Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Jun 25, 2021	2021_715672_0024	006813-21, 008050-21	Complaint

Licensee/Titulaire de permis

Mon Sheong Foundation
36 D'Arcy Street Toronto ON M5T 1J7

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

Mon Sheong Richmond Hill Long Term Care Centre
11199 Yonge Street Richmond Hill ON L4S 1L2

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 10, 11 and 14, 2021

The following intakes were completed during this inspection:

One intake related to a Follow Up inspection regarding inspection report #2021_882760_0012, issued to the home on April 23, 2021, with a compliance due date of May 11, 2021, related to r. 229 (4) and the internal IPAC program.

One intake related to a complaint received by the Director regarding concerns related to resident care and the temperatures in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator (AA), Associate Director of Care (ADOC), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, recreation aides, health screeners, maintenance workers, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Nutritional Care, Skin and Wound Care, Fall Preventions and Hot Weather. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control and medication administration practices in the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Safe and Secure Home

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

- **6 WN(s)**
- **3 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. 229. (4)	CO #002	2021_882760_0012	672

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #010, #011 and #013, who required assistance with eating.

Residents #010, #011 and #013 were served and ingesting their meals while not seated in an upright position.

During separate interviews, PSWs #103 and #107 indicated specified residents were routinely not seated in upright positions during food/fluid intake for an identified reason.

During separate interviews, RNs #105 and #110, RPN #109, PSW #102, the Associate Director of Care and Assistant Administrator indicated the expectation in the home was for residents to be seated in upright positions for all food and fluid intake, to minimize the risk of the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted in the home; record review of residents #010, #011 and #013 current written plans of care; interviews with PSWs, RPNs, RNs, ADOC and AA. [s. 73. (1) 10.]

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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector noted that several bottles of medications were stored in resident #006's bedroom. Inspector observed two more random resident rooms of the same resident home area and observed multiple bottles of medications, medicated treatment creams, eye drops, diabetic and wound care treatments and supplies in residents #007 and #008's bedrooms.

During separate interviews, RN #105, the Associate Director of Care (ADOC) and Assistant Administrator (AA) indicated the expectation in the home was for medications and medicated treatment creams to be stored in the locked medication room when not being used.

Sources: Observations conducted in the home, interviews with RN #105, ADOC and AA. [s. 129. (1) (a)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's personal health information was kept confidential in accordance with the Personal Health Information Protection Act, 2004.

During resident observations, there was personal health information posted outside of residents #007 and #008's bedrooms.

During separate interviews, RN #105, the ADOC and AA verified the posted forms breached the resident's confidentiality and the forms would be removed.

By not ensuring resident's personal health information was kept confidential in accordance with the Personal Health Information Protection Act, they were placed at risk of having their confidentiality breached and personal information shared without providing informed consent.

Sources: Identified documentation; interviews with RN #105, the ADOC and AA. [s. 3. (1) 11. iv.]

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 resident's personal health information is kept confidential in accordance with the Personal Health Information Protection Act, 2004, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A complaint was received by the Director which alleged that hot temperatures were occurring in resident bedrooms in the home prior to when the central air conditioning was turned on, which was scheduled to occur at the end of the month of May. Review of the internal temperature monitoring records from an identified period of time indicated the licensee was monitoring air temperatures once daily, instead of the required three times per day. During separate interviews, the Assistant Administrator and Administrator verified temperatures in the home were only being measured and documented once per day.

By not ensuring temperatures were measured at a minimum of three times per day, as per the requirement, residents were placed at possible risk of being exposed to rooms with elevated temperatures, which could lead to discomfort and dehydration.

Sources: Internal temperature monitoring records, and interviews with the Assistant Administrator and Administrator. [s. 21. (3)]

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 temperatures required to be measured under subsection (2) are documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a hand-hygiene program in accordance with evidence-based practices.

A follow-up inspection was conducted from Inspection #2021_882760_0012, which was issued to the licensee on April 23, 2021, where a Compliance Order was issued with a compliance due date of May 11, 2021, related to the legislation specific to r. 229 (4) and the infection prevention and control practices in the home.

During observations conducted in the home, Inspector observed the following:

- No hand hygiene was offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.
- Staff were not observed completing hand hygiene between assisting/serving residents during meals and nourishment services.
- RN #101 was observed physically assisting a resident, then returned to the medication cart to resume medication administration without completing hand hygiene.

The observations demonstrated that that there were inconsistent IPAC practices from the staff of the home related to hand hygiene principles. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program specific to hand hygiene, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted; internal policies related to hand washing and outbreak management, interviews with PSWs, RPNs, RNs, the Associate Director of Care and Assistant Administrator. [s. 229. (9)]

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 there is a hand-hygiene program in accordance with evidence-based practices, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #002 and #004 received care as was specified in their plan.

Compliance Order (CO) #001 related to O. Reg. 79/10, s. 6 (7) from Inspection 2021_882760_0012 was issued to the home on April 23, 2021, with a compliance due date of June 21, 2021. The Compliance Order regarded resident #002 and their fall prevention interventions. Observations conducted during the inspection noted resident #002 did not have identified fall prevention interventions implemented. During separate interviews, PSWs #104, #111 and RN #105 indicated the identified fall prevention interventions were not implemented for identified reasons.

Resident #004 was also noted to be at risk for falling and had several fall prevention interventions in place to assist the resident. During observations conducted, resident #004 was noted to not have identified fall prevention interventions implemented. During separate interviews, PSW #114 and RN #105 indicated the resident did not have identified fall prevention interventions implemented for a specified reason. The Assistant Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan and if interventions were listed within the plan of care that were no longer relevant to the resident, they were to be removed from the care plan and the changes were to be communicated with the staff.

By not ensuring residents #002 and #004 had fall prevention interventions implemented as indicated in their plan of care they were placed at risk of sustaining falls and/or possibly sustaining injuries as a result of falling.

Sources: Observations conducted, residents #002 and #004’s written plans of care, interviews with PSWs #104, #111, #114, RN #105 and the Assistant Administrator. [s. 6. (7)]

Issued on this 28th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2021_715672_0024
Log No. / No de registre :	006813-21, 008050-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 25, 2021
Licensee / Titulaire de permis :	Mon Sheong Foundation 36 D'Arcy Street, Toronto, ON, M5T-1J7
LTC Home / Foyer de SLD :	Mon Sheong Richmond Hill Long Term Care Centre 11199 Yonge Street, Richmond Hill, ON, L4S-1L2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Li

To Mon Sheong Foundation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #010, #011 and #013, who required assistance with eating.

Residents #010, #011 and #013 were served and ingesting their meals while not seated in an upright position.

During separate interviews, PSWs #103 and #107 indicated specified residents were routinely not seated in upright positions during food/fluid intake for an identified reason.

During separate interviews, RNs #105 and #110, RPN #109, PSW #102, the Associate Director of Care and Assistant Administrator indicated the expectation in the home was for residents to be seated in upright positions for all food and fluid intake, to minimize the risk of the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted in the home; record review of residents #010, #011 and #013 current written plans of care; interviews with PSWs, RPNs, RNs, ADOC and AA.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as more than three residents were observed attempting to eat while in an unsafe position.

Compliance History: One or more areas of non-compliance were issued to the home related to different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with section s. 129. (1) (a) of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Ensure that drugs and medicated treatment creams are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, which is kept secured and locked when not in use.

2. Conduct weekly audits of the resident home areas until compliance is achieved, to ensure medicated treatment creams are being stored in an appropriate area or the medication cart as outlined in the regulation. Keep a documented record of the audits completed.

3. Re-educate nursing staff (both Registered and PSWs) to remind them of the requirement for drugs and medicated treatment creams to be stored in an area or medication cart that is used exclusively for drugs and drug-related supplies. Keep a documented record of the education provided and staff signatures that education was received and understood.

Grounds / Motifs :

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

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector noted that several bottles of medications were stored in resident #006's bedroom. Inspector observed two more random resident rooms of the same resident home area and observed multiple bottles of medications, medicated treatment creams, eye drops, diabetic and wound care treatments and supplies in residents #007 and #008's bedrooms.

During separate interviews, RN #105, the Associate Director of Care (ADOC) and Assistant Administrator (AA) indicated the expectation in the home was for medications and medicated treatment creams to be stored in the locked medication room when not being used.

Sources: Observations conducted in the home, interviews with RN #105, ADOC and AA.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as residents had access to medications and medicated treatment creams.

Scope: The scope of this non-compliance was widespread, as all three resident rooms assessed were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 16, 2021

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 25th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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