An interview with DRC #103 indicated the HIR should be obtained unless prescribed otherwise by the physician. The DRC confirmed the HIR had not been recorded for the aforementioned dates and times, therefore the policy for HIR was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

2. A CIS was submitted to the MOHLTC on a specific date in 2018, for an alteration in mobility for resident #006 for which they received a treatment and returned to the home.

A review of the data for a specific date in 2018, for resident #006 indicated moderate cognitive impairment, required extensive assistance with ADLs and ambulated with a mobility device with one-person supervision and assistance. An assessment on a specific date in 2018, indicated resident #006 was at a moderate risk for alterations in mobility.

A review of resident #006's unwitnessed alterations in mobility, which required the HIR to be obtained and documented, indicated on 10 identified dates at specific

times the HIR was not obtained and documented.

An interview with the DRC #103 indicated the HIR should be obtained unless prescribed otherwise by the physician. The DRC confirmed the HIR had not been recorded for the aforementioned dates and times, therefore the policy for HIR was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

3. A CIS was submitted to the MOHLTC on a specific date in 2019, for an alteration in mobility for resident #007. On a specific date in 2019, following X-Ray confirmation of an injury the resident was sent to hospital.

A review of the data for a specific date in 2018, indicated resident #007 was moderately cognitively impaired, required two-person extensive assistance for ADLs, mobilized in a mobility device and was assessed a moderate risk for falls.

A review of resident #007's unwitnessed alterations in mobility on a specific date in 2018, which required the HIR to be obtained and documented, indicated on three identified dates at specific times the HIR was not obtained and recorded.

An interview with DRC #103 indicated the HIR should be obtained unless prescribed otherwise by the physician. The DRC confirmed the HIR had not been recorded for the aforementioned dates and times, therefore the policy for HIR was not followed. [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 that any Head Injury Report policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #015.

A CIS report was submitted to the MOHLTC on an identified date in 2018, with regard to improper treatment that resulted in harm to resident #015. The report detailed that during the provision of care using a mechanical device, resident #015 sustained an injury, was transferred to hospital and received treatment.

A review of the home's investigation notes into the incident determined that staff did not perform a safe transfer and kept the resident in a standing position longer than they could safely weight bear.

A review of resident #015's plan of care on a specific date in 2018, indicated the resident received care with the use of the mechanical device with two person extensive assistance and the resident could only weight bear for short periods of time.

A review of resident #015's mobility assessment on a specific date in 2017, indicated the resident required use of a mechanical device in their care. Two types of mechanical devices were identified, which could be used in the resident's care as needed.

An interview with PSW #118 indicated they were the primary caregiver for resident #015 and were following the resident's care plan at the time of the incident. On this occasion they had provided the resident with personal care and called PSW #105 for assistance to move the resident to their mobility device using one of the two mechanical devices. PSW #118 indicated that while the transfer was in progress, the resident required care and was lowered to a specific chair to rest. This occurred on two successive occasions. PSW #118 indicated that the resident cannot weight-bear for long periods of time. PSW #118 indicated that

they did not witness the resident sustain the injury, but once they noticed the injury they immediately called RPN #117. PSWs #118 and #105 indicated that they were unsure how the injury had occurred, but thought that the resident might have sustained the injury on the mechanical device.

An interview with ADOC #107 confirmed that the specific technique used by staff during the provision of care and movement of the resident was unsafe and that resident #015 sustained an injury as a result. ADOC #107 indicated further that once PSWs #118 and #105 saw that resident #015 was becoming weak, they should have stopped the care and called the nurse. The involved staff members received disciplinary action. [s. 36.]

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 staff used safe transferring and positioning devices or techniques when assisting resident #015, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS report was submitted to the MOHLTC on a specific date in 2018, with regard to an incident for which a resident was taken to hospital and which resulted in a significant change in resident #013's health status related to an injury.

The CIS report and resident #013's progress notes detailed that resident #013, when on an outing with family, received an injury to a specific location that caused pain, which continued into the following day. Resident #013 was assessed by their physician and a test was completed confirming an injury.

A review of resident #013's health care record failed to indicate that a formal pain assessment was conducted following the resident's initial and subsequent reports of a new onset of pain.

During interviews, RPN #114 and RN #115 indicated that when a resident presents with new pain they are to conduct and document a detailed pain assessment.

During an interview, RN #115 indicated a PSW reported to them that resident #013 complained of pain to a specific location during bedtime care. RN #115 followed up with the resident, did not note any abnormality and offered the resident pain medication, which was reportedly declined. RN #115 confirmed that they did not complete a formal pain assessment following resident #013's report of a new onset of pain.

An interview with DRC #103 indicated that if a resident communicated discomfort after an outing there would be an expectation from the nurse to follow up with the family and complete an assessment to investigate the cause. They indicated further that the home uses two different types of formal pain assessment tools depending on the resident's level of cognition. DRC #103 confirmed that an appropriate pain assessment was not completed for resident #013 on or around a specific date in 2018, when the resident expressed a new onset of pain. [s. 52. (2)]

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4) of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A review of a CIS indicated Public Health declared an outbreak in the home on a specific date in 2018. The date the CIS was submitted to the Ministry of Health and Long-Term Care (MOHLTC) three days later.

An interview with the Infection Prevention and Control Lead #107 confirmed the submission date to the MOHLTC on the CIR and agreed the MOHLTC was not immediately informed of the outbreak. [s. 107. (1) 5.]

Issued on this 1 st day of May, 2019 (A2)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by JUDITH HART (513) - (A2)
Inspection No. / No de l’inspection :	2019_634513_0006 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003269-18, 004396-18, 004928-18, 005725-18, 012396-18, 024844-18, 032955-18, 032956-18, 000078-19, 004607-19 (A2)
Type of Inspection / Genre d’inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 01, 2019(A2)
Licensee / Titulaire de permis :	The Kensington Health Centre 25 Brunswick Avenue, TORONTO, ON, M5S-2L9
LTC Home / Foyer de SLD :	The Kensington Gardens 25 Brunswick Avenue, TORONTO, ON, M5S-2L9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	William O'Neill

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 Kensington Health Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 LTCHA, 2007.
Specifically the licensee must do the following:

1. PCA #120 and every other PCA assigned to resident #005, and any other resident at risk for falls are to:
a) review each resident's written care plan prior to providing care, including the level of physical assistance required, and
b) provide care that is specified in the plan.

Grounds / Motifs :

(A2)
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.

The Ministry of Health and Long Term Care (MOHLTC) received a Critical Incident System (CIS) #2852-000010-19 report regarding an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The resident sustained a fall that resulted in an injury.

A review of the data for resident #005 indicated moderate cognitive impairment, required one-person extensive assistance for activities of daily living (ADL) with two-person assistance for mobility and was at an identified risk for alterations in mobility. A review of the progress notes for specific dates in 2018 and 2019, indicated the resident had several incidents of alterations in mobility without injury. On a specific date in 2019, resident #005 had an alteration in mobility while with one PCA,

sustained an injury, was investigated in hospital on a specific date and returned to the home with a diagnosed injury and treatments.

A review of resident #005's care plan dated February 10, 2019, indicated the resident required two-person side-by-side physical assistance for mobility.

An interview with PCA #120 indicated that on February 16, 2019, at 0845 hours(h) they assisted resident #005 to the dining room by one person physical assistance, without the assistance of another staff. PCA #120 indicated they did not review resident #005's plan of care regarding their need for assistance, but was aware where the information could be found. The PCA further stated being directed by another PCA to transfer the resident to the dining room without the assistance of another staff.

An interview with nurse manager #121 indicated the resident required two-person physical assistance to go to the dining room, however on February 16, 2019, resident #005 received physical assistance by one staff. The staff was disciplined. In this instance the PCA did not provide care to resident #005 as stipulated in the plan as resident #005 fell and sustained an injury.

The severity of this non-compliance was determined to be level three as there was actual harm/risk to the resident. The scope was isolated to one of three residents reviewed. The home had a level four compliance history as they had ongoing non-compliance with this section of the LTCA, 2007:
--WN with VPC issued January 26, 2018, under report 2017_493652_0019, and
--WN with VPC issued March 27, 2018, under report 2018_370649_0002.
As a result of actual harm/risk to the resident and ongoing non-compliance, a compliance order is warranted.

(513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2019(A1)

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 1 st day of May, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JUDITH HART (513) - (A2)

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