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

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

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
Oct 8, 2021	2021_833763_0017	007589-21	Complaint

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

IANA MOLOGUINA (763)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 24-27, 30-31, September 1, 3, 7-10, and 16, 2021.

The following complaint intakes regarding multiple care concerns were completed during this Complaint Inspection: log #012928-21, #012130-21, #011332-21, #010188 -21, #009052-21, #009045-21, #008933-21, #008628-21, #008580-21, #007589-21, #006367-21, #013784-21, #013398-21, #013842-21, and #014421-21.

Inspector Wing-Yee Sun (Inspector #691930) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Dietitian (RD), Environmental Supervisor (ES), Food Service Manager (FSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), environmental staff, activation staff, residents and residents' family members.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used equipment in accordance with manufacturers' instructions.

A complaint was received by the Ministry of Long-Term Care (MLTC) which indicated mattress stop clips were improperly used on a resident's bed. Inspector #763 observed beds in the home on several occasions. Several bed frames that were being used by residents:

- had mattress stop clips popped out of their intended position, failing to hold the mattress in place; or
- did not fit the mattress in the bed frame snuggly due to ill-fitting bedsheets or blanket layers present under the mattress.

Bed frame manuals for beds used in the home indicated that the mattress stop clips helped eliminate entrapment zone gaps between the mattress and the bed frame components. To prevent entrapment injury or death, the mattress had to fit snuggly within the mattress stop clips, and the clips needed to be installed correctly.

Staff interviews confirmed that the observed bed frames were not used in accordance with manufacturer's instructions, increasing risk of potential injury as indicated in the manuals.

Sources: home observations, bed frame manuals, family interviews, staff interviews (RPN #111 and ES #117). [s. 23.]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for a resident.

Inspector #763 observed the resident's room due to a complaint submitted to the MLTC. To accommodate the resident's preferences, the home implemented an intervention that increased the resident's risk of being unable to call for help if they had a fall in their room.

Record review and staff interviews indicated that the resident was at risk for falls and previously had a fall in their room. Staff admitted that if the resident had another fall, they would not be able to reach the call bell safely to call for help due to the implemented intervention.

Sources: home observations, family interviews, staff interviews (PSW #101 and ES #117). [s. 5.]

2. The licensee has failed to ensure that the home was a safe and secure environment when they failed to place a droplet/contact precautions sign on a resident room door.

Inspector #763 observed a resident in their room on isolation with a caddy on the room door filled with PPE. There was no sign on the door indicating what type of isolation protocols staff were to follow when entering the resident's room. A staff nearby was not sure what protocols to follow.

The nurse on the floor confirmed that the resident required droplet/contract precautions as they were on symptom monitoring for suspected COVID-19. They forgot to put an isolation sign on the door that morning.

Sources: home observations, droplet/contact precaution signs, staff interviews (PSW #112, RN #113, IPAC lead #122). [s. 5.]

3. The licensee has failed to ensure that the home was a safe and secure environment when staff failed to wear the required Personal Protective Equipment (PPE).

Inspector #763 observed direct care provision to co-residents by PSW #114 and #116. The residents were on isolation precautions due to symptom monitoring of suspected COVID-19. A sign upon room entry instructed staff to follow droplet/contact precautions, which included wearing eye protection, when providing direct care to the residents. Both staff wore gowns, gloves and masks but forgot to wear eye protection. The regular nurse on the floor confirmed staff needed to wear eye protection when providing direct care to these residents.

Sources: observations of resident and staff interactions, droplet/contact precaution signs, staff interviews (PSW #114 and #116, RPN #115, IPAC lead #122). [s. 5.]

4. The licensee has failed to ensure that the home was a safe and secure environment when staff failed to keep room curtains drawn between isolated residents.

According to the Ministry of Health and Long-Term Care document "Control of Respiratory Infection Outbreaks in Long Term Care Homes", residents on isolation who shared a room were to have privacy curtains drawn to limit the spread of infection.

Inspector #763 observed three pairs of co-residents in shared rooms that required to be on droplet/contact precautions as they were isolated to their rooms due to suspected COVID-19. The curtains were not drawn between residents on observation. Staff confirmed that curtains should have been drawn to limit the potential spread of infection.

Sources: home observations, MOHLTC - Control of Respiratory Infection Outbreaks in Long Term Care Homes (created November 2018), staff interviews (PSW #112, RPN #115, RN #113, IPAC lead #122, and other staff). [s. 5.]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident regarding the need to encourage them to attend the dining room for meals.

The MLTC received a complaint from a family member that indicated staff were not encouraging the resident to attend the dining room for meals.

The resident often refused to attend the dining room for meals. They had several interventions implemented to manage their nutritional needs, however their written care plan did not include encouraging the resident to attend the dining room at all meals as tolerated, which was a preference of the resident's family.

Staff indicated that each resident's plan of care encompassed their written care plan. The resident's family had a preference for the resident to attend the dining room at meals and staff confirmed that this needed to be captured in the resident's written care plan.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), family interviews, staff interviews (RPN #110, RD #118, and Administrator #100). [s. 6. (1) (c)]

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

The MLTC received complaints alleging that the home did not address the resident's care needs, including:

-the resident’s family notified the management team about a broken grooming product. A week later, the resident still did not have access to the product and the family had to request for one from staff on the unit.
-the resident’s family notified the management team about a change in the resident's health status. The management team asked the home's Nurse Practitioner to assess the change two days later.

The resident had a language barrier but was able to communicate most basic care needs to the staff. They also had some cognitive impairment due to their diagnoses. They were independent, requiring only occasional assistance with some activities of daily living. Staff interviews indicated that the resident had responsive behaviours and often refused care. Staff encouraged the resident to participate in care activities as much as tolerated.

Inspector #763 visited the resident in their room prior to some of the concerns brought forward by the family. They complained of the health condition above. The inspector notified the resident's regular nursing staff regarding the health condition.

The inspector followed up on the health condition with the staff after the Nurse Practitioner assessed the resident. Staff indicated that they were unaware of any changes in the resident's health condition until the family’s communication to the home. Staff did not know why the health condition was not assessed after it was noted by the inspector. They were also unaware that the resident's grooming product was missing until the family asked for a new one and indicated that the resident did not tell them about the missing item.

Staff confirmed that given the resident’s frequent refusal of many care interventions, it was important to monitor the resident’s status on every successful attempt to visit the resident’s room, to ensure their needs were met at all times. Record reviews and staff interviews indicated additional documentation tasks and reminders were implemented after concerns raised by the family to remind staff to check on resident needs, such as

the availability of grooming equipment.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), family interviews, staff interviews (PSW #101 and #120, RPN #119, DOC #129, and Administrator #100). [s. 6. (4) (a)]

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 in ensuring that staff collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The MLTC received a complaint which indicated the resident had not received their medication as prescribed.

Record review and staff interviews indicated that a new agency staff administered several medications to the resident several hours earlier than prescribed. The home's management team confirmed that staff were expected to administer prescribed medications within one hour of the scheduled administration time. The home found the agency nurse did not provide the medications as prescribed and was asked not to return to the facility.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan, Medication Administration Record (MAR)), family interviews, staff interviews (DOC #129 and Administrator #100). [s. 131. (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 in ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including the resident's responses to interventions, were documented.

The MLTC received a complaint that the resident refused care and the home failed to document their refusal in the resident's clinical record.

Record review and staff interviews indicated that external providers attempted to provide a service to the resident but the resident refused; they were expected to leave refusal paperwork with the nurse on duty but did not. The nurse on duty was also busy at the time and forgot to ask for the paperwork before the external providers left the home. The nurse also did not note the refusal in the resident’s record.

The home's management team reviewed the incident and confirmed that the resident's refusal needed to be documented in the resident's clinical record.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), family interviews, DOC #129 interview. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was monitored during meals when they ate in their room with the door closed.

The MLTC received a complaint from a family member that indicated staff were leaving the resident unmonitored in their room during meals.

The resident was independent at meals requiring only supervision and occasional set up help. Staff found that the resident's responsive behaviours increased if they monitored them too closely, and often let them eat alone in their room to minimize their behaviours.

Inspector #763 observed staff providing tray service to the resident. They brought the meal to the resident and left them alone in their room with the door closed during the meal.

The home’s dietitian and administrator confirmed that staff were expected to monitor all residents during meals due to risk of choking and that staff were unable to ensure adequate monitoring if a resident was left alone in their room with the door closed during the meal.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), family interviews, staff interviews (PSW #107, RD #118, and Administrator #100). [s. 73. (1) 4.]

Issued on this 15th day of October, 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) :	IANA MOLOGUINA (763)
Inspection No. / No de l'inspection :	2021_833763_0017
Log No. / No de registre :	007589-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 8, 2021
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 :	Kathy Metcalfe

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must be compliant with s. 23 of O. Reg 79/10.

Specifically the licensee must:

1) ensure that the mattress stop clips on all bed frames used in the home are used in accordance with manufacturer's instructions at all times;

2) educate all nursing, housekeeping and maintenance staff on the appropriate use of mattress stop clips for all bed frames used in the home, ensuring that any faulty clips are fixed on the spot if able or promptly reported to the maintenance department for repair;

3) document the education provided, including the date and names of staff members involved; education records are to be maintained and made available for inspector review;

4) perform weekly audits of mattress stop clip use on different resident home areas for a period of one month after the education is completed, and until no further concerns arise;

5) document the audits, indicating date and resident bed number audited, if any concerns were identified and if any follow up action was required.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used equipment in accordance with manufacturers' instructions.

A complaint was received by the Ministry of Long-Term Care (MLTC) which indicated mattress stop clips were improperly used on a resident's bed. Inspector #763 observed beds in the home on several occasions. Several bed frames that were being used by residents:

- had mattress stop clips popped out of their intended position, failing to hold the mattress in place; or
- did not fit the mattress in the bed frame snuggly due to ill-fitting bedsheets or blanket layers present under the mattress.

Bed frame manuals for beds used in the home indicated that the mattress stop clips helped eliminate entrapment zone gaps between the mattress and the bed frame components. To prevent entrapment injury or death, the mattress had to fit snuggly within the mattress stop clips, and the clips needed to be installed correctly.

Staff interviews confirmed that the observed bed frames were not used in accordance with manufacturer's instructions, increasing risk of potential injury as indicated in the manuals.

Sources: home observations, bed frame manuals, family interviews, staff interviews (RPN #111 and ES #117).

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

Severity: There was minimal risk associated with this non-compliance as the risk of resident entrapment or injury was minimal on observation.

Scope: The scope was widespread because improper use of mattress stop clips was observed on four out of five bed frames.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 23 with two Written Notifications (WNs) and one Voluntary Plan of Correction (VPC) issued to the home. (763)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 03, 2021

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

Specifically the licensee must:

1) ensure that room curtains between isolated residents are drawn when required;

2) educate all nursing staff on IPAC protocol for residents on isolation, including the need to keep room curtains drawn between residents;

3) document the education provided, including the date and names of staff members involved; education records are to be maintained and made available for inspector review;

4) perform weekly audits of room curtain use in rooms with residents on isolation on a variety of home areas for a period of one month after the education is completed, and until no further concerns arise;

5) document the audits, indicating when and where the audits were completed, if any concerns were identified and if any follow up action was required.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment when staff failed to keep room curtains drawn between isolated residents.

According to the Ministry of Health and Long-Term Care document "Control of Respiratory Infection Outbreaks in Long Term Care Homes", residents on isolation who shared a room were to have privacy curtains drawn to limit the spread of infection.

Inspector #763 observed three pairs of co-residents in shared rooms that required to be on droplet/contact precautions as they were isolated to their rooms due to suspected COVID-19. The curtains were not drawn between residents on observation. Staff confirmed that curtains should have been drawn to limit the potential spread of infection.

Sources: home observations, MOHLTC - Control of Respiratory Infection Outbreaks in Long Term Care Homes (created November 2018), staff interviews (PSW #112, RPN #115, RN #113, IPAC lead #122, and other staff).

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

Severity: There was minimal risk of harm because the residents observed did not have confirmed COVID-19.

Scope: This non-compliance was widespread as all three resident rooms requiring curtains to be drawn between residents were not using curtains appropriately.

Compliance History: 40 Written Notifications (WN), 27 Voluntary Plans of Correction (VPCs) and four Compliance Orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (763)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 03, 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 8th day of October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Iana Mologuina

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