Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

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
Jan 24, 2020	2020_644507_0001	014382-19, 024280-19	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

Isabel and Arthur Meighen Manor
155 Millwood Road TORONTO ON M4S 1J6

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

STELLA NG (507)

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): January 2, 3, 6 and 7, 2020.

The following intakes were inspected during this inspection:
Follow Up intake #014382-19 related to head injury routine, and
Critical Incident System intake #024280-19 related to improper transfer.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Physiotherapist (PT), Scheduling Clerk, Senior Account Executive (SAE) of Joerns and Substitute Decision-Maker (SDM).

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed resident health records, staff training records, and any relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
1 VPC(s)
2 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. 8. (1)	CO #001	2019_767643_0020	507

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. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA and O. Regulation 79/10: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On July 19, 2019, compliance order (CO) #001, from inspection #2019_767643_0020 was made under O. Reg. 79/10, s. 8 (1):

The licensee must be compliant with O. Reg. 79/10, s. 8 (1).

Specifically the licensee shall:
1) Ensure that registered staff are provided training on the home's falls prevention and management policy and the application of head injury routine assessments;
2) Develop and implement an auditing system to ensure that registered staff carry out and document head injury routine assessments as per the home's policy;
3) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

The compliance due date was November 29, 2019.

During this inspection, it was found that the home completed step 2 but failed to complete step 1 and 3.

Review of the home’s employee detail report indicated there was a total of 45 active registered staff employed as of January 3, 2020. Review of the home’s continuing education attendance records for falls documentation and initiation of head injury routine on two identified dates between July and December 2019, indicated there was a total of 17 registered staff that attended either training session.

In interviews, staff #122 and #100 confirmed that training on the home’s falls prevention and management policy and the application of head injury routine assessments had not been provided to all registered staff.

Review of the audit records for four months prior to this inspection, and interview with staff #100 confirmed that audit records did not include the name of the person completing the audit and the outcome of the audit. [s. 101. (3)]

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring devices or techniques when assisting resident #001.

An identified Critical Incident System (CIS) report was submitted to the Director on an identified date for a suspected incident of improper care which resulted in harm to resident #001.

Review of the progress notes of resident #001 for a period of six days related to the above mentioned injuries, indicated the following:
Day one: injuries were observed;
Day two: injured areas were observed more widespread, treatment was provided, assessed by on call home physician who documented the injuries were possibly caused by an identified device, and substitute decision-maker (SDM) was notified of the injuries;
Day three: assessed by Registered Dietitian (RD), and staff members were advised not to use sling A;

Day five: assessed by home physician, and investigation was ordered;
Day six: investigation results indicated an identified health condition.

Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) completed approximately three months prior to the discovery of the above mentioned injuries, indicated resident #001 required assistance for transfer. Review of the care plan approximately one month after the RAI-MDS was completed indicated resident #001 required assistance for transferring from one position to another. One of the interventions for transferring was to provide assistance with a mechanical lift. The same care plan also indicated resident #001 required assistance for toileting. One of the interventions for toileting included providing assistance using a mechanical lift for taking the resident to the bathroom, and transfer them on/ off toilet.

In an interview, staff #110 told the inspector that there are two different types of slings to be used with the mechanical lift in the home. Sling A is used for toileting purpose, and sling B is used for transferring a resident from bed to chair, and from chair to bed.

Review of the user instruction manual of the mechanical lift sling A indicated that sling A is designed specifically to facilitate the toileting process. The manual also indicated that sling A is not recommended for use from a lying position.

In an interview, staff #121 told the inspector that sling A is designed to transfer a person from a sitting position to another sitting position. If sling A is used to transfer a person from chair to bed, the head of the bed and the knee area must be elevated. So that when the person is transferred onto the bed, the person would be in a sitting position. Staff #121 further stated that there is a risk of putting extra strain on the person if the person is transferred from a sitting position to a lying position with sling A, because sling A is designed to transfer a person from a sitting position to another sitting position, not a lying position. In addition, the manufacturer does not recommend using sling A to transfer a person from a sitting position to a lying position.

In an interview, staff #115 stated that the day before the discovery of the injuries, they applied sling A onto resident #001, and intended to transfer the resident from the chair onto the toilet. When the resident was being lifted, staff #115 found that the resident needed to be changed instead of sitting on the toilet. Staff #115 and another staff member transferred the resident onto the bed while the resident was in sling A. Staff #115 told the inspector that when resident #001 was lowered onto the bed, the bed was flat.

In an interview, staff #100 stated that an investigation was initiated on the same day when resident #001's injuries were discovered. Two days later, they advised staff members not to use sling A to transfer resident #001 because they suspected the injuries were caused by the use of sling A. In addition, they did not want any pressure to be applied to the injured areas while the investigation was in progress. Staff #100 stated that there was a huge possibility resident #001's injuries were caused by using sling A, which was the incorrect sling to be used when transferring a resident from chair to bed. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to immediately report the suspicion and the information upon which it was based to the Director when a person who had reasonable grounds to suspect that improper care of resident #001 that resulted in harm to the resident had occurred.

An identified CIS report was submitted to the Director on an identified date for a suspected incident of improper care which resulted in harm to resident #001. According to the CIS report, resident #001 was found to have injuries 12 days prior to the submission of the CIS. Five days later, the home received investigation results indicating an identified health condition. The CIS report indicated the cause of the injuries was using sling A in transferring the resident from chair to bed the day prior to the discovery of the injuries.

In an interview, staff #100 stated that an investigation was initiated on the day when resident #001’s injuries were discovered. Two days later, they advised staff members not to use sling A to transfer resident #001 because they suspected the injuries were caused by using sling A. The investigation was completed five days later when the home received investigation results that indicated an identified health condition. Staff #100 further stated that there was a huge possibility resident #001’s injuries were caused by using sling A, which was the incorrect sling when transferring the resident from chair to bed the day prior to the discovery of the injuries. Staff #100 acknowledged that the Director should be informed of the improper care immediately when the home received investigation results, not seven days later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to immediately report the suspicion and the information upon which it is based to the Director when a person who has reasonable grounds to suspect that improper care of a resident that resulted in harm to the resident has occurred, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident.

An identified CIS report was submitted to the Director on an identified date for a suspected incident of improper care which resulted in harm to resident #001.

On an identified date, the inspector reviewed resident #001's current care plan which indicated the resident remain in a certain position for an identified time period after meals under one focus (focus A). On the same care plan, it indicated to keep the resident in the same position for half of the previous mentioned time period, after meals, under another focus (focus B).

Review the care plan history of resident #001 indicated focus A was initiated on an identified date by staff #104. Focus B was revised 14 months later by staff #104.

In an interview, staff #104 acknowledged that was their error not to delete the initial intervention when the resident was re-assessed and care plan was revised. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #001's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

An identified CIS report was submitted to the Director on an identified date for a suspected incident of improper care which resulted in harm to resident #001.

Review of the progress notes of resident #001 indicated that on an identified date, the resident was found to have injuries. Five days later, the home received investigation results indicating an identified health condition. The home physician was informed of investigation results two days later, and the doctor ordered an intervention. Another two days later, the home contacted resident #001's SDM in regards to the above mentioned significant changes of the resident's condition and the related plan of care.

In an interview, staff #100 acknowledged the home should have contacted resident #001's SDM when they received the investigation results, not four days later. [s. 6. (5)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's substitute decision-maker was notified of the results of the investigation required under section 23 (1) of the Act, immediately upon the completion of the investigation.

An identified CIS report was submitted to the Director on an identified date for a suspected incident of improper care which resulted in harm to resident #001.

In a conversation on an identified date, resident #001's SDM told the inspector that they were not aware of an investigation was being conducted for the cause of resident #001's above mentioned injuries, and they were not notified by the home of the outcome of the investigation.

In an interview, staff #100 stated that investigation was initiated on the day when resident #001's injuries were discovered. The investigation was completed five days later after interviewing the staff member and receiving the investigation results. Staff #100 further stated that they had a meeting with resident #001's SDM on the same day the SDM spoke with the inspector upon the SDM's request in regards to their concerns, including the outcome of the investigation of the resident's injuries. Staff #100 acknowledged it was a delay in notifying resident #001's SDM of the results of the investigation. [s. 97. (2)]

Issued on this 27th day of January, 2020

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l’inspection :	2020_644507_0001
Log No. / No de registre :	014382-19, 024280-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 24, 2020
Licensee / Titulaire de permis :	The Governing Council of the Salvation Army in Canada 2 Overlea Blvd, TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	Isabel and Arthur Meighen Manor 155 Millwood Road, TORONTO, ON, M4S-1J6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Julie Wong

To The Governing Council of the Salvation Army in Canada, you are hereby required to comply with the following order(s) by the date(s) set out below:

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, Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Order / Ordre :

The licensee must be compliant with LTCHA s. 101. (3).

Specifically the licensee shall:
1) Ensure that all registered staff are provided training on the home's falls prevention and management policy and the application of head injury routine assessments;
2) Maintain a written record of audits to ensure that registered staff carry out and document head injury routine assessments as per the home's policy. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to comply with the following requirement of the LTCHA and O. Regulation 79/10: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On July 19, 2019, compliance order (CO) #001, from inspection #2019_767643_0020 was made under O. Reg. 79/10, s. 8 (1):

The licensee must be compliant with O. Reg. 79/10, s. 8 (1).

Specifically the licensee shall:
1) Ensure that registered staff are provided training on the home's falls prevention and management policy and the application of head injury routine assessments;

2) Develop and implement an auditing system to ensure that registered staff carry out and document head injury routine assessments as per the home's policy;
3) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

The compliance due date was November 29, 2019.

During this inspection, it was found that the home completed step 2 but failed to complete step 1 and 3.

Review of the home's employee detail report indicated there was a total of 45 active registered staff employed as of January 3, 2020. Review of the home's continuing education attendance records for falls documentation and initiation of head injury routine dated September 19, 2019, and October 25, 2019, indicated there was a total of 17 registered staff that attended either training session.

In interviews, Executive Director (ED) #122 and Director of Care (DOC) #100 confirmed that training on the home's falls prevention and management policy and the application of head injury routine assessments had not been provided to all registered staff.

Review of the audit records for the months of September, October, November and December 2019, and interview with ED #100 confirmed that audit records did not include the name of the person completing the audit and the outcome of the audit.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 2 as it related to 28 out of 45 registered staff. The home had a level 1 compliance history as there was no previous noncompliance to the same subsection issued in the last 36 months. (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 31, 2020

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Regulation 79/10, s. 36.

Specifically the licensee shall:
1) Ensure that for resident #001 and all other residents who require assistance with transfer with a mechanical lift; staff use safe transferring techniques and devices to assist the resident, including and not limited to the use of the appropriate sling and as per manufacturer's instruction.
2) Develop and implement an auditing system to ensure staff are using safe techniques and devices when assisting residents with transfers with a mechanical lift as per manufacturer's instruction.
3) Maintain a written record of audits conducted of transferring techniques and devices in the home. The written record must include the date and location of the audit, the resident's name, staff member audited, equipment utilized, the name of the person completing the audit and the action required of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring devices or techniques when assisting resident #001.

An identified Critical Incident System (CIS) report was submitted to the Director on an identified date for a suspected incident of improper care which resulted in harm to resident #001.

Review of the progress notes of resident #001 for a period of six days related to the above mentioned injuries, indicated the following:
Day one: injuries were observed;
Day two: injured areas were observed more widespread, treatment was

provided, assessed by on call home physician who documented the injuries were possibly caused by an identified device, and substitute decision-maker (SDM) was notified of the injuries;
Day three: assessed by Registered Dietitian (RD), and staff members were advised not to use sling A;
Day five: assessed by home physician, and investigation was ordered;
Day six: investigation results indicated an identified health condition.

Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) completed approximately three months prior to the discovery of the above mentioned injuries, indicated resident #001 required assistance for transfer. Review of the care plan approximately one month after the RAI-MDS was completed indicated resident #001 required assistance for transferring from one position to another. One of the interventions for transferring was to provide assistance with a mechanical lift. The same care plan also indicated resident #001 required assistance for toileting. One of the interventions for toileting included providing assistance using a mechanical lift for taking the resident to the bathroom, and transfer them on/ off toilet.

In an interview, staff #110 told the inspector that there are two different types of slings to be used with the mechanical lift in the home. Sling A is used for toileting purpose, and sling B is used for transferring a resident from bed to chair, and from chair to bed.

Review of the user instruction manual of the mechanical lift sling A indicated that sling A is designed specifically to facilitate the toileting process. The manual also indicated that sling A is not recommended for use from a lying position.

In an interview, staff #121 told the inspector that sling A is designed to transfer a person from a sitting position to another sitting position. If sling A is used to transfer a person from chair to bed, the head of the bed and the knee area must be elevated. So that when the person is transferred onto the bed, the person would be in a sitting position. Staff #121 further stated that there is a risk of putting extra strain on the person if the person is transferred from a sitting position to a lying position with sling A, because sling A is designed to transfer a person from a sitting position to another sitting position, not a lying position. In addition, the manufacturer does not recommend using sling A to transfer a

person from a sitting position to a lying position.

In an interview, staff #115 stated that the day before the discovery of the injuries, they applied sling A onto resident #001, and intended to transfer the resident from the chair onto the toilet. When the resident was being lifted, staff #115 found that the resident needed to be changed instead of sitting on the toilet. Staff #115 and another staff member transferred the resident onto the bed while the resident was in sling A. Staff #115 told the inspector that when resident #001 was lowered onto the bed, the bed was flat.

In an interview, staff #100 stated that an investigation was initiated on the same day when resident #001's injuries were discovered. Two days later, they advised staff members not to use sling A to transfer resident #001 because they suspected the injuries were caused by the use of sling A. In addition, they did not want any pressure to be applied to the injured areas while the investigation was in progress. Staff #100 stated that there was a huge possibility resident #001's injuries were caused by using sling A, which was the incorrect sling to be used when transferring a resident from chair to bed.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one out of there residents reviewed. The home had a level 3 compliance history as there was one previous noncompliance to the same subsection issued in the last 36 months which included:
- A WN (written notification) and VPC (voluntary plan of correction) issued on December 13, 2019, under inspection report #2019_767643_0031,
- A WN and VPC issued on July 19, 2019, under inspection report #2019_767643_0020,
- A WN issued on July 18, 2018, under inspection report #2018_514566_0003, and
- A WN and VPC issued on July 18, 2018, under inspection report #2018_370649_0008.
(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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 24th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : STELLA NG

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