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
Jul 30, 2020	2020_808535_0009	002731-20, 002977-20, 003624-20, 003633-20, 004784-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Craiglee Nursing Home
102 Craiglee Drive SCARBOROUGH ON M1N 2M7

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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 25, 27, 29, off-site May 26, 28, 2020.

The following intakes were completed during this inspection: Log #s: 002731-20 (related to nutrition and hydration), 003633-20 (related to abuse), 003624-20 (related to fall), 004784-20 (related to fall), 002977-20 (related to abuse).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of Care (ADOC), Nurse Manager (NM), Food Service Manager, Social Services Worker (SSW), registered staff (RN/RPN) and personal support worker (PSW).

During the course of the inspection, the inspector conducted observations of the home including resident home areas, resident and staff interactions, resident to resident interactions, the provision of resident care, reviewed clinical health records, internal investigation notes and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 73. (1)	CO #001	2019_804600_0027	535

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #002 and #004 were protected from abuse by anyone in the home.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain; and,

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “verbal abuse” means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) related to an incident of abuse by PSW #107 towards resident #004.

A review of the CIS report, previous staff schedule roster and progress notes indicated that on an identified date, resident #004 activated the call bell assistance and PSW #107 answered and aided the resident. The progress notes indicated that the resident did not know the name of the PSW while reporting the incident, but they recalled a brief description of the PSW. During the immediate day shift, resident #004 reported the interaction to the registered staff; and the resident requested not to have that PSW

support their care going forward. The registered staff conducted a head to toe assessment and documented the results. The incident was reported to the home's social services worker (SSW) to support the resident and the ADOC.

During an interview, PSW #107 recalled providing care for resident #004 during that shift and verified that the resident required support but denied any negative interactions. According to the PSW, the resident called for support and they had an interaction, however they did not inform the registered staff on duty nor document the incident had occurred.

During an interview, RPN #106 verified the information as documented and stated that they completed a head to toe assessment which revealed altered skin integrity to an identified part of the body. The RPN also verified that they informed the SSW, ADOC, family and documented the information in the physician's book for follow up next visit.

During an interview, SSW #109 verified that the resident informed them about the interaction with the PSW. The SSC recalled that the resident had altered skin integrity on an identified part of the body and that the registered staff completed an assessment. The SSW also verified that they provided emotional support to the resident regarding the incident.

During an interview, ADOC #101 verified that they interviewed the resident related to the alleged incident and although the resident could not recall the name of the PSW, they accurately described the PSW by distinct features. The ADOC stated that resident #004 wanted to report the incident just to have a record made in case it happened again, and the resident requested not to have that PSW support their care and that change was granted.

The ADOC stated that their expectation was that all staff adhered to the Residents' Rights; and verified that the PSW's interaction with resident #004 would be considered verbal, emotional and physical abuse. Furthermore, the ADOC verified that the PSW was counseled and provided with pertinent education material to review prior to returning to work; and they were asked to report all incidents to the registered staff on duty if they observe altered skin issues or have negative interactions with residents while providing care going forward. [s. 19. (1)]

2. A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) related to an incident of abuse by PSW #107 towards resident #002.

A review of the CIS report, previous staff schedule roster and progress notes indicated that on an identified date, resident #002 activated the call bell for assistance and PSW #107 answered and aided the resident. As noted, the resident could not recall the time the incident occurred but was sure the incident occurred on the previous shift, and they were able to identify the PSW by name. During the next shift, resident #002 reported to the registered staff that the PSW interacted with them negatively while providing care. The resident requested to speak with the home's social services worker (SSW) to file a complaint. The registered staff on duty conducted a head to toe assessment and documented no bruising or injury. The incident was reported to the home's SSW to support the resident and the ADOC.

During an interview, PSW #107 recalled the incident and verified that they provided care for resident #002 and that they had a negative interaction. According to the PSW, they answered multiple calls for the resident during that shift. The PSW recalled the interaction and that they entered the room alone and attempted to provide the care and during the interaction the resident suddenly grabbed the PSW's hand during the care. The resident subsequently used a few colorful words and told the PSW to leave and get out of their room. The PSW recalled that the resident was upset during the interaction, therefore, they got support from another PSW to finish providing the resident's care. The PSW admitted that the resident's written care plan included care to be provided by two-persons but that they were providing care alone for the resident during the initial incident; that they told the registered staff on duty about the interaction with the resident but the staff was busy and might not have understood what they were trying say; and verified that they did not document the interaction nor that the resident had grabbed their hand while providing care.

During an interview, RPN #106 verified the information as documented and stated that the resident reported the interaction with the PSW. The RPN stated that resident #002 mentioned PSW #107 by name since they knew the staff. The RPN completed a head to toe assessment and did not observe altered skin integrity or other injury. The home's SSW and ADOC were informed of the incident for support and follow up.

During an interview, SSW #109 verified that they discussed the incident with the resident and provided support. The SSW stated that this incident happened approximately two weeks after another resident accused the same PSW of a similar incident. Both residents similarly stated it was the action and the tone the PSW used while providing the care which were inappropriate.

During an interview, ADOC #101 verified that they interviewed the resident related to the alleged incident. The ADOC stated that the resident called the PSW by name when they reported the interaction with the PSW which caused them to feel pain. The ADOC attended the resident's room with Nurse Manager #102 and they both thought the story sounded very familiar. The ADOC confirmed the resident required total care but that sometimes they used one staff because the resident was able to support turning independently. However, the resident's care plan, listed two staff to provide care.

PSW #107 was sent home on administrative leave while an investigation was conducted related to the alleged incident. During the interview, the PSW was informed that there should have been two staff present because of the resident's identified behavior as noted in the written care plan. The ADOC stated that their expectation was that PSWs adhere to the Residents' Rights while providing care. Furthermore, the ADOC verified that the PSW was disciplined; and that they were not working in the home.

The ADOC also acknowledged that the PSW's interactions with resident #002 and #004 would be considered verbal, emotional and physical abuse. Therefore, the home failed to ensure residents were protected from abuse by anyone in the home. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 resident #001.

The Ministry of Long-Term Care (MLTC) received a critical incident systems (CIS) report related to an incident which caused resident #001 to be transferred to hospital with significant changes in health status.

Record review of the critical incident report and the Point Click Care (PCC) documentation system progress notes indicated that on an identified date, resident #001 was ambulating with their mobility device. Upon entry to the residents' lounge, the resident may have been tripped over an equipment which was located at the entrance of the lounge. The resident was found by a registered staff lying on the ground with their walker on the side, and an injury to an identified part of their body. The resident was assessed by the registered staff, nurse manager and physiotherapist who were onsite. An ambulance was called and the resident was transported to the acute care hospital where they were diagnosed with an injury which required treatment. The resident was returned to the facility post procedure.

During separate interviews, RPN #103 and Nurse Manager (NM) #104 both verified the incident occurred as documented above. RPN #103 further stated they were completing med-pass when they heard a bang and the resident made a sound. Upon entry they found the resident on the ground and considering the proximity of the equipment, which was not secured at the entrance of the lounge, they believed the resident might have tripped on that equipment. RPN #103 also verified that the equipment was usually stored in that location for easy access but that it should have been folded and stored securely out of the way. The RPN verified that the equipment was no longer stored in that location after the incident. RPN #103 also verified that the resident was unsupervised when they ambulated to the lounge and that they should have been supervised during ambulation as per the plan of care.

The ADOC documented in the critical incident and stated in an interview that the staff on the unit did not witness the fall but that they heard when the resident fell; and that the resident required supervision and directions when on and off the unit. ADOC #101 verified that the equipment was normally stored at that location because it was the only convenient place for use, but that the expectation was for staff to fold the equipment securely when not in use which would have avoided the tripping hazard. The inspector observed that the equipment was folded and safely stored in a different location in the home.

Therefore, the home failed to ensure that the facility was a safe and secure environment for resident #001. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for all residents, to be implemented voluntarily.

Issued on this 4th day of August, 2020

[redacted]

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) :	VERON ASH (535)
Inspection No. / No de l’inspection :	2020_808535_0009
Log No. / No de registre :	002731-20, 002977-20, 003624-20, 003633-20, 004784-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 30, 2020
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Craiglee Nursing Home 102 Craiglee Drive, SCARBOROUGH, ON, M1N-2M7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Rebecca Macaalay

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

To CVH (No. 1) LP, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee must do the following:

1. Ensure resident #002, #004 and all other residents are protected from abuse by anyone in the home.

2. Develop and implement a quality improvement process to ensure that if/when a staff member is disciplined and re-trained related to an alleged/actual incident of abuse, the staff have understood and enacted their training going forward.

3. Ensure care is provided to resident #002 by all direct care staff as directed in the resident's written care plan.

Grounds / Motifs :

1. The licensee has failed to ensure resident #002 and #004 were protected from abuse by anyone in the home.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain; and,

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) related to an incident of abuse by PSW #107 towards resident #004.

A review of the CIS report, previous staff schedule roster and progress notes indicated that on an identified date, resident #004 activated the call bell assistance and PSW #107 answered and aided the resident. The progress notes indicated that the resident did not know the name of the PSW while reporting the incident, but they recalled a brief description of the PSW. During the immediate day shift, resident #004 reported the interaction to the registered staff; and the resident requested not to have that PSW support their care going forward. The registered staff conducted a head to toe assessment and documented the results. The incident was reported to the home's social services worker (SSW) to support the resident and the ADOC.

During an interview, PSW #107 recalled providing care for resident #004 during that shift and verified that the resident required support but denied any negative interactions. According to the PSW, the resident called for support and they had an interaction, however they did not inform the registered staff on duty nor document the incident had occurred.

During an interview, RPN #106 verified the information as documented and stated that they completed a head to toe assessment which revealed altered skin integrity to an identified part of the body. The RPN also verified that they informed the SSW, ADOC, family and documented the information in the physician's book for follow up next visit.

During an interview, SSW #109 verified that the resident informed them about the interaction with the PSW. The SSC recalled that the resident had altered skin integrity on an identified part of the body and that the registered staff

completed an assessment. The SSW also verified that they provided emotional support to the resident regarding the incident.

During an interview, ADOC #101 verified that they interviewed the resident related to the alleged incident and although the resident could not recall the name of the PSW, they accurately described the PSW by distinct features. The ADOC stated that resident #004 wanted to report the incident just to have a record made in case it happened again, and the resident requested not to have that PSW support their care and that change was granted.

The ADOC stated that their expectation was that all staff adhered to the Residents' Rights; and verified that the PSW's interaction with resident #004 would be considered verbal, emotional and physical abuse. Furthermore, the ADOC verified that the PSW was counseled and provided with pertinent education material to review prior to returning to work; and they were asked to report all incidents to the registered staff on duty if they observe altered skin issues or have negative interactions with residents while providing care going forward. [s. 19. (1)] (535)

2. A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) related to an incident of abuse by PSW #107 towards resident #002.

A review of the CIS report, previous staff schedule roster and progress notes indicated that on an identified date, resident #002 activated the call bell for assistance and PSW #107 answered and aided the resident. As noted, the resident could not recall the time the incident occurred but was sure the incident occurred on the previous shift, and they were able to identify the PSW by name. During the next shift, resident #002 reported to the registered staff that the PSW interacted with them negatively while providing care. The resident requested to speak with the home's social services worker (SSW) to file a complaint. The registered staff on duty conducted a head to toe assessment and documented no bruising or injury. The incident was reported to the home's SSW to support the resident and the ADOC.

During an interview, PSW #107 recalled the incident and verified that they provided care for resident #002 and that they had a negative interaction.

According to the PSW, they answered multiple calls for the resident during that shift. The PSW recalled the interaction and that they entered the room alone and attempted to provide the care and during the interaction the resident suddenly grabbed the PSW's hand during the care. The resident subsequently used a few colorful words and told the PSW to leave and get out of their room. The PSW recalled that the resident was upset during the interaction, therefore, they got support from another PSW to finish providing the resident's care. The PSW admitted that the resident's written care plan included care to be provided by two-persons but that they were providing care alone for the resident during the initial incident; that they told the registered staff on duty about the interaction with the resident but the staff was busy and might not have understood what they were trying say; and verified that they did not document the interaction nor that the resident had grabbed their hand while providing care.

During an interview, RPN #106 verified the information as documented and stated that the resident reported the interaction with the PSW. The RPN stated that resident #002 mentioned PSW #107 by name since they knew the staff. The RPN completed a head to toe assessment and did not observe altered skin integrity or other injury. The home's SSW and ADOC were informed of the incident for support and follow up.

During an interview, SSW #109 verified that they discussed the incident with the resident and provided support. The SSW stated that this incident happened approximately two weeks after another resident accused the same PSW of a similar incident. Both residents similarly stated it was the action and the tone the PSW used while providing the care which were inappropriate.

During an interview, ADOC #101 verified that they interviewed the resident related to the alleged incident. The ADOC stated that the resident called the PSW by name when they reported the interaction with the PSW which caused them to feel pain. The ADOC attended the resident's room with Nurse Manager #102 and they both thought the story sounded very familiar. The ADOC confirmed the resident required total care but that sometimes they used one staff because the resident was able to support turning independently. However, the resident's care plan, listed two staff to provide care.

PSW #107 was sent home on administrative leave while an investigation was

conducted related to the alleged incident. During the interview, the PSW was informed that there should have been two staff present because of the resident's identified behavior as noted in the written care plan. The ADOC stated that their expectation was that PSWs adhere to the Residents' Rights while providing care. Furthermore, the ADOC verified that the PSW was disciplined; and that they were not working in the home.

The ADOC also acknowledged that the PSW's interactions with resident #002 and #004 would be considered verbal, emotional and physical abuse. Therefore, the home failed to ensure residents were protected from abuse by anyone in the home. [s. 19. (1)]

The severity of this issue was determined as minimum harm or minimum risk. The scope of the issue was patterned since two residents were affected. The licensee had five previous findings of non-compliance with this section of the LTCHA in February 2020 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2020_653589_0004; January 2019 that resulted in inspectors issuing a written notification (WN) in Inspection #2019_804600_0027; September 2019 that resulted in inspectors issuing a compliance order (CO) in Inspection #2019_530726_0006; September 2018 that resulted in inspectors issuing a compliance order (CO) in Inspection #2018_630589_0009; and October 2017 that resulted in inspectors issuing a compliance order (CO) in Inspection 2017_632502_0012. As such, a Compliance Order is warranted. (535)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 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 30th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Veron Ash

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