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

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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
May 26, 2020	2020_641665_0007	022731-19	Follow up

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

JOY IERACI (665), NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 15, 18-21, 25, 26 and 28, 2020. Off site interviews March 2, 3 and 4, 2020.

Follow up log #022731-19 related to plan of care was inspected.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s.6(7), identified in a concurrent Critical Incident System (CIS) inspection #2020_641665_0005 (Log #021843-19/CIS #2824-000060-19 and Log #002604-20/CIS #2824-000011-20) related to fall prevention and management were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Physicians (PHY), Pharmacy Manager (PM), Physiotherapist (PT), Occupational Therapist (OT), Unit Managers (UMs), Nursing Informatics (NI), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Private Caregivers (PC), family members and residents.

During the course of the inspection, the inspectors observed staff and resident interactions, reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1.The licensee has failed to ensure that there was a written plan of care for resident #032 that set out, the planned care for the resident.

During a follow up inspection for compliance order (CO) #001 under inspection #2019_641665_0019, served November 15, 2019, with a compliance due date (CDD) of February 14, 2020, resident #032's written plan of care was reviewed.

Review of resident #032's kardex on an identified date in 2020, and a specified assessment completed two months earlier by PT #113, documented that the resident was transferred with an identified mechanical device; however, the clinical records did not indicate the sling size to be used.

In interviews, RN #106, RPN #108 and PSW #105 informed the inspector that the sling size was documented in the specified assessment and in the support actions in Point Click Care (PCC) which gets populated into the kardex. The RN and RPN reviewed the resident's assessments and support actions and confirmed that the sling size was not documented. The PSW indicated that they were not aware of the sling size to be used for resident #032. The PSW had asked the private caregiver of the resident to confirm that the sling in the resident's room was the correct sling size.

In an interview, PT #113 indicated that they document a resident's transfer status in their assessment, but it was not the home's practice to document the assessed sling size to be used. The PT stated if a resident was assessed to require the identified mechanical device for transfers, they would communicate the sling size to the registered staff and

would only update the resident's support actions in PCC to reflect the device, not the sling size.

In an interview, UM #114 stated that each resident that had been assessed requiring a sling for transfers were provided with their own sling and left in their room. The UM indicated that it was not the home's practice for the PT to document the sling size in their assessment and in the support actions.

This evidence was reviewed with DOC #101 and they indicated they will update the written plans of care to include the sling size to be used for resident transfers.

This non compliance is issued as the home failed to ensure that the planned care for resident #032 was in the resident's written plan of care related to the sling size used for transfers.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #004, #008 and #005 as specified in the plan.

On November 15, 2019, the following CO #001 from inspection report #2019_641665_0019, with a CDD of February 14, 2020, was made under LTCHA 2007, c. 8, s. 6. (7) was issued:

The licensee must be compliant with s.6 (7) of the Long Term Care Home Act (LTCHA), 2007.
Specifically, the licensee must:
1. Ensure residents #004, #032 and any other resident, are provided care by an identified number of staff when required as per the plan of care.
2. Ensure resident #032 and any other resident are transferred with the appropriate mechanical device as specified in the plan of care.
3. Ensure Personal Support Workers (PSWs) #102 and #110 receive re-training on the home's policy titled "Minimal Lift and Client/Resident Handling Policy". The re-training should be documented with the date and who provided the retraining.
4. Develop and implement an auditing tool that documents when the registered staff and PSWs are made aware of the change in the plan of care for resident #032 and any other resident, related to transfers.
5. Ensure audits are conducted to ensure resident #004 receives care during an identified shift by the identified number of staff when required as per the plan of care.

6. Ensure audits are conducted to ensure PSWs #102 and #110 provide care to resident #032 and any other resident with the assistance of the long term care home staff, not family and or companions, when required as per the plan of care.
7. Maintain a written record of the audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit, the outcome of the audits, actions taken to address any concerns and an evaluation of the results.

The licensee completed steps #2 to #7, and failed to complete step #1.

Review of resident #004's written plan of care directed staff to provide all care with an identified number of staff for both PSWs and registered staff on all shifts.

In an interview, PSW #105 stated that they provided care to the resident on their own on an identified date, as their partner was busy with other residents. The PSW was aware that resident #004's plan of care required an identified number of staff for care.

In an interview, UM #103 confirmed that the written plan of care directed staff to provide care to the resident with the identified number of staff. They acknowledged that staff did not follow the plan of care of resident #004 regarding the number of staff for all care.

This non compliance is issued as PSW #105 failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

3. A CIS report was submitted to the Ministry of Long Term Care (MLTC) on an identified date in 2020, related to falls prevention. The CIS report indicated resident #008 was found on the bedside floor by the RN and PSW during safety rounds. The resident had the bed remote in their hand and the bed was noted to be in a high position. Record review of resident #008's progress notes in PCC the following day, indicated the resident was found at an identified time, alert, complained of pain to two identified areas, and had an area of altered skin integrity. The physician was paged and ordered to transfer resident #008 to the hospital. The hospital informed the home that resident #008 sustained specified injuries. Based on the hospital update documented in the CIS report, there were anticipated changes to the resident's activities of daily living (ADLs).

Record review of resident #008's written plan of care on an identified date, directed staff to encourage resident #008 to use an identified fall intervention.

Record review of resident #008's kardex in Point of Care (POC) indicated for falls prevention, staff was to encourage resident #008 to use the identified intervention and check the intervention every shift.

During an observation, resident #008 did not have the identified intervention in place.

In interviews, PSWs #120 and #124 indicated they were aware that resident #008 should have had the identified intervention in place, but could not find them and reported this to the registered nurse.

In an interview, RPN #140 verified that resident #008 should have had the identified intervention in place.

During another observation on an identified date in 2020, resident #008's private companion verified that the resident did not have the identified intervention in place.

In an interview, RPN #126 indicated that resident #008’s identified intervention was not available as it was being labelled by laundry.

In an interview, OT #123 indicated resident #008 had an order for the intervention since an identified month in 2018, and refused the intervention, but staff were required to encourage the resident to use it.

This non compliance is issued as staff failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

4. A Critical Incident System (CIS) report was submitted to the Ministry of Long term Care (MLTC), related to an alleged fall of resident #005. A description of the incident in this CIS indicated that on an identified date in 2019, resident #005 sustained an identified area of altered skin integrity of unknown origin. Resident #005's substitute decision maker (SDM) reported to UM #103, that they were not informed of the incident, resident #005 had an identified injury, was unable to perform a specified physical ability the prior evening and suspected resident #005 might have fallen. This report mentioned, upon assessment by the RN, the nurse noted; identified areas of altered skin integrity. Resident #005 complained of pain to their SDM when UM #103 assessed an identified area.

Record review of resident #005's progress notes in PCC completed by PT #113, one day

after the incident, indicated they met with resident #005's SDM and was asked to assess resident #005 as they had pain to an identified area. This note indicated upon PT #113's assessment, resident #005 had a specified injury and altered skin integrity to the identified area mentioned above. Resident #005 exhibited an identified behaviour with an identified facial expression upon assessment to the identified area.

Record review of resident #005's written plan of care for the period of the fall indicated they were at an identified risk for falls due to their identified health and physical status.

Record review of resident #005's kardex indicated resident required an identified number of staff members for transfers with an identified mechanical device.

In an interview PSW #134 indicated when resident #005 sustained the fall they walked resident #005 from their bed with the assistance of RPN #135 to the washroom. PSW #134 acknowledged they did have access to resident #005's written plan of care and was aware they should have used the identified mechanical device. PSW #134 acknowledged they did not follow the resident #005's plan of care.

In an interview RPN #135 indicated they were told by PSW #134 that resident #005 could walk a few steps, and indicated they did not assist PSW #134 to walk the resident to the washroom, but observed the PSW walking resident #005 to the washroom.

UM #103 acknowledged that PSW #134 and RPN #135 did not follow resident #005's plan of care and verified that resident #005 required the identified mechanical device for transfers.

This non compliance is issued as PSW #134 and RPN #135 failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

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, (a) the planned care for the resident, to be implemented voluntarily.

Issued on this 4th day of June, 2020

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) :	JOY IERACI (665), NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2020_641665_0007
Log No. / No de registre :	022731-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 26, 2020
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, TORONTO, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Simon Akinsulie

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:

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2019_641665_0019, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.6 (7) of the Long Term Care Homes Act (LTCHA), 2007.

The licensee shall prepare, submit and implement a plan to ensure that care is provided to residents #004, #005 and #008 and any other residents, as specified in their plan of care. The plan must include, but is not limited, to the following:

1. Develop and implement a process/processes to ensure:
a) resident #004 and any other resident, are provided care by two staff when required as per the plan of care;
b) resident #005 and any other resident are transferred with the appropriate mechanical device as specified in the plan of care;
c) resident #008 and any other resident who are at risk for falls are provided with falls prevention and management interventions, including an identified fall intervention when required, as per their plan of care.

2. Ensure the interdisciplinary team reviews resident #004's plan of care to reflect the resident's assessed needs with the involvement of the resident and/or the substitute-decision maker.

3. Ensure that any changes to resident #004's plan of care are communicated to the direct care staff (registered staff and personal support workers (PSWs).

4. Develop and implement an auditing tool that documents staff are providing resident #008 and any other resident with fall prevention and management

interventions, including an identified fall intervention, when required as per the plan of care.

5. Ensure audits are conducted to ensure resident #005 and any other resident are transferred with the appropriate mechanical device, when required as per the plan of care.

6. Maintain a written record of the audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit, the outcome of the audits, actions taken to address any concerns and an evaluation of the results.

Please submit the written plan for achieving compliance for inspection 2020_641665_007 to Joy Ieraci, LTC Homes Inspector, MLTC, by email to TorontoSAO.moh@ontario.ca by June 16, 2020.

Please ensure the submitted written plan does not contain any PI/PHI (personal information/personal health information).

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #004, #008 and #005 as specified in the plan.

On November 15, 2019, the following CO #001 from inspection report #2019_641665_0019, with a CDD of February 14, 2020, was made under LTCHA 2007, c. 8, s. 6. (7) was issued:

The licensee must be compliant with s.6 (7) of the Long Term Care Home Act (LTCHA), 2007.
Specifically, the licensee must:
1. Ensure residents #004, #032 and any other resident, are provided care by an identified number of staff when required as per the plan of care.
2. Ensure resident #032 and any other resident are transferred with the appropriate mechanical device as specified in the plan of care.
3. Ensure Personal Support Workers (PSWs) #102 and #110 receive re-training on the home's policy titled "Minimal Lift and Client/Resident Handling Policy". The re-training should be documented with the date and who provided the

retraining.
4. Develop and implement an auditing tool that documents when the registered staff and PSWs are made aware of the change in the plan of care for resident #032 and any other resident, related to transfers.
5. Ensure audits are conducted to ensure resident #004 receives care during an identified shift by the identified number of staff when required as per the plan of care.
6. Ensure audits are conducted to ensure PSWs #102 and #110 provide care to resident #032 and any other resident with the assistance of the long term care home staff, not family and or companions, when required as per the plan of care.

7. Maintain a written record of the audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit, the outcome of the audits, actions taken to address any concerns and an evaluation of the results.

The licensee completed steps #2 to #7, and failed to complete step #1.

Review of resident #004's written plan of care directed staff to provide all care with an identified number of staff for both PSWs and registered staff on all shifts.

In an interview, PSW #105 stated that they provided care to the resident on their own on an identified date, as their partner was busy with other residents. The PSW was aware that resident #004's plan of care required an identified number of staff for care.

In an interview, UM #103 confirmed that the written plan of care directed staff to provide care to the resident with the identified number of staff. They acknowledged that staff did not follow the plan of care of resident #004 regarding the number of staff for all care.

This non compliance is issued as PSW #105 failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. (665)

2. A CIS report was submitted to the Ministry of Long Term Care (MLTC) on an

identified date in 2020, related to falls prevention. The CIS report indicated resident #008 was found on the bedside floor by the RN and PSW during safety rounds. The resident had the bed remote in their hand and the bed was noted to be in a high position. Record review of resident #008's progress notes in PCC the following day, indicated the resident was found at an identified time, alert, complained of pain to two identified areas, and had an area of altered skin integrity. The physician was paged and ordered to transfer resident #008 to the hospital. The hospital informed the home that resident #008 sustained specified injuries. Based on the hospital update documented in the CIS report, there were anticipated changes to the resident's activities of daily living (ADLs).

Record review of resident #008's written plan of care on an identified date, directed staff to encourage resident #008 to use an identified fall intervention.

Record review of resident #008's kardex in Point of Care (POC) indicated for falls prevention, staff was to encourage resident #008 to use the identified intervention and check the intervention every shift.

During an observation, resident #008 did not have the identified intervention in place.

In interviews, PSWs #120 and #124 indicated they were aware that resident #008 should have had the identified intervention in place, but could not find them and reported this to the registered nurse.

In an interview, RPN #140 verified that resident #008 should have had the identified intervention in place.

During another observation on an identified date in 2020, resident #008's private companion verified that the resident did not have the identified intervention in place.

In an interview, RPN #126 indicated that resident #008's identified intervention was not available as it was being labelled by laundry.

In an interview, OT #123 indicated resident #008 had an order for the intervention since an identified month in 2018, and refused the intervention, but

staff were required to encourage the resident to use it.

This non compliance is issued as staff failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan. (665)

3. A Critical Incident System (CIS) report was submitted to the Ministry of Long term Care (MLTC), related to an alleged fall of resident #005. A description of the incident in this CIS indicated that on an identified date in 2019, resident #005 sustained an identified area of altered skin integrity of unknown origin. Resident #005's substitute decision maker (SDM) reported to UM #103, that they were not informed of the incident, resident #005 had an identified injury, was unable to perform a specified physical ability the prior evening and suspected resident #005 might have fallen. This report mentioned, upon assessment by the RN, the nurse noted; identified areas of altered skin integrity. Resident #005 complained of pain to their SDM when UM #103 assessed an identified area.

Record review of resident #005's progress notes in PCC completed by PT #113, one day after the incident, indicated they met with resident #005's SDM and was asked to assess resident #005 as they had pain to an identified area. This note indicated upon PT #113's assessment, resident #005 had a specified injury and altered skin integrity to the identified area mentioned above. Resident #005 exhibited an identified behaviour with an identified facial expression upon assessment to the identified area.

Record review of resident #005's written plan of care for the period of the fall indicated they were at an identified risk for falls due to their identified health and physical status.

Record review of resident #005's kardex indicated resident required an identified number of staff members for transfers with an identified mechanical device.

In an interview PSW #134 indicated when resident #005 sustained the fall they walked resident #005 from their bed with the assistance of RPN #135 to the washroom. PSW #134 acknowledged they did have access to resident #005's written plan of care and was aware they should have used the identified mechanical device. PSW #134 acknowledged they did not follow the resident #005's plan of care.

In an interview RPN #135 indicated they were told by PSW #134 that resident #005 could walk a few steps, and indicated they did not assist PSW #134 to walk the resident to the washroom, but observed the PSW walking resident #005 to the washroom.

UM #103 acknowledged that PSW #134 and RPN #135 did not follow resident #005's plan of care and verified that resident #005 required the identified mechanical device for transfers.

This non compliance is issued as PSW #134 and RPN #135 failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents #004, #008 and #005. The scope of the issue was a level 2 as it is related to three of six residents reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this subsection of the LTCHA and four or more compliance orders (CO) that included:
- CO #001 issued July 27, 2017 (2017_486653_0012), complied November 21, 2017
- Voluntary plan of correction (VPC) issued December 3, 2018 (2018_766500_0017)
- VPC issued May 14, 2019 (2019_751649_0007)
- written notification (WN) issued October 10, 2019 (2019_817652_0019);
- CO #001 issued November 15, 2019 (2019_641665_0019)

Additionally, the LTCH has a history of eight other compliance orders to other sections and subsections in the last 36 months. (665)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 13, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

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