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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2017	2017_486653_0012	031229-16, 032377-16, 035290-16, 035448-16, 001433-17, 002288-17, 005419-17, 006971-17, 007875-17, 012670-17	Critical Incident System

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

ROMELA VILLASPIR (653), NICOLE RANGER (189), NITAL SHETH (500)

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 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, and July 4, 5, 6, 2017.

The following were inspected concurrently during this inspection:
Critical Incident (CI) intakes related to prevention of abuse: log #(s) 031229-16, 032377-16, 035290-16, 035448-16, 002288-17, 006971-17, and 012670-17;
intakes related to falls prevention: log #(s) 001433-17, 005419-17, and 007875-17.

During the course of the inspection, the inspector (s) conducted a tour of the resident home areas, observed staff to resident interactions, reviewed clinical health records, staff training records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Maker (SDM), Private Companions (PCs), Administrative Assistant (AA), Housekeeping Aides (HKAs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Social Workers (SWs), Physiotherapist (PT), Occupational Therapist (OT), Registered Dietitian (RD), Physicians, Clinical Educator, Unit Director, Unit Manager, Supervisor of Environmental Services, Environmental Services Manager (ESM), Human Resources Business Partner, Manager for Human Resources, Executive Director of Human Resources, Client Relations Officer, Medical Director, Associate Director of Care and Resident Experience (ADOC), and the Director of Care and Resident Experience (DOC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

On an identified date, the home submitted a Critical Incident System (CIS) report related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that on an identified date, resident #004 had a fall resulting in hospitalization.

Review of progress note on an identified date, revealed resident #004 had an unwitnessed fall and he/ she was transferred to the hospital thereafter. Review of hospital notes on an identified date, revealed resident #004 sustained an injury on an identified body part.

Review of progress note on an identified date, revealed that the Physiotherapist (PT) assessed the resident post hospitalization. The PT noted that resident #004 needed an identified equipment and he/ she asked for a loaner equipment for the resident. Review of Registered Practical Nurse (RPN) #121's progress note on an identified date, revealed

that the resident received the identified equipment from the Occupational Therapist (OT).

Review of resident #004's written plan of care on two identified dates, did not identify the equipment under the falls interventions. Both written plans of care indicated an identified falls prevention intervention.

Interview with RPN #110 stated resident #004 had not been using the identified falls prevention intervention since he/ she received the identified equipment. RPN #110 acknowledged that the resident's written plan of care did not provide clear directions.

Interview with the Director of Care and Resident Experience (DOC) acknowledged that resident #004's written plan of care did not set out clear directions to staff. [s. 6. (1) (c)]

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

On an identified date, the home submitted a CIS report related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that on an identified date, resident #004 had a fall resulting in hospitalization.

Review of resident's Fall Risk Assessment on an identified date, identified him/ her as being at high risk for falls.

Review of resident #004's written plan of care on an identified date, revealed his/ her toileting ability was impaired. The written plan of care required an identified number of staff to remain throughout to supervise for safety and ensure process was complete.

Review of progress note on an identified date, revealed resident #004 had an unwitnessed fall. The resident was being assisted on the toilet by the Personal Support Worker (PSW) at the time. The PSW turned his/ her back to retrieve an item when he/ she heard something and checked, the resident was found on the floor. Resident #004 was sent out to the hospital to rule out injury. Review of hospital notes on an identified date, revealed resident #004 sustained an injury on an identified body part.

Interview with PSW #105 confirmed he/ she was toileting resident #004 at the time. The PSW stated he/ she left the resident on the toilet unsupervised to get an item from the room. As the PSW turned around and left the washroom, the resident was found lying on

the floor. PSW #105 confirmed he/ she was not supposed to leave resident #004 during toileting. The PSW confirmed he/ she did not follow resident #004's written plan of care at the time of the incident.

Interview with RPN #102 stated during that morning, PSW #105 called him/ her to resident #004's washroom. The RPN attended to the resident and found him/ her lying on the floor in the washroom. The RPN indicated the resident was guarding an identified body part. The Registered Nurse (RN) was called and he/ she did an assessment, then resident #004 was transferred to the hospital thereafter. RPN #102 further indicated that PSW #105 had told him/ her that the resident was on the toilet and when he/ she stepped out from the washroom to retrieve an item, the resident had fallen. The RPN stated that the PSW should not have left the resident alone in the washroom. RPN #102 acknowledged that PSW #105 did not follow resident #004's written plan of care.

Interview with the DOC acknowledged the above-mentioned incident, and stated that PSW #105 did not follow resident #004's written plan of care. He/ she further indicated that the home's expectation was for staff to follow the resident's written plan of care.

The severity of the non-compliance was actual harm.

The scope of the non-compliance was isolated to resident #004.

A review of the home's compliance history within the last three years revealed a Voluntary Plan of Correction (VPC) was previously issued for non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7) within inspection report #2014_405189_0003 dated February 4, 2015. [s. 6. (7)]

3. On an identified date, the home submitted a CIS report related to staff to resident abuse. The CIS indicated that on an identified date, resident #004 had a fall with no injury.

Review of progress note on an identified date, revealed resident #004 had an unwitnessed fall. The PSW notified the RPN that the resident was on the floor. When the RPN attended to the resident in his/ her bedroom, the RPN found him/ her on the floor. The RPN and RN assessed the resident and noted an alteration in skin integrity on four identified body parts. Resident complained of pain when the identified body part was touched. The PSW stated he/ she left the resident in the bedroom on an identified equipment after changing his/ her clothing. The PSW left to assist another resident, and

when he/ she came back to resident #004's bedroom after a few minutes, he/ she found the resident on the floor.

Review of resident #004's written plan of care on an identified date, revealed resident was at a high risk for falls. The written plan of care directed staff to carry out identified falls prevention interventions.

Interview with PSW #106 revealed that on an identified date, resident #004 had an unwitnessed fall in his/ her bedroom. The PSW stated he/ she was getting the resident ready for bed at that time, and he/ she placed the resident in the bedroom near the door, on an identified equipment. The PSW left to assist another resident and came back to resident #004's bedroom after two to three minutes. PSW #106 found the resident lying on the floor. The PSW confirmed that the identified falls prevention interventions were not in place at the time he/ she left resident #004 in the bedroom. PSW #106 acknowledged he/ she did not provide the resident's care as specified in the plan.

Interview with RPN #108 acknowledged the above-mentioned incident and confirmed that the resident's written plan of care was not followed at the time of the incident.

Interview with the DOC acknowledged the above-mentioned incident and stated that the home's expectation was for staff to follow the resident's written plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of care set out in the plan of care had been documented.

On on an identified date, the home submitted a CIS report related to an allegation of staff to resident abuse.

Interview with the Associate Director of Care and Resident Experience (ADOC) revealed that the home conducted an investigation of the incident and found the allegation of abuse unsubstantiated. However, during the investigation, the ADOC found that PSW #140 was observed on video surveillance in an identified manner during his/ her shift on an identified date, and also found that the PSW charted at the beginning of his/ her shift on all residents prior to providing care to the residents.

Record review of resident #011, #016, #017, #018's Personal Care Flow Sheets on an identified date, confirmed that PSW #140 documented at 2300 hrs of care received, prior to providing care to the resident.

Interview with the DOC revealed that the home's expectation was for the PSW to document at the end of his/ her shift or after providing care to the resident. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 sets out clear directions to staff and others who provide direct care to the resident;
-that the following are documented: The provision of the care set out in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

On an identified date, the home submitted a CIS report related to an allegation of staff to resident abuse. The CIS stated that resident #013 reported to his/ her family member that PSW #109 abused him/ her by locking him/ her in an identified manner.

Interview with PSW #109 revealed that on an identified shift, the resident was getting out of bed frequently to go to the washroom. PSW #109 reported that he/ she provided the resident with an identified toileting device but the resident refused. PSW #109 reported that he/ she placed the resident in the washroom a number of times during that identified shift. PSW #109 reported the resident continued to get out of bed, so he/ she called RPN #164 and was instructed to put the resident in an identified equipment and place beside him/ her at the nursing station. PSW #109 reported that he/ she placed the resident in an identified equipment, and brought the resident to an identified area.

Record review of the physician's orders and the written plan of care did not indicate the use of a restraint for resident #013. Interview with resident #013 confirmed that he/ she was placed in an identified equipment and was unable to get up from it.

Interview with the DOC confirmed that the use of the identified equipment to prevent the resident from getting out of it was considered a restraint, and that the identified equipment was not to be used to restrain the resident. [s. 110. (2) 1.]

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 following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On June 19, 2017, at 1152 hrs, on the 7th floor north side, inspector #653 observed a medication cart located near the dining room to be unlocked and unsupervised. Residents and family members were passing by the area. The inspector was able to open the cart and access the contents inside. RPN #188 returned to the medication cart at 1157 hrs and confirmed that the medication cart was supposed to be locked when left unsupervised.

Interview with the DOC stated that the home's expectation was for medication carts to be locked and secure at all times. [s. 130. 1.]

2. On June 22, 2017, at 1013 hrs, on the 2nd floor south side, inspector #116 observed a medication cart and a treatment cart in an accessible nursing station unlocked and unattended. Inspector #116 was able to gain access to the contents of the indicated carts.

An unlabelled white medication cup with crushed medications was stored on top of the treatment cart. Two Beneprotein powder packets along with several empty blister packs that contained resident's names and prescribed medications inscribed on the packets were found on top of the medication cart. RN #128 who was assigned to the carts was observed in the dining room where the cart was not visible. At approximately 1020 hrs, RN #128 returned to the medication and treatment cart and acknowledged that the medication and treatment carts were left unlocked and unsupervised.

Interviews held with RN #128 and the DOC confirmed that both the medication and treatment carts were to be locked at all times when unsupervised. [s. 130. 1.]

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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

Issued on this 31st day of July, 2017

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) :	ROMELA VILLASPIR (653), NICOLE RANGER (189), NITAL SHETH (500)
Inspection No. / No de l'inspection :	2017_486653_0012
Log No. / Registre no:	031229-16, 032377-16, 035290-16, 035448-16, 001433-17, 002288-17, 005419-17, 006971-17, 007875-17, 012670-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 27, 2017
Licensee / Titulaire de permis :	THE JEWISH HOME FOR THE AGED 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
LTC Home / Foyer de SLD :	THE JEWISH HOME FOR THE AGED (2824) 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
	Dr. William Reichman

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 Administrator /
Nom de l'administratrice ou de l'administrateur :

To THE JEWISH HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall do the following:
1. Review with all direct care staff the nature of this incident and the importance of not leaving residents unattended as directed by the plan of care.
2. Maintain a record of the education provided, including dates, times, trainers, attendees, and material taught.
3. Ensure all direct care staff who provide care to resident #004, follow his/ her plan of care regarding the number of staff required to provide toileting assistance to the resident.

Please submit the above-mentioned documentation to romela.villaspir@ontario.ca. This order shall be complied no later than October 31, 2017.

Grounds / Motifs :

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

On an identified date, the home submitted a CIS report related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that on an identified date, resident #004 had a fall resulting in hospitalization.

Review of resident's Fall Risk Assessment on an identified date, identified him/ her as being at high risk for falls.

Review of resident #004's written plan of care on an identified date, revealed his/

her toileting ability was impaired. The written plan of care required an identified number of staff to remain throughout to supervise for safety and ensure process was complete.

Review of progress note on an identified date, revealed resident #004 had an unwitnessed fall. The resident was being assisted on the toilet by the Personal Support Worker (PSW) at the time. The PSW turned his/ her back to retrieve an item when he/ she heard something and checked, the resident was found on the floor. Resident #004 was sent out to the hospital to rule out injury. Review of hospital notes on an identified date, revealed resident #004 sustained an injury on an identified body part.

Interview with PSW #105 confirmed he/ she was toileting resident #004 at the time. The PSW stated he/ she left the resident on the toilet unsupervised to get an item from the room. As the PSW turned around and left the washroom, the resident was found lying on the floor. PSW #105 confirmed he/ she was not supposed to leave resident #004 during toileting. The PSW confirmed he/ she did not follow resident #004's written plan of care at the time of the incident.

Interview with RPN #102 stated during that morning, PSW #105 called him/ her to resident #004's washroom. The RPN attended to the resident and found him/ her lying on the floor in the washroom. The RPN indicated the resident was guarding an identified body part. The Registered Nurse (RN) was called and he/ she did an assessment, then resident #004 was transferred to the hospital thereafter. RPN #102 further indicated that PSW #105 had told him/ her that the resident was on the toilet and when he/ she stepped out from the washroom to retrieve an item, the resident had fallen. The RPN stated that the PSW should not have left the resident alone in the washroom. RPN #102 acknowledged that PSW #105 did not follow resident #004's written plan of care.

Interview with the DOC acknowledged the above-mentioned incident, and stated that PSW #105 did not follow resident #004's written plan of care. He/ she further indicated that the home's expectation was for staff to follow the resident's written plan of care.

The severity of the non-compliance was actual harm.

The scope of the non-compliance was isolated to resident #004.

A review of the home's compliance history within the last three years revealed a Voluntary Plan of Correction (VPC) was previously issued for non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7) within inspection report #2014_405189_0003 dated February 4, 2015. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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