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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 7, 2019	2019_723606_0007	023928-18, 024824-18, 030973-18, 031015-18, 031016-18, 031549-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

JANET GROUX (606), HEATHER PRESTON (640)

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): April 3, 4, 5, 8, and 12, 2019.

The following Critical Incident System (CIS) intakes were inspected:
a resident fall which resulted in a hip fracture; a resident fall which resulted in a spinal fracture; a resident fall which resulted in a pelvis and left elbow fracture; and an allegation of resident abuse.

The following Follow Up (FU) intakes were inspected:
Log #031015-18, follow-up to CO#001 from inspection #2018_728696_0008 / 025431-18 regarding s. 19. (1), CDD Nov 20, 2018; and Log #031016-18, follow-up to CO#002 from inspection #2018_728696_0008 / 025431-18 regarding r. 50. (2), CDD Dec 04, 2018.

The following Critical Incident System intakes were inspected during this Critical Incident System Inspection:
Log #031949-18 regarding an allegation of staff to resident physical abuse.
PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s.19. (1) was identified in Inspection Report # 2019_723606_0006 which was conducted concurrently with this inspection and is included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (DOC), the Behavioural Support of Ontario (BSO) Nurse, the Minimum Data Set (MDS) and Point Click Care (PCC) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Care Clerk, Clinical Consultant, Sheridan College Students, Sheridan College Teacher, Substitute Decision Makers (SDM) and residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. 50. (2)	CO #002	2018_728696_0008	606

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 that residents were protected from abuse by anyone.

Critical Incident System reported staff to resident abuse.

Registered Practical Nurse (RPN) Student #128 told the inspector that they and RPN student #129 witnessed Personal Support Worker (PSW) #141 handle resident #011 in an inappropriate manner and made a derogatory comment about the resident to the two RPNs. They stated that they immediately reported the incident to their teacher and the home.

The home's records confirmed the information provided to the inspector by RPN Student #128.

The Administrator stated that the home conducted an investigation and found that PSW #141 behaved in an abusive manner toward resident #011.

The licensee failed to protect resident #011 from abuse. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by anyone.

A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported resident to resident abuse causing injuries.

Resident #020's progress notes stated the resident was found on the floor by PSW #137 and was observed with injuries. Resident #006 was identified to have responsive behaviours of frequently wandering into other residents' rooms particularly resident #020's room in the past. The plan of care directed staff to monitor and re-direct resident #006 when observed wandering into another resident's room and documentation indicated that the interventions were ineffective.

Resident #020 told the Long Term Care Homes (LTCH) Inspector that they saw resident #006 in their room.

PSW #137 and RPN #139 stated that resident #020 was found on the floor with injuries and that resident #020 told them that they had an altercation with resident #006 in the room.

The Administrator acknowledged that they have information that resident #006 was in resident #020's room with the resident and saw resident #020 fall to the floor.

The home failed to protect resident #020 from abuse from resident #006. [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. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

A follow-up inspection to Compliance Order (CO) #002 from inspection #2018_728696_0008 regarding s. 50. (2), Compliance Due Date (CDD) of December 04, 2018, was completed.

Resident #015's clinical records stated the resident was identified as at risk for skin integrity impairments.

Resident #015's plan of care did not include a focus, goals or interventions that identified

that the resident was at risk for skin integrity breakdown.

RPN #122, the home's Skin and Wound Program lead, stated that when a resident has been identified to have a skin integrity impairment, it should be included in the plan of care.

The licensee failed to ensure that there was written plan of care for resident #015 that set out, (a) the planned care for the resident; (b) the goals the care was intended to achieve; and (c) clear directions to staff and others who provided direct care to the resident. [s. 6. (1)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident.

Resident #012 was assessed to have wandering behaviours and on an identified date, the resident wandered into another resident's room without their mobilty aide and fell resulting in a serious injury.

The resident was assessed to be have a fall risk level and was assessed to require an identified level of physical assistance.

Review of the clinical record identified the resident's behaviour of wandering was not included in the plan of care. The interventions related to falls prevention were incomplete.

The resident fell as a result of falling in another resident's room. This wandering behaviour and any interventions related to it, were not included in the plan of care as a fall prevention intervention. The other areas identified were not specific or clear based on the assessment of fall risk for the resident.

RPN #123 acknowledged the plan of care for resident #012 was incomplete and had not been revised based on the admission assessments of the resident. [s. 6. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident; and to ensure that the care set out in the plan of care was based on an assessment of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s.109, the licensee was required to ensure that there was a written policy in place regarding the minimizing of restraining of a resident. Specifically, staff did not comply with the licensee's policy on PASDs' that directed staff to implement a number of interventions.

The clinical record was reviewed and the plan of care did not include the purpose, time frame for use, monitoring, checking and repositioning of the resident and any special care needs required by resident #012 during the use of an identified mobility aide.

RPN #123 acknowledged the plan of care for resident #012 did not include the items required by the licensee's policy related to the implementation and use of a PASD. [s. 8. (1) (b)]

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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that alternatives to the use of a PASD had been considered and tried prior to including the PASD in the resident's plan of care.

Resident #012 sustained a serious injury as a result of a fall. They returned to the home and was assigned an identified mobility aide as a PASD for positioning and comfort.

The resident's plan of care stated that the resident was able to get out of their mobility aide when the mobility aide was in an identified position The LTCH Inspector observed they the resident was not able to get out of the mobility aide due to their physical and mental condition.

PSW #124 and RPN #122 stated they did not recall any alternatives that had been considered prior to the implementation of the identified mobility aide RPN#125 and RN #126 told the Inspector the documentation related to the trial of alternatives, was documented on the "Least Restraint -PASD Assessment" form.

The clinical record was reviewed and the least restraint assessment form for resident #012 did not include documentation related to the trial of alternatives.

The licensee failed to ensure that alternatives to the use of a PASD had been considered and tried prior to including the PASD in the resident's plan of care. [s. 33. (4) 1.]

2. The licensee failed to ensure that the use of a PASD had been consented to by the resident or the resident's s SDM.

A mobility aide identified as a PASD, was implemented for resident #012 for positioning after they sustained a serious injury from a fall.

RPNs #122 and #124 told the Inspector that prior to implementing an identified mobility aide as a PASD and annually thereafter, consent was to be obtained from the resident or their SDM.

The clinical record was reviewed and the PASD consent form with resident #012's name on it, was not dated or signed by the resident or their SDM. RPN #124 acknowledged this had not occurred.

The licensee failed to obtain consent for the use of the tilt wheelchair as a PASD for resident #012. [s. 33. (4) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #012 fell and sustained a serious injury.

RPN #122 told the LTCH Inspector that an initial assessment of the area of altered skin integrity was expected to be completed.

The clinical record was reviewed by the Inspector. There were no initial skin and wound assessments, using the home's clinically appropriate assessment instrument, completed for the area of altered skin integrity as acknowledged by the Resident Assessment Instrument and Minimum Data Set/Point Click Care (MDS/PCC) Coordinator.

The licensee failed to ensure that resident #012 received a skin and wound assessment of their altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

RPN #122 told the LTCH Inspector that weekly reassessments of the area of altered skin integrity were expected to be completed. The first reassessment was due on an identified date.

The clinical record was reviewed by the LTCH Inspector. There were no weekly skin and wound reassessments completed for the area of altered skin integrity for resident #012 and no record of when the wound was healed as acknowledged by the MDS/PCC Coordinator.

The licensee failed to ensure that resident #012 had their altered skin integrity reassessed weekly.

The following is further evidence to support the compliance order Inspection #2017_536171_0023 issued on November 9, 2018, with a Compliance Due Date of December 4, 2018. [s. 50. (2) (b) (iv)]

Issued on this 11th day of June, 2019

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

Ministère 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) :	JANET GROUX (606), HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2019_723606_0007
Log No. / No de registre :	023928-18, 024824-18, 030973-18, 031015-18, 031016-18, 031549-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 7, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Emily Bosma

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

Ministère 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

To Extendicare (Canada) Inc., 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

Ministère 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)

Linked to Existing Order / Lien vers ordre existant: 2018_728696_0008, CO #001;

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.
Specifically, the licensee must ensure that residents #011, #020, and any other resident are protected from abuse by anyone

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #001 from inspection # 2018_728696_0008 dated November 9, 2018, with a compliance due date (CDD) of November 20, 2018.

The licensee was ordered to:
a) The licensee must be compliant with s. 19 (1) of the LTCHA.
b) Ensure that resident #001, #031, and any other resident are protected from abuse by anyone.
The licensee completed part b).
The licensee failed to ensure that part a) of CO#001 was completed.

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Critical Incident System reported staff to resident abuse.

Registered Practical Nurse (RPN) Student #128 told the inspector that they and RPN student #129 witnessed Personal Support Worker (PSW) #141 handle resident #011 in an inappropriate manner and made a derogatory comment about the resident to the two RPNs. They stated that they immediately reported

the incident to their teacher and the home.

The home's records confirmed the information provided to the inspector by RPN Student #128.

The Administrator stated that the home conducted an investigation and found that PSW #141 behaved in an abusive manner toward resident #011.

The licensee failed to protect resident #011 from abuse. [s. 19. (1)]

(606)

2. The licensee has failed to ensure that residents were protected from abuse by anyone.

A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported resident to resident abuse causing injuries.

Resident #020's progress notes stated the resident was found on the floor by PSW #137 and was observed with injuries. Resident #006 was identified to have responsive behaviours of frequently wandering into other residents' rooms particularly resident #020's room in the past. The plan of care directed staff to monitor and re-direct resident #006 when observed wandering into another resident's room and documentation indicated that the interventions were ineffective.

Resident #020 told the Long Term Care Homes (LTCH) Inspector that they saw resident #006 in their room.

PSW #137 and RPN #139 stated that resident #020 was found on the floor with injuries and that resident #020 told them that they had an altercation with resident #006 in the room.

The Administrator acknowledged that they have information that resident #006 was in resident #020's room with the resident and saw resident #020 fall to the floor.

The home failed to protect resident #020 from abuse from resident #006. [s. 19. (1)]

The severity of Non-Compliance (NC) was determined at level 2 as there was minimal harm or minimal risk.
The scope was level 2, patterned as 2/3 (67%) of the residents inspected were affected.
The compliance history was level 5, an order was re-issued to the same sub-section and the licensee has had three (or fewer) COs issued in the same or different section in the past 3 years.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 09, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 7th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

Service Area Office /
Bureau régional de services : Central West Service Area Office