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

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 23, 2021	2021_882760_0012	001473-21, 002556-21, 002557-21, 002558-21, 002658-21, 003737-21	Critical Incident System

Licensee/Titulaire de permis

Mon Sheong Foundation
36 D'Arcy Street Toronto ON M5T 1J7

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

Mon Sheong Richmond Hill Long Term Care Centre
11199 Yonge Street Richmond Hill ON L4S 1L2

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

JACK SHI (760)

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): April 13, 14, 15, 19, 20, 2021.

The following intakes were completed in this critical incident inspection:

Three logs were related to falls;

Log # 002558-21, follow up to Compliance Order (CO) #001, LTCHA s. 19 (1), related to abuse and neglect, issued under inspection #2021_715672_0003, on February 10, 2021, with a compliance date of March 10, 2021, was inspected;

Log # 002557-21, follow up to Compliance Order (CO) #002, O. Reg. 79/10 s. 73 (2), related to nutritional care, issued under inspection #2021_715672_0003, on February 10, 2021, with a compliance date of February 20, 2021, was inspected;

Log # 002556-21, follow up to Compliance Order (CO) #003, O. Reg. 79/10 s. 229 (4), related to infection prevention and control, issued under inspection #2021_715672_0003, on February 10, 2021, with a compliance date of February 20, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Agency Personal Support Workers (Agency PSW), Personal Support Workers (PSW), Associate Director of Resident Care (ADRC) and the Assistant Administrator (AA).

During the course of the inspection, the inspector conducted observations and record reviews.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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

- **5 WN(s)**
- **1 VPC(s)**
- **2 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	2021_715672_0003	760
O.Reg 79/10 s. 73. (2)	CO #002	2021_715672_0003	760

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 failed to ensure that two residents' fall prevention interventions were provided as specified in their plan of care.

A resident's care plan stated that they had a fall prevention intervention in place to ensure their safety. The progress notes indicated that the resident sustained a fall with an adverse outcome. A PSW, an RN and an RPN all stated that the fall prevention intervention was not provided to this resident at the time of their fall. The PT stated that the fall prevention intervention may have reduced the risk of harm to the resident, if it was implemented and the staff should have followed the interventions that were in place as per the resident's plan of care. There was actual harm to the resident as they sustained a negative outcome following their fall and a fall prevention intervention in this resident's plan of care, may have improved their outcomes, if it was provided.

Sources: A resident's care plan, progress notes; Interviews with a PSW, an RPN, an RN, a PT and other staff. [s. 6. (7)]

2. A review of another resident's care plan indicated a fall prevention intervention was implemented for the resident. A review of the progress notes and an interview with the RPN indicated that the resident sustained a fall and the fall prevention intervention was not in place at the time of their fall. There was potential risk to the resident because the fall prevention intervention was a way to reduce an adverse outcome, if they sustained a fall.

Sources: A resident's care plan, progress notes; Interview with an RPN and other staff. [s. 6. (7)]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Compliance Order (CO) #003 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_715672_0003 issued on February 10, 2021, with a compliance due date of February 20, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff continued to be noncompliant with the implementation of the home's IPAC program.

According to the AA, there were a number of residents on contact/droplet precautions at a time during the inspector's inspection at the home. The home has a universal masking and face shield policy in place for all resident home areas and rooms.

As per Directive #3, the home’s visitor’s policy must include providing strategies for supporting visitors in understanding and adhering to the home’s visitor policy and to ensure that residents, staff & visitors are protected in the home from the risk of viruses.

Observations were carried throughout the home during this inspection and noted the following:
- A resident on contact/droplet precautions was seen outside their room. The RN brought the resident back to their room and stated the agency PSW should have known to have kept the resident in their room.
- The inspector was inside an elevator with a PSW. An activation aide was seen coming into the elevator after getting the PSW’s approval. The AA stated that there are signs posted outside the elevators to ensure there are only two people inside an elevator at one time to maintain social distancing.
- An agency PSW was seen wearing their gloves while walking from the soiled utilities room to the nursing station. The RN immediately told the agency PSW to remove their gloves. The RN stated that the agency PSW should have removed their gloves, when they went to the nursing station and apply a new pair of gloves when they return to the soiled utilities room.
- A visitor was seen inside a resident's room without wearing any additional personal protective equipment (PPE). The resident was on contact/droplet precautions at the time of this observation. The AA stated that this person should have worn the appropriate PPE required for contact/droplet precautions, prior to entering this resident's room.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a person inside the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the AA, an RN and other staff; Observations made throughout the home during the inspector's inspection. [s. 229. (4)]

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PSW, an RN and an RPN were mentioned in the Critical Incident Systems (CIS) report related to a resident's fall.

A CIS report was submitted by the home regarding a fall that a resident sustained. A review of the submitted CIS report indicated that it did not mention a PSW, an RN and an RPN, who had all responded to the resident’s fall. The AA indicated that the names of all involved staff in a CIS report should be included and that these staff members should have been named in the CIS report.

Sources: A CIS report; Home’s investigation notes; Interviews with a PSW, an RPN, the AA and other staff. [s. 107. (4) 2.]

2. The licensee failed to ensure that a PSW was mentioned in the CIS report related to a resident's fall.

A CIS report was submitted by the home related to a fall that a resident sustained. An interview with an RPN indicated that a PSW had notified them about the resident’s fall. The name of this PSW was not identified in the home’s CIS report. The AA indicated that all the staff involved in a critical incident should be in the CIS report.

Sources: A CIS report; Interviews with an RPN, the AA and other staff. [s. 107. (4) 2.]

3. The licensee failed to ensure that a PSW was mentioned in the CIS report related to a resident's fall.

A CIS report was submitted by the home related to a fall that a resident sustained. The CIS report stated that a PSW had reported to the RPN that the resident sustained a fall. The CIS report did not name who this PSW was. The AA indicated that the PSW's name should have been included in the CIS report.

Sources: A CIS report; Interviews with the AA and other staff. [s. 107. (4) 2.]

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 who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident., to be implemented voluntarily.

WN #4: 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 the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for two residents.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home's policy and procedure "Fall Prevention and Management Program". The policy stated that a neurological observation chart will be completed for any unwitnessed fall.

A resident sustained a fall and a neurological monitoring chart was initiated for the resident. The RN had documented a response on a number of their scheduled checks. The AA stated that this documented response was not appropriate for the neurological assessment and did not follow the home's policy.

Sources: Fall Prevention and Management policy; A resident's progress notes and neurological observation; Interview an RN, the AA and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

2. Another resident sustained a number of unwitnessed falls during a period of time in the home. Neurological monitoring was started for the resident for each of these falls. A review of the neurological monitoring assessments indicated that a response was documented for a number of their scheduled checks. Two RPNs both stated that this documented response was not appropriate and staff should have documented the correct response, if it was applicable to the resident.

Sources: Fall Prevention and Management policy; A resident's progress notes and neurological observations; Interview with two RPNs and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that an RPN used safe transferring techniques with a resident, after they sustained an unwitnessed fall.

An observation was made by the inspector, when they noticed a resident on the floor. The RPN was immediately called by the inspector and the RPN responded accordingly. Afterwards, the RPN transferred the resident from the floor by themselves. The AA stated that this was not a safe transferring technique because of the resident's condition. The AA stated the RPN should have asked a second staff to assist in transferring the resident from the floor. There was potential risk to the resident, as the failure to utilize a second staff member to transfer this resident from the floor may have caused potential injuries to the resident, following an unwitnessed fall they had sustained.

Sources: Observation on a resident unit; Interviews with the RPN, the AA and other staff. [s. 36.]

Issued on this 26th day of April, 2021

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) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2021_882760_0012
Log No. / No de registre :	001473-21, 002556-21, 002557-21, 002558-21, 002658-21, 003737-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 23, 2021
Licensee / Titulaire de permis :	Mon Sheong Foundation 36 D'Arcy Street, Toronto, ON, M5T-1J7
LTC Home / Foyer de SLD :	Mon Sheong Richmond Hill Long Term Care Centre 11199 Yonge Street, Richmond Hill, ON, L4S-1L2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Li

To Mon Sheong Foundation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Specifically, the licensee must:

1. Ensure the plan of care is being to provided to residents in relation to their fall prevention interventions.

Grounds / Motifs :

1. The licensee failed to ensure that two residents' fall prevention interventions were provided as specified in their plan of care.

A resident's care plan stated that they had a fall prevention intervention in place to ensure their safety. The progress notes indicated that the resident sustained a fall with an adverse outcome. A PSW, an RN and an RPN all stated that the fall prevention intervention was not provided to this resident at the time of their fall. The PT stated that the fall prevention intervention may have reduced the risk of harm to the resident, if it was implemented and the staff should have followed the interventions that were in place as per the resident's plan of care. There was actual harm to the resident as they sustained a negative outcome following their fall and a fall prevention intervention in this resident's plan of care, may have improved their outcomes, if it was provided.

Sources: A resident's care plan, progress notes; Interviews with a PSW, an RPN, an RN, a PT and other staff. (760)

2. A review of another resident's care plan indicated a fall prevention intervention was implemented for the resident. A review of the progress notes

and an interview with the RPN indicated that the resident sustained a fall and the fall prevention intervention was not in place at the time of their fall. There was potential risk to the resident because the fall prevention intervention was a way to reduce an adverse outcome, if they sustained a fall.

Sources: A resident's care plan, progress notes; Interview with an RPN and other staff.

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

Severity: There was actual harm to the first resident because they sustained an adverse outcome after their fall and potential risk of harm to the second resident from the staff not providing and following the interventions as specified in their plan of care.

Scope: The scope of this non-compliance demonstrated a pattern because the care set out in the plan of care, was not provided to two of the three residents reviewed during the inspection.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 6 (7) of the LTCHA, and 2 WNs and 1 VPC were issued to the home. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2021_715672_0003, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. Compliance Order (CO) #003 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_715672_0003 issued on February 10, 2021, with a compliance due date of February 20, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff continued to be noncompliant with the implementation of the home's IPAC program.

According to the AA, there were a number of residents on contact/droplet precautions at a time during the inspector's inspection at the home. The home has a universal masking and face shield policy in place for all resident home areas and rooms.

As per Directive #3, the home's visitor's policy must include providing strategies for supporting visitors in understanding and adhering to the home's visitor policy and to ensure that residents, staff & visitors are protected in the home from the risk of viruses.

Observations were carried throughout the home during this inspection and noted the following:
- A resident on contact/droplet precautions was seen outside their room. The RN brought the resident back to their room and stated the agency PSW should have known to have kept the resident in their room.
- The inspector was inside an elevator with a PSW. An activation aide was seen coming into the elevator after getting the PSW's approval. The AA stated that there are signs posted outside the elevators to ensure there are only two people inside an elevator at one time to maintain social distancing.
- An agency PSW was seen wearing their gloves while walking from the soiled utilities room to the nursing station. The RN immediately told the agency PSW to remove their gloves. The RN stated that the agency PSW should have removed their gloves, when they went to the nursing station and apply a new pair of gloves when they return to the soiled utilities room.
- A visitor was seen inside a resident's room without wearing any additional personal protective equipment (PPE). The resident was on contact/droplet precautions at the time of this observation. The AA stated that this person should have worn the appropriate PPE required for contact/droplet precautions, prior to entering this resident's room.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a person inside the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the AA, an RN and other staff; Observations made throughout the home during the inspector's inspection.

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

Severity: There was actual risk of harm to the residents because some staff and a person in the home continued to be non-compliant with the proper IPAC

measures, which may possibly lead to cross contamination.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #003 was issued on February 10, 2021, (Inspection 2021_715672_0003) with a compliance due date of February 20, 2021. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 11, 2021

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 23rd day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

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