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 le Loi de 2007 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
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2018;	2018_751649_0011 (A1)	009205-18	Complaint

Licensee/Titulaire de permis

Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership
c/o All Seniors Care Living Centres 175 Bloor Street East, Suite 601 TORONTO ON M4W 3R8

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

Cedarvale Terrace
429 Walmer Road TORONTO ON M5P 2X9

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

Amended by JULIEANN HING (649) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On the licensee order report, order #001, the word exiting was changed to existing.

Issued on this 19 day of September 2018 (A1)

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 le Loi de 2007 les foyers de soins de longue durée

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

Amended by JULIEANN HING (649) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 17, 22, 23, 24, 25, 29, 31 and June 1, 2018.

Log #009205-18 related to an allegation of abuse, continence care and bowel management, plan of care, dining and snack, and personal care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Manager (NM), acting Nurse Manager (A-NM), Manager of Clinical Informatics, Registered Dietitian (RD), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide (DA), Residents and Family members.

During the course of the inspection the Inspector observed staff to residents' interactions, conducted interviews, reviewed relevant policies, observed meal services, reviewed staff training records, and residents' health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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

5 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) alleging resident #001 had been transferred to hospital because of a change in health. The resident's family was contacted by the the hospital advising that the resident required treatment due to an identified medical condition. The resident passed away in hospital.

Review of the resident's clinical records indicated upon their discharge from hospital to the long-term care (LTC) home, the resident had a history of a second identified medical condition that required monitoring.

A physician order indicated to give an identified medication related to the second identified medical condition, to the resident, during circumstances specified by the prescriber. According to the electronic Medication Administration Record (e-MAR) the resident received scheduled medications that increased their risk of having the second identified medical condition. The resident's history of the second identified medical condition was not mentioned in their care plan. A review of progress notes from the resident's admission until their transfer to hospital did not indicate any documentation of any issues related to the second identified medical condition.

A review of the e-MAR documentation and progress notes for an identified period did not indicate that the medication was given to the resident as prescribed by the physician during circumstances specified by the prescriber.

In an interview Personal Support Worker (PSW) #107 told the Inspector they recall a situation when resident #001 was in the circumstance and appeared in pain. The PSW was unable to recall which day this had occurred and stated they had documented in point of care (POC) and had reported it to the nurse.

In interviews Registered Practical Nurse (RPN) #111 and #112 told the Inspector they have daily access to the clinical dashboard in point click care (PCC) that showed residents who were subject to the circumstance and for what period of time. RPN #111 confirmed they had not been monitoring the resident and therefore had never given the prescribed medication.

In interviews the Nurse Manager (NM) #104, the Director of Care (DOC), and the Executive Director (ED) acknowledged that the prescribed medication should have been administered to the resident as ordered by the prescriber and confirmed neglect of the resident occurred since no action was taken by the home. [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:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The license has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the MOHLTC alleging resident #001 had been transferred to hospital because of a change in health. The resident's family was contacted by the the hospital advising that the resident required treatment due to an identified medical condition. The resident passed away in hospital.

A review of physician's order indicated to give an identified medication during circumstances specified by the prescriber.

Review of the e-MAR indicated the resident received scheduled medications that increased their risk of the second identified medical condition.

The resident's history of the second identified medical condition was not mentioned in the resident care plan. A review of progress notes from the resident's admission until their transfer to hospital did not indicate any documentation of any issues related to second identified medical condition.

A review of the e-MAR documentation and progress notes for an identified period did not indicate that the medication was given to the resident as prescribed by the physician during the circumstances specified by the prescriber.

In interviews RPN #111 and #112 confirmed that the physician order to give a prescribed medication in the circumstance had not been followed. RPN #111 confirmed they had not been monitoring the resident in the circumstance and therefore had never given the prescribed medication.

In interviews the NM #104, and the DOC confirmed that the physician order had not been followed as the resident was not administered the prescribed medication in the circumstance. [s. 131. (2)]

2. Resident #002 was randomly selected as a result of non-compliance identified with resident #001.

A review of the resident's e-MAR indicated to give an identified medication when in the circumstance.

A review of the e-MAR documentation and progress notes for an identified period did not indicate that the medication was given to the resident as prescribed by the physician when the resident was in the circumstance.

In interviews the RPN #116, NM #104, and the DOC confirmed that the physician order had not been followed as prescribed. [s. 131. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A complaint was received by the MOHLTC alleging resident #001 had been transferred to hospital because of a change in health. The resident's family was contacted by the the hospital advising that the resident required treatment due to an identified medical condition. The resident passed away in hospital.

A review of the home's policy indicated if a resident is prone to the second identified medical condition, a dietary referral is made for further assessment. Nutritional interventions are implemented and documented in the resident's plan of care.

A review of resident's #001 clinical record and assessments did not indicate a dietary referral was made to the Registered Dietitian (RD) for the second identified medical condition on admission or anytime thereafter.

In an interview RD #109 confirmed they had not received a referral and was not aware up until the interview with the Inspector that resident #001 had a history of a second identified medical condition. The RD stated had they known the resident was at risk for the second identified medical condition they perhaps would have ordered something.

Interviews with RPNs #111 and #112 confirmed that the home's policy had not been followed as no referral had been sent to the RD. The nurses acknowledged they too were both unaware of the resident's history of the second identified medical condition.

In interviews with RN #104, RN #102 and the DOC confirmed that the home's policy had not been followed as no referral was sent to the RD on admission to indicate that resident #001 had a history of a second identified medical condition. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating or drinking was served a meal until someone was available to provide assistance required by the resident.

A complaint was received by the MOHLTC alleging resident #001 had to stay in an identified area of the home for their meals and by the time they got their food it was cold.

During an observation on May 17, 2018, of the lunch meal service on an identified floor the Inspector observed residents #004 and #005s' meals were placed in front of the residents for approximately 10 minutes (1225 to 1235 hours) until they were assisted by PSW #103.

During an interview PSW #113 who was observed at the same table feeding two other residents, told the Inspector that residents #004 and #005s' meals were served at approximately 1210 hours same time as the other two residents. According to the PSW the residents' meals and drinks were served by another PSW and stated the meals should only be served to the residents when there is someone available to assist with the meal. Therefore, residents #004 and #005s' meals were on the table in front of the residents for approximately 25 minutes getting cold before they were assisted by PSW #103.

Residents #004 and #005 were not interviewable.

During an interview PSW #103 told the Inspector they were at another table assisting other residents with their meals. PSW #113 and #103 confirmed that both residents required staff assistance with their meals.

In interviews the NM #104 and the DOC confirmed that residents #004 and #005s' meals should not have been served until there was someone available to assist the residents. [s. 73. (2) (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 no resident who requires assistance with eating or drinking is served a meal until someone is available to provide assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A complaint was received by the MOHLTC alleging resident #001 had been transferred to hospital because of a change in health. The resident's family was contacted by the the hospital advising that the resident required treatment due to an identified medical condition. The resident passed away in hospital.

Review of the resident's clinical records indicated upon their discharge from hospital to the long-term care (LTC) home, the resident had a history of a second identified medical condition that required monitoring.

A review of the resident's admission assessments, progress notes, and the resident's care plan did not identify the resident as having the second identified medical condition that required monitoring.

During interviews RPN #111 and #112 confirmed they were not aware that the resident had a history of a second identified medical condition on admission and acknowledged the resident's care plan should have been updated to reflect this diagnosis.

In interviews the NM #104, and the DOC confirmed that the resident's care plan should have been updated to reflect the planned care of the resident. [s. 6. (1)]

2. A complaint was received by the MOHLTC alleging resident #001 had to stay in an identified area of the home for their meals and by the time they got their food it was cold.

Resident #001 was not in the home during the inspection and passed away in hospital.

A review of the resident's most current written plan of care indicated the resident should have their meals in the main dining room.

The home does not have a dining room area on that unit where resident #001 resided so the residents went down to the dining room on the main floor for their meals.

During interviews PSW #106 and #107 told the Inspector that when the resident was first admitted they had their meals in the main dining room and due to responsive behaviours, a decision was made for the resident to eat on the unit.

In an interview the RN #104 and the DOC acknowledged that the resident's care plan should have been updated to reflect the planned care for the resident of having their meals on the unit instead of the main dining room. [s. 6. (1) (a)]

Issued on this 19 day of September 2018 (A1)

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JULIEANN HING (649) - (A1)

Inspection No. / No de l'inspection : 2018_751649_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009205-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 19, 2018;(A1)

Licensee / Titulaire de permis : Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership
c/o All Seniors Care Living Centres, 175 Bloor Street East, Suite 601, TORONTO, ON, M4W-3R8

LTC Home / Foyer de SLD : Cedarvale Terrace
429 Walmer Road, TORONTO, ON, M5P-2X9

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership, 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. 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 O.Reg. 79/10, s. 19 (1).

Specifically, the licensee shall ensure that residents who are at risk of constipation are not neglected by staff.

Upon receipt of this compliance order the licensee shall:
1. Ensure all direct care staff (including PSWs and registered staff) are trained and knowledgeable on the home's process of monitoring residents' bowel movements, review the plan of care for existing residents with bowel movement concerns and what interventions should be implemented, including and not limited to, PSWs report to the registered staff, registered staff to refer to the RD etc.
2. Documentation of what was included in the training, who attended the training, and the dates the training was provided must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) alleging resident #001 had been transferred to hospital because of a change in health. The resident's family was contacted by the the hospital advising that the resident required treatment due to an identified medical condition. The resident passed away in hospital.

Review of the resident's clinical records indicated upon their discharge from hospital to the long-term care (LTC) home, the resident had a history of a second identified medical condition that required monitoring.

A physician order indicated to give an identified medication related to the second identified medical condition, to the resident, during circumstances specified by the prescriber. According to the electronic Medication Administration Record (e-MAR) the resident received scheduled medications that increased their risk of having the second identified medical condition. The resident's history of the second identified medical condition was not mentioned in their care plan. A review of progress notes from the resident's admission until their transfer to hospital did not indicate any documentation of any issues related to the second identified medical condition.

A review of the e-MAR documentation and progress notes for an identified period did not indicate that the medication was given to the resident as prescribed by the physician during circumstances specified by the prescriber.

In an interview Personal Support Worker (PSW) #107 told the Inspector they recall a situation when resident #001 was in the circumstance and appeared in pain. The PSW was unable to recall which day this had occurred and stated they had documented in point of care (POC) and had reported it to the nurse.

In interviews Registered Practical Nurse (RPN) #111 and #112 told the Inspector they have daily access to the clinical dashboard in point click care (PCC) that showed residents who were subject to the circumstance and for what period of time. RPN #111 confirmed they had not been monitoring the resident and therefore had never given the prescribed medication.

In interviews the Nurse Manager (NM) #104, the Director of Care (DOC), and the Executive Director (ED) acknowledged that the prescribed medication should have been administered to the resident as ordered by the prescriber and confirmed neglect of the resident occurred since no action was taken by the home.

The severity of this non-compliance was identified as actual harm or risk, the scope was identified as isolated. Review of the home's compliance history revealed that a voluntary plan of correction (VPC) was issued on May 8, 2017, under inspection report #2017_641513_0006 for non-compliance with the LTCHA, 2007 O.Reg. 79/10, s.19 (1). Due to the severity of actual harm or risk and previous non-compliance with a VPC a compliance order is warranted.

(649)

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

Oct 23, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be complaint with O.Reg. 79/10, s. 131. (2).

Specifically, the licensee shall ensure that residents who require medications are administered in accordance with the directions for use specified by the prescriber.

Upon receipt of this compliance order the licensee shall:
1. Ensure residents who are prescribed medication are administered drugs in accordance with the directions for use specified by the prescriber.
2. The home will develop and implement an audit tool to ensure the physician's orders for PRN medications are followed by the compliance due date.

Grounds / Motifs :

1. Resident #002 was randomly selected as a result of non-compliance identified with resident #001.

A review of the resident's e-MAR indicated to give an identified medication when in the circumstance.

A review of the e-MAR documentation and progress notes for an identified period did not indicate that the medication was given to the resident as prescribed by the physician when the resident was in the circumstance.

In interviews the RPN #116, NM #104, and the DOC confirmed that the physician order had not been followed as prescribed. (649)

2. The license has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the MOHLTC alleging resident #001 had been transferred to hospital because of a change in health. The resident's family was contacted by the the hospital advising that the resident required treatment due to an identified medical condition. The resident passed away in hospital.

A review of physician's order indicated to give an identified medication during circumstances specified by the prescriber.

Review of the e-MAR indicated the resident received scheduled medications that increased their risk of the second identified medical condition.

The resident's history of the second identified medical condition was not mentioned in the resident care plan. A review of progress notes from the resident's admission until their transfer to hospital did not indicate any documentation of any issues related to second identified medical condition.

A review of the e-MAR documentation and progress notes for an identified period did not indicate that the medication was given to the resident as prescribed by the physician during the circumstances specified by the prescriber.

In interviews RPN #111 and #112 confirmed that the physician order to give a prescribed medication in the circumstance had not been followed. RPN #111 confirmed they had not been monitoring the resident in the circumstance and therefore had never given the prescribed medication.

In interviews the NM #104, and the DOC confirmed that the physician order had not been followed as the resident was not administered the prescribed medication in the circumstance.

The severity of this non-compliance was identified as actual harm, or risk the scope was identified as pattern. Review of the home's compliance history revealed that a written notification (WN) was issued on December 15, 2017, under inspection report #2017_652625_0020 for non-compliance with LTCHA, 2007 O.Reg. 79/10, s. 131 (2). Due to the severity of actual harm or risk and previous non-compliance with a WN a compliance order is warranted. (649)

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

Oct 23, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS 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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 19 day of September 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JULIEANN HING - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Toronto