Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2019	2019_787640_0024	011959-19, 015198-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

Lee Manor Home
875 Sixth Street East OWEN SOUND ON N4K 5W5

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

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): September 9, 10 and 11, 2019.

During the course of the inspection the LTCH Inspector toured the home, interviewed residents and staff, observed the provision of care, reviewed clinical records and policy/procedures.

The following Critical Incident (CI) reports were reviewed:

Log #011959-19 related to fall with fracture
Log #0150198-19 related to fall with fracture

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), residents, Fall Lead, Continence Care Lead, Clinical Documentation and Information Coordinator (CDI-C), the Director of Care (DOC) and the Executive Director.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to residents #001, #002 and #004.

a) Resident #001 was at moderate risk of falling and had multiple falls. They were assessed to be frequently incontinent of urine.

The Long-Term Care Homes (LTCH) Inspector reviewed the plan of care that directed staff, as part of a toileting program, to toilet the resident at specific times of the day, evening and night.

PSWs #101, #105 and #106 said the resident did not have a specific toileting program with actual times but they did toilet the resident before and after meals and when they asked.

b) Resident #002 was at moderate risk for falls and had three falls. Two falls resulted in significant injury. The resident required extensive assistance.

The resident told the LTCH Inspector the last time they fell, they had to use the washroom and thought they could get there themselves. They fell and were found on the floor with significant injuries.

The plan of care directed staff, as part of a toileting program, to assist the resident to the washroom at specific times of the day, evening and night.

PSWs #101 and #102 told the LTCH Inspector the resident did not have a toileting program and they would assist the resident when they asked for help. They encouraged

the resident to use the washroom after meals.

c) Resident #004 was at moderate to high risk for falls. They required extensive assistance of two persons.

The plan of care directed staff, as part of a toileting program, to assist the resident to the washroom at specific times of the day, evening and night and other times when the resident asked.

PSWs #102 and #103 told the LTCH Inspector that they take the resident to the toilet before breakfast and before lunch on the day shift. They said they did not know if the resident had specific times to be toileted in the plan of care. They said the resident tells them when they needed to use the washroom.

The Continence Lead said it was expected the residents be toileted as per their specific toileting plans and staff were to document when they toileted any resident.

The licensee failed to ensure that the toileting programs, included in the plan of care for residents #001, #002 and #004 were provided. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care as set out in the plan of care for resident #001 was documented.

Resident #001 was assessed to be at moderate risk for falls and had nine falls.

One of the fall prevention interventions included in the plan of care, was to monitor the resident every hour for safety.

PSWs #105 and #106 told the LTCH Inspector the resident required monitoring every hour to keep them safe. They tried to keep the resident close to the nurse's station for monitoring. They said they were to document the hourly monitoring but were not able to locate anywhere in their documentation tool to sign they had completed the task.

The LTCH Inspector reviewed a documentation survey report for August and September 2019. The report identified required documentation for the task of hourly monitoring for the hours of 2300 to 0600 hours. The hours of 0700, up to and including 2200, were not included in the documentation tool.

The DOC and the Clinical Documentation and Information Coordinator (CDI-C) said staff were expected to document the hourly monitoring of a resident when the plan of care directed them to monitor the resident. They were both unaware that 16 hours in the day, there was no place for the PSWs to document that they had monitored resident #001.

The licensee failed to ensure that the provision of hourly monitoring care as set out in resident #001's plan of care, was documented. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that the provision of care as set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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 or protocol, the policy or protocol was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s.49(1), the license was required to have a falls prevention and management program that provided strategies to

monitor residents.

Specifically, staff did not comply with the licensee's policy "Fall Prevention", policy #VII-G-30.00 with a last revision date of December 2015, which directed staff to complete head injury routine (HIR) for suspected head injury, un-witnessed falls and for residents who were prescribed an anticoagulant. The HIR included specific times for neurological assessment to be completed for 72 hours following the fall.

a) Resident #001 was assessed to be at moderate risk for falls and had nine falls.

On an identified date in July 2019, the resident had an un-witnessed fall and they sustained injuries.

RPN #101 said the HIR would have been initiated for this un-witnessed fall. The HIR was completed on paper and kept at the back of the resident's chart.

The clinical record was reviewed and HIR had been initiated following the fall.

On an identified date in August 2019, under the night shift heading, there was a note stating "sleeping" and the neurological assessment was not completed at that time.

The DOC told the LTCH Inspector that it was an expectation that HIR be completed at all times and that residents were to be wakened to have their assessment completed.

b) Resident #002 was assessed to be at high risk for falls and had three falls. All three falls were un-witnessed. The resident was being administered an anticoagulant.

The LTCH Inspector reviewed the clinical record, specifically the chart, and there were no HIR assessments located.

RPN #101 and the DOC both reviewed the resident's chart and were not able to locate any completed HIR forms for any of the three falls for resident #002.

c) Resident #003 was assessed to be at moderate risk for falls and had three un-witnessed falls.

RPN #104 said that they fell all the time and they then did not initiate the HIR.

The LTCH Inspector reviewed the resident's chart and there were no HIR assessments completed for any of the three recent un-witnessed falls. The resident was prescribed an anti-platelet medication.

The DOC stated it was an expectation for all un-witnessed falls and for all falls sustained by a resident who was being administered an anticoagulant, that HIR be initiated and completed as per the policy.

The licensee failed to ensure that their policy "Falls Prevention" policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who had fallen had a post fall assessment conducted using a clinically appropriate assessment instrument specifically designed for falls.

a) On an identified date in June 2019, resident #001 fell to the floor. They had pain and was transferred to the hospital.

b) On an identified date in August 2019, resident #002 was found on the floor in their bedroom and sustained injuries.

For both residents, staff completed a "Risk Management" report, an electronic tool used to report all types of incidents, as their initial post-fall assessment tool.

RPN #100 told the LTCH Inspector that when a resident had fallen, they were directed to complete a "Risk Management" tool in PCC as the only initial post fall assessment.

The home's "Falls Prevention" policy, policy #VII-G-30.00 with a last revision date of December 2015, directed staff to complete the electronic post fall assessment by using the "Post Fall Huddle" or "Fall Incident Report".

The Fall Lead/DOC said the "Risk Management" tool was the tool that staff were to initiate as an initial post fall assessment. They were unable to demonstrate that the tool had been reviewed based on evidence-based practice and said that it was not a clinically appropriate assessment instrument specifically designed for the assessment of falls.

The licensee failed to ensure that residents who had fallen were assessed using a clinically appropriate assessment instrument specifically designed for the assessment of falls. [s. 49. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 26th day of September, 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

Ministère de la Santé et 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 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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2019_787640_0024
Log No. / No de registre :	011959-19, 015198-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 25, 2019
Licensee / Titulaire de permis :	Corporation of the County of Grey 595 9th Avenue East, OWEN SOUND, ON, N4K-3E3
LTC Home / Foyer de SLD :	Lee Manor Home 875 Sixth Street East, OWEN SOUND, ON, N4K-5W5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renate Cowan

To Corporation of the County of Grey, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must ensure that:
1) Residents #001, #002 and #004, and any other resident, are provided with the care set out in their plans of care related to their toileting programs and,
2) Documentation is included in the PSWs documentation tools to demonstrate that the toileting program was provided as per the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to residents #001, #002 and #004.

a) Resident #001 was at moderate risk of falling and had multiple falls. They were assessed to be frequently incontinent of urine.

The Long-Term Care Homes (LTCH) Inspector reviewed the plan of care that directed staff, as part of a toileting program, to toilet the resident at specific times of the day, evening and night.

PSWs #101, #105 and #106 said the resident did not have a specific toileting program with actual times but they did toilet the resident before and after meals and when they asked.

b) Resident #002 was at moderate risk for falls and had three falls. Two falls resulted in significant injury. The resident required extensive assistance.

The resident told the LTCH Inspector the last time they fell, they had to use the

washroom and thought they could get there themselves. They fell and were found on the floor with significant injuries.

The plan of care directed staff, as part of a toileting program, to assist the resident to the washroom at specific times of the day, evening and night.

PSWs #101 and #102 told the LTCH Inspector the resident did not have a toileting program and they would assist the resident when they asked for help. They encouraged the resident to use the washroom after meals.

c) Resident #004 was at moderate to high risk for falls. They required extensive assistance of two persons.

The plan of care directed staff, as part of a toileting program, to assist the resident to the washroom at specific times of the day, evening and night and other times when the resident asked.

PSWs #102 and #103 told the LTCH Inspector that they take the resident to the toilet before breakfast and before lunch on the day shift. They said they did not know if the resident had specific times to be toileted in the plan of care. They said the resident tells them when they needed to use the washroom.

The Continence Lead said it was expected the residents be toileted as per their specific toileting plans and staff were to document when they toileted any resident.

The licensee failed to ensure that the toileting programs, included in the plan of care for residents #001, #002 and #004 were provided.

The severity of this issue was determined to be level 3, actual risk/actual harm. The scope of the issue was determined to be level 3, widespread. The compliance history was determined to be level 2, previous non-compliance in other areas of the LTCHA.
(640)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Nov 15, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of the LTCHA.

Specifically, the licensee must ensure that:

1) Any resident who meets the requirement for the initiation of head injury routine (HIR), according to the licensee's evidence-based HIR policy, that HIR is initiated and completed as per the licensee's policy.
2) All registered staff be provided education and training regarding the licensee's HIR policy and that a record is kept of that training and education.

Grounds / Motifs :

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 or protocol, the policy or protocol was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s.49(1), the license was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's policy "Fall Prevention", policy #VII-G-30.00 with a last revision date of December 2015, which directed staff to complete head injury routine (HIR) for suspected head injury, un-witnessed falls and for residents who were prescribed an anticoagulant. The HIR

included specific times for neurological assessment to be completed for 72 hours following the fall.

a) Resident #001 was assessed to be at moderate risk for falls and had nine falls.

On an identified date in July 2019, the resident had an un-witnessed fall and they sustained injuries.

RPN #101 said the HIR would have been initiated for this un-witnessed fall. The HIR was completed on paper and kept at the back of the resident's chart.

The clinical record was reviewed and HIR had been initiated following the fall.

On an identified date in August 2019, under the night shift heading, there was a note stating "sleeping" and the neurological assessment was not completed at that time.

The DOC told the LTCH Inspector that it was an expectation that HIR be completed at all times and that residents were to be wakened to have their assessment completed.

b) Resident #002 was assessed to be at high risk for falls and had three falls. All three falls were un-witnessed. The resident was being administered an anticoagulant.

The LTCH Inspector reviewed the clinical record, specifically the chart, and there were no HIR assessments located.

RPN #101 and the DOC both reviewed the resident's chart and were not able to locate any completed HIR forms for any of the three falls for resident #002.

c) Resident #003 was assessed to be at moderate risk for falls and had three un-witnessed falls.

RPN #104 said that they fell all the time and they then did not initiate the HIR.

The LTCH Inspector reviewed the resident's chart and there were no HIR assessments completed for any of the three recent un-witnessed falls. The resident was prescribed an anti-platelet medication.

The DOC stated it was an expectation for all un-witnessed falls and for all falls sustained by a resident who was being administered an anticoagulant, that HIR be initiated and completed as per the policy.

The licensee failed to ensure that their policy "Falls Prevention" policy was complied with.

The severity of this issue was determined to be level 2, minimal harm, minimal risk. The scope of this issue was determined to be level 3, widespread. The compliance history was determined to be level 2, previous non-compliance in other areas of the LTCHA.
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with s. 49 (2) of the LTCHA.

Specifically, the licensee must ensure that:

1) A clinically appropriate, evidence-based assessment instrument specifically designed for falls be implemented and,
2) All registered staff are provided training on the use of the specific falls assessment instrument and a record is kept of that training.

Grounds / Motifs :

1. The licensee failed to ensure that residents who had fallen had a post fall assessment conducted using a clinically appropriate assessment instrument specifically designed for falls.

a) On an identified date in June 2019, resident #001 fell to the floor. They had pain and was transferred to the hospital.

b) On an identified date in August 2019, resident #002 was found on the floor in their bedroom and sustained injuries.

For both residents, staff completed a "Risk Management" report, an electronic tool used to report all types of incidents, as their initial post-fall assessment tool.

RPN #100 told the LTCH Inspector that when a resident had fallen, they were directed to complete a "Risk Management" tool in PCC as the only initial post fall

assessment.

The home's "Falls Prevention" policy, policy #VII-G-30.00 with a last revision date of December 2015, directed staff to complete the electronic post fall assessment by using the "Post Fall Huddle" or "Fall Incident Report".

The Fall Lead/DOC said the "Risk Management" tool was the tool that staff were to initiate as an initial post fall assessment. They were unable to demonstrate that the tool had been reviewed based on evidence-based practice and said that it was not a clinically appropriate assessment instrument specifically designed for the assessment of falls.

The licensee failed to ensure that residents who had fallen were assessed using a clinically appropriate assessment instrument specifically designed for the assessment of falls.

The severity of this issue was determined to be level 2, minimal risk, minimal harm. The scope of the issue was determined to be level 3, widespread. The compliance history was determined to be level 3, previous non-compliance issued for the same section and subsection of the LTCHA, as follows:

- VPC issued under inspection #2018_678680_0002 on February 12, 2018. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 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 25th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

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