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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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5700 rue Yonge 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 4, 2018	2018_644507_0011	024023-16, 004941-17, 005682-17, 027112-17, 028470-17	Critical Incident System

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street NORTH YORK ON M2K 1E1

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

Seniors' Health Centre
2 Buchan Court NORTH YORK ON M2J 5A3

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

STELLA NG (507)

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): May 7 -11, 14 - 17, 2018.

The following intakes were completed in this Critical Incident System Inspection:
Log #024023-16, CIS #2744-000034-16 related to resident to resident abuse, responsive behaviours and bedtime and sleep routines;
Log #004941-17, CIS #2744-000005-17 related to resident to resident abuse;
Log #005682-17, CIS #2744-000007-17 related to resident to resident abuse;
Log #027112-17, CIS #2744-000033-17 related to transferring and positioning; and
Log #028470-17, CIS #2744-000038-17 related to injuries with unknown cause.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Interim Associate Director of Care (IADOC), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) co-ordinator, Environmental Supervisor (ES) and residents.

During the course of the inspection, the inspector conducted observation of provision of care, record review of resident and home records, staff schedule and relevant home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.O. 2007, c.8, 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 protect residents from abuse by anyone.

A) An identified Critical Incident System (CIS) report on an identified date received through the CIS stated that on the same identified date, at an identified time, resident #006 was found on the floor in the resident's room and resident #005 was also in the room. Resident #006 sustained an injury and was sent to the hospital for treatment.

In an interview, staff #108 stated that on the above mentioned identified date and time, staff #108 responded to resident #006's alarm and found resident #006 on the floor, and heard resident #006 telling resident #005 to get out of the room. Staff #108 called for help and staff separated both residents.

During the inspection, the inspector observed residents #005 and #006 both in chairs and were not interviewable.

Record review of the progress notes of resident #005 indicated that resident #005 was admitted to the home five months prior to the above mentioned incident. Record review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed two months prior indicated that resident #005 exhibited responsive behaviours on a daily basis and the behaviours were not easily altered.

Record review of the Resident Assessment Protocol (RAP) worksheet two months prior for resident #005 identified that resident #005 exhibited responsive behaviours and behaviours were not always easily altered.

Record review of the progress notes for resident #005 for a ten week period prior to the above mentioned incident documented the resident exhibited responsive behaviours on many occasions.

Record review of the written plan of care dated seven weeks prior for resident #005 failed to include a focus on the above mentioned responsive behaviours and related interventions.

In interviews, staff #109 and #111 stated the written plan of care should be updated every quarter and when there is a new condition observed; and that registered staff are responsible for updating the written plan of care for the residents on their unit.

In an interview, staff #119 stated the registered staff are responsible for updating the

written plan of care every quarter and when it is needed, such as change of resident's status. Staff #119 further stated that when a resident exhibited responsive behaviours, staff should have detailed notes and identify the certain responsive behaviours and triggers, if possible, and develop interventions. Staff #119 acknowledged there were no interventions developed in relation to resident #005's identified responsive behaviours and resident #006 was injured because of resident #005's above mentioned identified responsive behaviours.

B) Another identified CIS on an identified date received through the Critical Incident System, stated that two days prior, at an identified time resident #004 was observed exhibiting identified responsive behaviour towards resident #003. As a result, resident #003 sustained an injury.

In an interview, staff #107 stated that on the identified date, at the identified time, staff heard and responded to the commotion from an identified location on the unit, and observed resident #004 exhibiting responsive behaviour towards resident #003. Staff #107 further stated it was not clear what caused the conflict between residents #003 and #004.

During the course of the inspection, the inspector observed residents #003 and #004 in separate locations and both residents were not interviewable.

Record review of the progress notes for resident #003 indicated that during assessment conducted after the above mentioned incident, resident #003 was observed in pain and was sent to the hospital for further assessment. Resident #003 was diagnosed with an injury.

Record review of the progress notes for resident #004 indicated that on an identified date two months prior, resident #004 was observed exhibiting responsive behaviour towards another resident, and was confirmed through an interview with staff #103. Staff #103 stated they were not sure what caused resident #004's action on the identified date.

Record review of the written plan of care on an identified date (the written plan of care for the period when the above mentioned incident occurred), for resident #004 failed to identify any interventions in relation to resident #004's above mentioned identified responsive behaviours.

In an interview, staff #107 stated that the written plan of care should be updated every

quarter and when there is a new condition observed, and registered staff are responsible for updating the written plan of care for the residents on their perspective units.

In an interview, staff #119 stated that registered staff are responsible for updating a resident's written plan of care every quarter and when there is a change in a resident's status. Staff #119 acknowledged resident #004's written plan of care was not updated when the resident exhibited the above mentioned responsive behaviour as documented on the identified date, and interventions were not developed and implemented to minimize the risk and potentially harmful interactions between and among residents. Staff #119 also acknowledged that resident #003 was injured because of resident #004's above mentioned identified responsive behaviour. [s. 19. (1)]

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

An identified CIS on an identified date received through the Critical Incident System, stated that resident #007 fell from the chair and sustained an injury.

In an interview, staff #114 stated that on an identified date, staff #114 and #122 transferred resident #007 from the chair to another chair with a mechanical lift in the resident's room. When the transfer was completed, staff #122 left the room, and staff #114 took the mechanical lift to the hallway for charging. Staff #114 heard a noise and found resident #007 lying on the floor. Registered staff were alerted and assessments were completed.

Review of the above mentioned CIS report indicated that resident #007 sustained an injury and was sent to the hospital for treatment.

Resident #007 was not available for an interview as the resident no longer resided in the home.
Staff #122 was not available for an interview as the PSW was no longer employed by the home.

In an interview, staff #114 stated that the brakes of the specific chair were locked prior to the transfer and appeared stable. Staff #114 further stated the specific chair was taken to the maintenance department for inspection because the chair was observed tilted after the incident.

Record review of the above mentioned CIS report indicated that the maintenance staff found one of the mechanisms in adjusting the height of the chair was missing, and was confirmed through an interview by staff #116.

In an interview, staff #116 stated that the specific chair used for resident #007 was the older model. There were mechanisms in place so that the height of the chair could be adjusted. Staff #116 also stated if the mechanism was not applied properly, it could pose a risk when a resident was placed on the chair. Staff #116 further stated that the specific chairs were not included in the home's routine, preventive and remedial maintenance schedule. It was the nursing staff's responsibilities to ensure all mechanisms were applied properly prior to using the chair for residents.

In an interview, staff #114 stated staff used the older model of the specific chairs for residents all the time, and the same chair had been used for resident #007 in the past by staff #114. Staff #114 further stated that the mechanisms were not checked prior to transferring resident #007 from the chair to the specific chair on the above mentioned identified date.

In an interview, staff #119 stated staff should check and to ensure the equipment was safe prior to transfer. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

An identified Critical Incident System (CIS) report on an identified date received through the CIS stated that on the same identified date, at an identified time, resident #006 was found on the floor in the resident's room and resident #005 was also in the room. As a result, resident #006 sustained an injury and was sent to the hospital for treatment.

During the inspection, the inspector observed residents #005 and #006 both in chairs and were not interviewable.

Record review of the progress notes of resident #005 indicated that resident #005 was admitted to the home five months prior to the above mentioned incident. Record review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed two months prior indicated that resident #005 exhibited responsive behaviours on a daily basis and the behaviours were not easily altered.

Record review of the Resident Assessment Protocol (RAP) worksheet two months prior for resident #005 identified that resident #005 exhibited responsive behaviours and behaviours were not always easily altered.

Record review of the progress notes for resident #005 for a ten week period prior to the above mentioned incident documented the resident exhibited responsive behaviours on many occasions.

Record review of the written plan of care dated seven weeks prior for resident #005 failed to include a focus on the above mentioned responsive behaviours and related interventions.

In interviews, staff #109 and #111 stated the written plan of care should be updated every quarter and when there is a new condition observed; and that registered staff are responsible for updating the written plan of care for the residents on their unit.

In an interview, staff #119 stated the registered staff are responsible for updating the written plan of care every quarter and when it is needed, such as change of resident's status. Staff #119 further stated that when a resident exhibited responsive behaviours, staff should have detailed notes and identify the certain responsive behaviours and triggers, if possible, and develop interventions. Staff #119 acknowledged there were no interventions developed in relation to resident #005's identified responsive behaviours. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #4: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

An identified CIS on an identified date received through the Critical Incident System, stated that resident #007 fell from the chair and sustained an injury.

In an interview, staff #114 stated that on an identified date, staff #114 and #122 transferred resident #007 from the chair to another chair with a mechanical lift in the resident's room. When the transfer was completed, staff #122 left the room, and staff #114 took the mechanical lift to the hallway for charging. Staff #114 heard a noise and found resident #007 lying on the floor. Registered staff were alerted and assessments were completed.

Review of the above mentioned CIS report indicated that resident #007 sustained an injury and was sent to the hospital for treatment.

In an interview, staff #113 acknowledged the home had been aware of resident #007's injury on the date the incident occurred, and failed to inform the Director until two business days later. [s. 107. (3)]

Issued on this 22nd day of June, 2018

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

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2018_644507_0011
Log No. / No de registre :	024023-16, 004941-17, 005682-17, 027112-17, 028470-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 4, 2018
Licensee / Titulaire de permis :	North York General Hospital 4001 Leslie Street, NORTH YORK, ON, M2K-1E1
LTC Home / Foyer de SLD :	Seniors' Health Centre 2 Buchan Court, NORTH YORK, ON, M2J-5A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Bock

To North York General Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

The licensee must be compliant with s. 19(1) of the Act.

Specifically the licensee must:
a) Ensure interventions are developed and implemented for all responsive behaviours exhibited by any resident.
b) Ensure all interventions developed for all responsive behaviours exhibited by any resident are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
c) Implement an on-going auditing process to ensure that interventions are developed and implemented for residents who exhibit responsive behaviours, and the interventions are included in the resident's written plan of care, and the written plan of care is revised and updated when the resident's status changes.
d) Maintain a written record of audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone.

A) An identified Critical Incident System (CIS) report on an identified date received through the CIS stated that on the same identified date, at an identified time, resident #006 was found on the floor in the resident's room and resident #005 was also in the room. Resident #006 sustained an injury and was sent to the hospital for treatment.

In an interview, staff #108 stated that on the above mentioned identified date and time, staff #108 responded to resident #006's alarm and found resident

#006 on the floor, and heard resident #006 telling resident #005 to get out of the room. Staff #108 called for help and staff separated both residents.

During the inspection, the inspector observed residents #005 and #006 both in chairs and were not interviewable.

Record review of the progress notes of resident #005 indicated that resident #005 was admitted to the home five months prior to the above mentioned incident. Record review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed two months prior indicated that resident #005 exhibited responsive behaviours on a daily basis and the behaviours were not easily altered.

Record review of the Resident Assessment Protocol (RAP) worksheet two months prior for resident #005 identified that resident #005 exhibited responsive behaviours and behaviours were not always easily altered.

Record review of the progress notes for resident #005 for a ten week period prior to the above mentioned incident documented the resident exhibited responsive behaviours on many occasions.

Record review of the written plan of care dated seven weeks prior for resident #005 failed to include a focus on the above mentioned responsive behaviours and related interventions.

In interviews, staff #109 and #111 stated the written plan of care should be updated every quarter and when there is a new condition observed; and that registered staff are responsible for updating the written plan of care for the residents on their unit.

In an interview, staff #119 stated the registered staff are responsible for updating the written plan of care every quarter and when it is needed, such as change of resident's status. Staff #119 further stated that when a resident exhibited responsive behaviours, staff should have detailed notes and identify the certain responsive behaviours and triggers, if possible, and develop interventions. Staff #119 acknowledged there were no interventions developed in relation to resident #005's identified responsive behaviours and resident #006 was injured because of resident #005's above mentioned identified responsive behaviours.

B) Another identified CIS on an identified date received through the Critical Incident System, stated that two days prior, at an identified time resident #004 was observed exhibiting identified responsive behaviour towards resident #003. As a result, resident #003 sustained an injury.

In an interview, staff #107 stated that on the identified date, at the identified time, staff heard and responded to the commotion from an identified location on the unit, and observed resident #004 exhibiting responsive behaviour towards resident #003. Staff #107 further stated it was not clear what caused the conflict between residents #003 and #004.

During the course of the inspection, the inspector observed residents #003 and #004 in separate locations and both residents were not interviewable.

Record review of the progress notes for resident #003 indicated that during assessment conducted after the above mentioned incident, resident #003 was observed in pain and was sent to the hospital for further assessment. Resident #003 was diagnosed with an injury.

Record review of the progress notes for resident #004 indicated that on an identified date two months prior, resident #004 was observed exhibiting responsive behaviour towards another resident, and was confirmed through an interview with staff #103. Staff #103 stated they were not sure what caused resident #004's action on the identified date.

Record review of the written plan of care on an identified date (the written plan of care for the period when the above mentioned incident occurred), for resident #004 failed to identify any interventions in relation to resident #004's above mentioned identified responsive behaviours.

In an interview, staff #107 stated that the written plan of care should be updated every quarter and when there is a new condition observed, and registered staff are responsible for updating the written plan of care for the residents on their perspective units.

In an interview, staff #119 stated that registered staff are responsible for updating a resident's written plan of care every quarter and when there is a change in a resident's status. Staff #119 acknowledged resident #004's written plan of care was not updated when the resident exhibited the above mentioned

responsive behaviour as documented on the identified date, and interventions were not developed and implemented to minimize the risk and potentially harmful interactions between and among residents. Staff #119 also acknowledged that resident #003 was injured because of resident #004's above mentioned identified responsive behaviour. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk to residents #003 and #006. The scope of the issue was a 2 as it related to two residents. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Compliance Order (CO) issued January 24, 2017 (2016_413500_0009), and
- Voluntary Compliance Plan (VPC) issued January 17, 2017 (2016_503649_0024)

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
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

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 4th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : STELLA NG

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