Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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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 25, 2020	2020_769646_0012	018470-20	Critical Incident System

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

IVY LAM (646)

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): September 11, 14, and 15, 2020.

The following intake was completed during this CIS inspection:
CIS #2591-000014-20 related to unexpected death.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Behavioural Support Manager (BSM), Program Therapists, Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Substitute Decision Maker (SDM), and Family Member.

During the course of this inspection, the inspector reviewed residents' and home's records, relevant policies and procedures, and conducted observations, including staff-resident interactions and resident care provision.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours

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

- **2 WN(s)**
- **0 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	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 O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and implemented to meet the needs of a resident who could not communicate in the language used in the home.

An incident occurred where a resident was found lying unresponsive on the floor in their room. The resident was found by another resident, who notified a Personal Support Worker (PSW) for help. The resident was assessed by a Registered Practical Nurse (RPN) and a Registered Nurse (RN). The cause of death was determined by the coroner.

Review of documentation for the resident showed that eight days prior to the resident's passing, an RPN had initiated monitoring for the resident. The RPN was unable to complete an assessment that day with the resident due to a language barrier.

Seven days later, the BSM documented that the first assessment and another assessment were not yet done due to the resident's language barrier, and that a staff would be arranged to assist with translation.

The BSM stated that the two assessments should have been completed with the resident. These two assessments would have informed the staff of the risk and severity of the resident's condition and appropriate interventions would be identified. However, neither of the assessments were completed due to a language barrier.

The BSM stated that the two assessments were not completed as the staff who assisted with translation was not available. However, the staff who assists with translation stated they were in the home during that time period, and no one had approached them to provide translation for the resident.

The BSM stated that there were no appropriate strategies developed and implemented in the home to provide translation for the resident's required assessments.

Sources: Critical Incident System (CIS) report, Resident's clinical records, assessment templates, completed monitoring record; interviews with PSWs; RPN, RN, BSM, Program Therapists, and DOC. [s. 43.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

An RPN had initiated monitoring for the resident. The BSM stated that two assessments should have been completed with the resident. These two assessments would have informed the staff of the risk and severity of the resident's condition and appropriate interventions would be identified. Additional precautions would also be taken to ensure that the resident's environment was safe.

Interviews with multiple PSWs, RPNs, RNs, a Program Therapist and the BSM stated they had not performed the additional precautions for the resident to ensure that the environment was safe for the resident.

Review of resident #001's most recent care plan did not show the monitoring intervention.

Review of the resident's monitoring record did not indicate the reason the resident was being monitored.

Interview with the BSM stated that registered staff should have written the behaviours that the resident was being monitored for on the monitoring tool and documented the reason the resident was being monitored in the resident's records so that it could be communicated to the PSWs and registered staff in subsequent shifts.

Review of the monitoring records during the time the resident was monitored showed that the resident did not have behaviours, but there was no indication of the reason why the resident was being monitored.

An RPN and the BSM stated that the resident's written care plan should have been updated with their behavior and that the interventions for the resident including the monitoring. However, neither the RPN nor the BSM updated the resident's written care plan.

Interviews with the PSW who was assigned to the resident on the night of the incident and the RPN who responded to the incident stated various reasons for the resident's monitoring, none of which were the actual reason.

Interviews with staff members stated they were not aware of the reason for monitoring the resident, and this had not been communicated to them from shift reports.

Interview with an RPN stated that they did not attempt one of the assessments with the resident. Interview with the BSM stated they had not attempted the other assessment or reattempted the first assessment with the resident, as the staff who usually provided translation for the resident was not available. However, the staff who assists with translation stated they were in the home during that time period, and no one had approached them to provide translation for the resident. The nursing and behavioural support staff had not collaborated in arranging and providing a translator for the resident to complete their required assessments.

Without the collaboration of PSWs, registered staff, and the behavioural support manager in the assessment of the resident, there was increased risk that the resident would not receive the proper care and interventions required to address their identified risk and health condition.

Sources: CIS report, Resident's clinical records, assessment templates, completed monitoring record, home's Behavioural Management and Responsive Behaviour

Philosophy and Assessment policy (Revised June 5, 2019); interviews with PSWs; RPN, RN, BSM, Program Therapists, and DOC. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of two residents collaborated with each other in the development of their plans of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Review of the residents' most recent care plans showed that both residents had a language communication tool to assist with communication.

Observation of both residents' room showed a printed sheet for each resident posted on their walls, which included translated words under the headings: greetings, activities of daily living, dining, and medical terms.

Interview with a Program Therapist who worked on the unit stated they were aware of the residents' language barriers, and would use simple English to communicate with them or request family members to translate.

Separate interviews with PSWs, an RN and the BSM stated that both residents had language barriers and could not speak or understand English well. The staff also stated they used their own ways to communicate with the two residents, including using hand gestures, calling their SDM to translate, asking a staff who spoke the residents' language to translate, or use a website translator. However, none of these strategies were listed on either residents' written plans of care. The staff explained that these were communication methods that they had tried individually but were not part of a developed plan for the residents.

Interview with another Program Therapist clarified that the communication tool were the sheets of paper in the residents' room, and PSWs should be aware of it when they see the sheet in the resident's room. They further stated that staff should know about the communication tool, as it was stated in the residents' written plans of care.

Other than one Program Therapist, interviews with all staff members above were not aware of the communication tools that were in the residents' room.

Interviews with nursing, program therapy, and behavioural support staff showed that they tried different strategies to communicate with the residents who had language barriers

but did not collaborate with each other in developing the residents' plans of care for communication to ensure that the different aspects of care were integrated, consistent with, and complemented each other.

Sources: CIS report, both residents' electronic records; interviews with PSWs; RPN, RN, BSM, Program Therapists, and DOC. [s. 6. (4) (b)]

3. Refer to non-compliance 2. [s. 6. (4) (b)]

Additional Required Actions:

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

Issued on this 14th day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	IVY LAM (646)
Inspection No. / No de l’inspection :	2020_769646_0012
Log No. / No de registre :	018470-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 25, 2020
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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s.43.

Specifically, the licensee shall ensure that:

1) Strategies are developed and implemented to meet the assessment needs of the resident who does not speak the language used in the home.

2) The home identifies residents who cannot communicate in the language used in the home and who require translation for behavioural assessments.

3) Strategies are developed and implemented to meet the behavioural assessment needs of residents who cannot speak the language used in the home, to ensure that these residents receive timely assessments.

4) The strategies above are documented in the residents' written care plans and communicated to the PSWs and registered staff, and any other staff identified by the home as appropriate.

5) A record is kept for items #1, 2, 3, and 4, including the dates of assessments, the names of resident assessed, staff members involved in the assessments, and interventions developed and implemented for the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies were developed and implemented to meet the needs of a resident who could not communicate in the

language used in the home.

An incident occurred where a resident was found lying unresponsive on the floor in their room. The resident was found by another resident, who notified a Personal Support Worker (PSW) for help. The resident was assessed by a Registered Practical Nurse (RPN) and a Registered Nurse (RN). The cause of death was determined by the coroner.

Review of documentation for the resident showed that eight days prior to the resident's passing, an RPN had initiated monitoring for the resident. The RPN was unable to complete an assessment that day with the resident due to a language barrier.

Seven days later, the BSM documented that the first assessment and another assessment were not yet done due to the resident's language barrier, and that a staff would be arranged to assist with translation.

The BSM stated that the two assessments should have been completed with the resident. These two assessments would have informed the staff of the risk and severity of the resident's condition and appropriate interventions would be identified. However, neither of the assessments were completed due to a language barrier.

The BSM stated that the two assessments were not completed as the staff who assisted with translation was not available. However, the staff who assists with translation stated they were in the home during that time period, and no one had approached them to provide translation for the resident.

The BSM stated that there were no appropriate strategies developed and implemented in the home to provide translation for the resident's required assessments.

Sources: Critical Incident System (CIS) report, Resident's clinical records, assessment templates, completed monitoring record; interviews with PSWs; RPN, RN, BSM, Program Therapists, and DOC.

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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

An order was made by taking the following factors into account:

Severity: The home identified that the resident required assessments. There was actual risk related to the lack of communication strategies in place for the resident, as the necessary assessments to determine the severity of their condition and the level of risk could not be done due to the language barrier, and appropriate interventions for the resident could not be implemented without these assessments.
Scope: This was an isolated case as no other incidents of residents not receiving assessments due to not being able to communicate in the language or languages used in the home were identified during this inspection.
Compliance History: Six written notifications (WN), 14 voluntary plans of correction (VPC) and nine compliance orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 04, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must comply with LTCHA 2007, c. 8, s. 6 (4).

Specifically, the licensee shall ensure that:

1) When a resident is placed on monitoring, the reason for the monitoring is clearly stated and communicated to PSWs and registered staff who work with the resident.

2) There is collaboration between PSWs, registered staff, program therapy staff in the assessment of communication needs of residents who cannot communicate in the language used in the home.

3) There is collaboration between PSWs, registered staff, program therapy, and behavioural management staff in developing appropriate interventions to address the needs of residents in item #2.

4) The written care plans of the identified residents are updated and communicated with nursing, program therapy, and behavioural support staff who work with the identified residents.

5) A record is kept of the dates of assessments, the names of staff involved in the assessments, the names of residents assessed, and interventions developed and implemented for the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

An RPN had initiated monitoring for the resident. The BSM stated that two assessments should have been completed with the resident. These two assessments would have informed the staff of the risk and severity of the resident's condition and appropriate interventions would be identified. Additional precautions would also be taken to ensure that the resident's environment was safe.

Interviews with multiple PSWs, RPNs, RNs, a Program Therapist and the BSM stated they had not performed the additional precautions for the resident to ensure that the environment was safe for the resident.

Review of resident #001's most recent care plan did not show the monitoring intervention.

Review of the resident's monitoring record did not indicate the reason the resident was being monitored.

Interview with the BSM stated that registered staff should have written the behaviours that the resident was being monitored for on the monitoring tool and documented the reason the resident was being monitored in the resident's records so that it could be communicated to the PSWs and registered staff in subsequent shifts.

Review of the monitoring records during the time the resident was monitored showed that the resident did not have behaviours, but there was no indication of the reason why the resident was being monitored.

An RPN and the BSM stated that the resident's written care plan should have been updated with their behavior and that the interventions for the resident including the monitoring. However, neither the RPN nor the BSM updated the resident's written care plan.

Interviews with the PSW who was assigned to the resident on the night of the incident and the RPN who responded to the incident stated various reasons for the resident's monitoring, none of which were the actual reason.

Interviews with staff members stated they were not aware of the reason for monitoring the resident, and this had not been communicated to them from shift reports.

Interview with an RPN stated that they did not attempt one of the assessments with the resident. Interview with the BSM stated they had not attempted the other assessment or reattempted the first assessment with the resident, as the staff who usually provided translation for the resident was not available.

However, the staff who assists with translation stated they were in the home during that time period, and no one had approached them to provide translation for the resident. The nursing and behavioural support staff had not collaborated in arranging and providing a translator for the resident to complete their required assessments.

Without the collaboration of PSWs, registered staff, and the behavioural support manager in the assessment of the resident, there was increased risk that the resident would not receive the proper care and interventions required to address their identified risk and health condition.

Sources: CIS report, Resident's clinical records, assessment templates, completed monitoring record, home's Behavioural Management and Responsive Behaviour Philosophy and Assessment policy (Revised June 5, 2019); interviews with PSWs; RPN, RN, BSM, Program Therapists, and DOC. (646)

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of two residents collaborated with each other in the development of their plans of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Review of the residents' most recent care plans showed that both residents had a language communication tool to assist with communication.

Observation of both residents' room showed a printed sheet for each resident posted on their walls, which included translated words under the headings: greetings, activities of daily living, dining, and medical terms.

Interview with a Program Therapist who worked on the unit stated they were aware of the residents' language barriers, and would use simple English to communicate with them or request family members to translate.

Separate interviews with PSWs, an RN and the BSM stated that both residents had language barriers and could not speak or understand English well. The staff also stated they used their own ways to communicate with the two residents, including using hand gestures, calling their SDM to translate, asking a staff who

spoke the residents' language to translate, or use a website translator. However, none of these strategies were listed on either residents' written plans of care. The staff explained that these were communication methods that they had tried individually but were not part of a developed plan for the residents.

Interview with another Program Therapist clarified that the communication tool were the sheets of paper in the residents' room, and PSWs should be aware of it when they see the sheet in the resident's room. They further stated that staff should know about the communication tool, as it was stated in the residents' written plans of care.

Other than one Program Therapist, interviews with all staff members above were not aware of the communication tools that were in the residents' room.

Interviews with nursing, program therapy, and behavioural support staff showed that they tried different strategies to communicate with the residents who had language barriers but did not collaborate with each other in developing the residents' plans of care for communication to ensure that the different aspects of care were integrated, consistent with, and complemented each other.

Sources: CIS report, both residents' electronic records; interviews with PSWs; RPN, RN, BSM, Program Therapists, and DOC.
(646)

3. Refer to non-compliance 2.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm because the staff did not collaborate to develop the residents' plans of care to address their language barriers and communication needs.
Scope: Out of the three residents reviewed, the staff had not collaborated to develop communication strategies for two residents.
Compliance History: In the past 36 months, the licensee was found to be non-compliant with LTCHA s. 6. (4), and two voluntary plans of correction (VPC), and one compliance orders (CO) were issued. (646)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 04, 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 25th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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