Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 09, 2019	2019_751649_0012 (A1)	002266-18, 005036-18, 009875-18, 009884-18, 013609-18, 030432-18, 030537-18, 002056-19, 004228-19	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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The following revisions were made to the finding of non-compliance under the LTCHA, 2007, s. 6 (1) (c) in the licensee report for inspection #2019_751649_0012, and will also be reflected in the public report:
- Removed reference to resident #002 in opening statement (paragraph 1), as this finding only related to resident #003, and two typographical errors referring to resident #002 (paragraphs 3 and 4) in this finding were corrected to resident #003.
- Deleted paragraphs 6 and 9 related to review of resident #003's care plan, as they were both duplicate paragraphs, and duplicated content in paragraph 4.
- Deleted paragraphs 8 and 10, as they duplicated paragraphs 5 and 7.
- Deleted paragraph 11, as new content was added in substitution (see below)
- A new paragraph was added between paragraphs 7 and 12 (in the original version), which described Inspector #722's interview with PSW #108 concerning how resident #003 was transferred upon return from hospital.

The following revision was made to the finding of non-compliance under the LTCHA, 2007, s. 6 (3) in inspection report #2019_751649_0012 (Public Report only):
- A new paragraph was added after paragraph 2, to include the review of resident care plans to support this finding.

Issued on this 9 th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 3, 4, 5, 6, 7, 10, and 11, 2019.

The following intakes were completed in this critical incident system (CIS) inspection:

Log #002266-18/ CIS #2744-000005-18 related to duty to protect and falls prevention and management,

Log #009875-18/ CIS #2744-000016-18 related to critical incidents and transferring and positioning technique,

Log #013609-18/ CIS #2744-000022-18 related to critical incidents and plan of care,

Log #005036-18/ CIS #2744-000010-18 related to infection prevention and control program, and

Log #002056-19 related to follow-up order under s. 19. (1).

The following intakes were completed related to falls prevention and management:

Log #030537-18/ CIS #2744-000045-18

Log #009884-18/ CIS #2744-000014-18

Log #030432-18/ CIS #2744-000044-18

Log #004228-19/ CIS # 2744-000008-19

PLEASE NOTE: A Written Notification and a Voluntary Plan of Correction related

to LTCHA, 2007, c.8, s.6. (7), identified in a concurrent inspection #2019_751649_0011 (Log #013308-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant directors of care (ADOCs), nurse practitioner (NP), registered nurses (RNs), physiotherapist (PT), resident assessment instrument-minimum data set (RAI-MDS) coordinator, registered practical nurses (RPNs), personal support workers (PSWs), and residents.

The inspectors conducted observations of staff to resident interactions, conducted observations of residents, reviewed residents' health records, investigation notes, staffing schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_626501_0022	652

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

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 :

(A1)
1. The licensee failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to the resident.

A critical incident system report was received by the Director when resident #003 fell and sustained injuries that resulted in hospitalization.

Inspector #722 reviewed the Patient Transfer Record and Discharge Summary for resident #003, which indicated that the resident required assistance with Activities of Daily Living (ADLs), assistance of two persons for mobility and transfer.

Inspector #722 reviewed the care plan for resident #003 which indicated the following:
- A method of transfer was specified prior to the resident's hospitalization, and remained the same for a specified period after readmission to the home;
- Two different transfer methods were identified on the same specified date several days after the resident was readmitted from hospital, and one method identified use of a specified mechanical device; and
- On a later specified date, the care plan was revised to only include one transfer method that involved use of a specified mechanical device.

Inspector #722 reviewed the assessments and progress notes for resident #003, which indicated that the physiotherapist completed a transfer assessment, and indicated that the resident required a specified transfer method, involving a specified mechanical device.

A progress note was also identified by Inspector #722, which indicated on an identified date, that RN #117 observed resident #002 being pushed by a PSW on an identified device and was transferred to a mobility device with the aid of two staff. RN #117 clarified during an interview with Inspector #722 that the specified mechanical device was not used during this transfer.

During an interview with Inspector #722, PSW #108 indicated that they had routinely provided care to the resident since they returned from the hospital after their fall. PSW #108 described their understanding of the resident's abilities, and described the method they used to transfer the resident; both of these descriptions differed from the resident's abilities and transfer methods specified in their plan of care. The PSW also indicated that the equipment required for transferring the resident as specified in their plan of care was not available in the resident's room.

During an interview with Inspector #722, ADOC #107 indicated that the directions in resident #003's plan of care related to transferring were unclear when they returned from hospital. The ADOC confirmed that the resident's care plan was not updated to reflect their transfer needs on readmission. The ADOC also confirmed that the plan of care was unclear when there were two different transfer methods specified in the care plan and staff were using various methods to transfer the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care covered all aspects of care for residents #002 and #003, including nursing and personal support.

CIS reports were received by the Director for the following falls that resulted in injuries: residents #002 fell and sustained an injury; and resident #003 fell and sustained multiple injuries.

Inspector #722 reviewed the electronic health records in PointClickCare (PCC) for residents #002 and #003. For both residents, there were no interventions related to Toileting or Transfers in the resident's care plans, from their dates of admission until later specified dates when identified interventions were added to their plans

of care. There were also no interventions related to Mobility in resident #003's care plan for a specified period, as all previous interventions were discontinued on specified dates when the resident was in the hospital due to their fall.

Inspector #722 separately interviewed PSWs #106, #108, #111, and #112, related to the care involving residents #002 and #003. All PSWs indicated during interviews that they know what care is required for a resident related to falls, mobility, and transfers, either by working with the resident when they are part of their assignment, or by accessing the full care plan or the resident's Kardex, on the computer using PCC. The PSWs also indicated that they become aware of changes to resident's plan of care by notification from the nursing staff at shift report, and through updates to the care plan in PCC.

ADOC #110 was interviewed by Inspector #722 about the plan of care for residents #002 and #003, and acknowledged that the care plans in PCC for both residents were lacking interventions related to transfers, mobility, and assistance with toileting for the periods detailed above. The ADOC also indicated that there should have been interventions identified in the care plan for those areas, and confirmed that the care plan was a guide for direct care staff to know what care was required for each resident.

The DOC also confirmed the findings above and acknowledged that the care plans in PCC should have included interventions related to toileting, mobility, and transfers for residents #002 and #003 over the periods specified above. The DOC acknowledged that the plan of care did not cover all aspects of care for these residents. [s. 6. (3)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to residents #002, #015, and #014 as specified in their plans.

(i) A CIS report was received by the Director when resident #002 fell and sustained an injury, which resulted in hospitalization.

Inspector #722 reviewed the electronic health record for resident #002, which indicated that the resident was to have three devices: one device on the bed and two devices on the floor on either side of the bed.

During the inspection, Inspector #722 made two separate observations of the resident's room, and on both occasions there was no device in place on the bed,

and only one device on the side of the bed.

Inspector #722 interviewed PSW #111, who thought that the resident was supposed to have a device on their bed and could not recall if the resident was supposed to have two devices on the floor on either side of the bed. The PSW indicated that they would have to check the resident's care plan in PCC to find out what was supposed to be in place.

During a separate interview with Inspector #722, PSW #112 indicated that resident #002 has been in their primary care assignment for several months, and that they had never seen a device on the resident's bed. PSW #112 also indicated that they would put down one device beside the resident's bed. PSW #112 was not aware that the resident was supposed to have a device on their bed and two devices on the floor.

Inspector #722 interviewed ADOC #110, who confirmed that the resident was expected to have a device in place on their bed, and two devices on either side of the bed. The ADOC was unable to explain why the device on the bed was not being used, and why there was only one device in place on the floor. The ADOC confirmed that these interventions were required as per the plan of care.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #015 as specified in the plan.

(ii) Resident #015 was selected for sample expansion related to non-compliance identified for #010.

Record review of resident #015's plan of care under the electronic medication administration record (e-MAR), indicated to give an identified intervention if the resident was experiencing an identified condition.

A review of resident #015's records indicated they experienced this condition during specified periods.

A review of progress notes and e-MAR for the above mentioned period, indicated that the resident's care plan had not been followed as they were not given the scheduled intervention when they experienced the identified condition.

In an interview with RPN #120 they explained, that the person who would receive

this information should have given the resident the intervention and charted. According to the RPN they suspected that the resident did not experience this condition but it was not charted. The RPN acknowledged that the resident's plan of care had not been followed.

In an interview with ADOC #121, they acknowledged that there needs to be better communication between the staff and explained that the technology is there to provide the information needed.

The inspector concluded that resident #015's plan of care had not been followed since the resident's intervention was not implemented when the resident experienced the identified condition.

(iii) Resident #014 was selected for sample expansion related to non-compliance identified for #010.

Record review of resident #014's plan of care under the e-MAR, indicated to give an identified intervention if the resident was experiencing an identified condition.

A review of resident #014's records indicated they experienced this condition during specified periods.

A review of progress notes and e-MAR for the above mentioned period, indicated that the resident's care plan had not been followed since they were not given the scheduled intervention when they experienced the identified condition.

In an interview with RPN #120 they explained, that the resident is independent with going to the washroom and the PSW should ask them if they had experienced this condition and enter this information in point of care (POC) and any discrepancy should inform the registered staff. The RPN further explained that if the PSWs had not checked with the resident to determine whether they experienced this condition, would not have reported any concern and therefore, the resident's interventions would not have been followed. They stated that the registered staff have to start asking more questions or teach PSWs how to communicate this information to them on a daily basis before the end of shift.

In an interview with ADOC #121, they acknowledged that the resident's e-MAR is part of their plan of care and explained there was a disconnect.

The inspector concluded that resident #014's plan of care had not been followed since their intervention was not implemented when the resident did experience the identified condition. [s. 6. (7)]

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 there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident, that the plan of care covers all aspects of care for residents including nursing and personal support, and that the care set out in the plan of care is provided to residents as specified in their plans, to be implemented voluntarily.

WN #2: 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 staff used safe transferring and positioning devices or techniques when assisting resident #003.

A CIS report was received by the Director when resident #003 fell and sustained multiple injuries, which resulted in hospitalization.

Inspector #722 reviewed the assessments and progress notes for resident #003, which indicated that the physiotherapist completed a transfer assessment, and indicated that the resident required a two-person transfer, using a mechanical lift.

Inspector #722 reviewed the care plan for resident #003 in PCC, which indicated that two staff were to transfer the resident with a mechanical lift for all transfers.

A progress note was identified by Inspector #722, which indicated that RN #117 observed resident #002 being pushed by a PSW on an identified device, the resident was transferred to a mobility device with the aid of two staff. RN #117 clarified during an interview with Inspector #722 that the mechanical lift was not used during this transfer.

An incident described in the progress notes by RN #117 and an interview with PSW #108 confirmed that direct care staff were unclear about the appropriate method for transferring resident #003 when they returned from the hospital.

During an interview with Inspector #722, PSW #108 indicated that they had provided care to the resident since they returned from the hospital. PSW #108 indicated that the resident could weight bear a little, and that they would sometimes use the waist belt to pivot-transfer the resident into their mobility device. The PSW also indicated that sometimes two or three staff would assist to pivot transfer the resident. The PSW indicated that there was not a lift in the resident's room, and that they did not recall ever using the mechanical lift to transfer the resident to their mobility device.

During an interview with Inspector #722, ADOC #107 indicated that the resident should have been transferred with the mechanical lift and confirmed that the resident was not transferred safely when the mechanical lift was not used by direct care staff during an identified period to transfer the resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

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. (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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident that caused an injury to resident #004, for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

A CIS report was received by the Director for a fall involving resident #004 where the resident sustained an injury and was transferred to hospital.

Inspector #722 reviewed the progress notes, which confirmed that the resident sustained the fall on an identified date. The post fall assessment was completed by ADOC #107, which indicated a significant change in the resident's health condition. The notes indicated that the physician was contacted and resident was immediately transferred to the hospital.

Inspector #722 interviewed ADOC #107, who indicated that they were the charge nurse on duty on the day the resident fell. The ADOC confirmed that the resident had sustained a fall that resulted in a significant change in the resident's condition.

During the interview, the ADOC indicated that they had forgotten to notify management of the home of the incident, which was why it was not immediately reported, and acknowledged understanding that as the charge nurse, it was their responsibility to do so.

During an interview with Inspector #722, the DOC stated that the charge nurse was responsible for notifying the management team of the incident, so that the DOC or ADOCs could submit the critical incident report. The DOC acknowledged that the critical incident report for resident #004's fall, which resulted in a significant change in the resident's condition, was not submitted immediately as required. [s. 107. (3) 4.]

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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the unexpected death of resident #021 was immediately reported to the Director.

A review of the MOHLTC CIS report and progress notes confirmed resident #021 experienced an unexpected death.

DOC #113 confirmed the CIS report regarding the unexpected death of resident #021 was not immediately reported to the Director.

The Director was informed seven days after the incident. [s. 107. (1)]

Issued on this 9 th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by COREY GREEN (722) - (A1)
Inspection No. / No de l'inspection :	2019_751649_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002266-18, 005036-18, 009875-18, 009884-18, 013609-18, 030432-18, 030537-18, 002056-19, 004228-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 09, 2019(A1)
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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To North York General Hospital, 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

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:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9 th day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by COREY GREEN (722) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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