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

Sudbury Service Area Office
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159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2020	2020_679687_0007	009068-20, 010187-20	Complaint

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Gabriel's Villa of Sudbury
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): June 10-12, 15-18, and 23 to 26, 2020.

The following intakes were inspected during this Complaint Inspection.

- Two complaints submitted to the Director regarding menu options and food safety concerns.

A Critical Incident System (CIS) Inspection #2020_679687_0006 and a Follow-up Inspection #2020_679687_0005 were conducted concurrently with this inspection.

PLEASE NOTE: A Written Notification and Compliance Order related s 8 (1) (b) of the Ontario Regulation (O. Reg.) 79/10, was identified in a concurrent inspection #2020_679687_0006, and have been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Minimum Data Set (MDS) Coder, Personal Care Assistants (PCAs), Food Service Assistants (FSAs), Kitchen Cook, family members and residents.

During the course of the inspection, the inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Food Quality

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 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 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 Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

A) In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the home's "Narcotic – Missing" policy, last revised date December 7, 2018, which indicated that when there was a discrepancy in the narcotic count, the Registered Practical Nurse (RPN) would notify the Registered Nurse (RN) and a search would be conducted for a possible cause for the discrepancy.

The home submitted a Critical Incident (CI) report to the Director related to resident #001's missing narcotic medication.

Inspector #687 conducted a review of resident #001's electronic progress notes and identified that RPN #107 had documented that the resident's narcotic medication was missing.

In an interview with RPN #110 and #116, they both stated that when a registered staff received a report or discovered a missing narcotic medication from a resident, this would be reported immediately to the RN for further direction.

During an interview conducted by Inspector #687 with RN #106, the RN stated that they

were not aware of resident #001's missing narcotic medication. The RN further stated that when the resident's narcotic medication was noted missing by RPN #107, the RPN was expected to notify them immediately according to the home's Missing Narcotic policy.

In an interview with the Assistant Director of Care (ADOC), they stated that when resident #001's narcotic medication was noted missing by RPN #107, the RN was supposed to be notified immediately. The ADOC further stated that they had spoken to RPN #107 about this incident and was provided with education regarding missing and monitoring of narcotic medications.

B) In accordance with O. Reg 79/10, s 68 (2) (c), as part of the organized program of nutrition care and dietary services required under clause 11 (2) of the Act, the licensee must ensure that the program included the implementation of interventions to mitigate and manage those risks.

Specifically, the staff did not comply with the home’s “Food Service Temperatures” last reviewed March 7, 2019, which indicated that temperatures would be recorded for each dining room and that Food Service staff would be accountable for accurate recording to ensure that all food items were safe for consumption and to prevent the growth of and/or toxin production by pathogens in potentially hazardous food.

A complaint was submitted to the Director which indicated an alleged incident of uncooked food served by the home.

During an observation in a specified dining room, Inspector #687 observed that Food Service Assistant (FSA) #129 had not taken the food/fluid temperatures prior to serving meals to two residents.

In another observation conducted by Inspector #687, it was observed that FSA #136 had not taken the food/fluid temperatures prior to serving meals to eleven residents.

In a record review of the Daily Food/Fluid Temperatures from the specified home area for the month of May 2020, Inspector #687 identified that the food/fluid temperatures were not taken 19 days and was only partially taken three days out of 28 days.

Inspector #687 conducted an interview with FSA #129 and they stated that they should have had taken the food/fluid temperatures prior to serving meals to residents in the

dining room and that they were sorry.

In an interview with the Food Service Manager (FSM), they stated that food temperatures were taken initially in the kitchen and prior to the FSA serving the food in the dining room home areas. The FSM further stated that the food temperature check was important for the resident's health and safety. The FSM acknowledged that they had identified and investigated this incident in the past and re-educated the staff member. [s. 8. (1) (b)]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the evening meal was not served before 5:00 p.m.

A complaint was submitted to the Director which indicated an alleged incident of uncooked food served by the home.

During an observation in a specified dining room, Inspector #687 observed that FSA #129 had served a dinner meal to resident #012 and #021 prior to 1700 hours.

In another observation conducted in a different dining room, Inspector #687 observed that FSA #136 had served meals to eleven residents prior to 1700 hours.

Inspector #687 reviewed the home's Daily Meal times posted on the board for the two specified dining room areas and identified that dinner meal service was at 1700 hours.

A review of the home's policy titled "Meal Service – Villas", last revised on November 18, 2018, indicated that meal time schedule was at:
- Breakfast: 0900;
- Lunch: 1230, and
- Dinner: 1700.

In an interview with FSA #129, they stated that dinner meal service would start at 1700 hours.

During an interview with the FSM, they acknowledged that the dinner meal service was at 1700 hours. The FSM further stated that the FSAs were not supposed to serve the dinner meal service before 1700 hours as this was a mandate under the Long Term Care Act. [s. 71. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the evening meal is not served before 5:00 p.m., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system provided documentation on the production sheet of any menu substitutions.

A complaint was submitted to the Director which indicated an alleged incident of uncooked food served by the home.

a) During an observation in a specified dining room, Inspector #687 observed that the modified texture dessert being served was different from the Therapeutic Menu production sheet.

In an interview with FSA #133, they stated that in the Therapeutic Menu production sheet for modified texture dessert, it indicated a specific dessert but was substituted with a different dessert instead.

b) During an observation in the adjacent dining room, Inspector #687 observed that the modified texture dessert was different from the Therapeutic Menu production sheet.

In an interview with FSA #126, they stated that in the Therapeutic Menu production sheet for modified texture dessert, it indicated a specific dessert but was substituted with a different dessert instead.

c) During an observation in another dining room, Inspector #687 observed that modified texture dessert was different from the Therapeutic Menu production sheet.

In an interview with FSA #133, they stated that in the Therapeutic Menu production sheet for modified texture dessert, it indicated a specific dessert but was substituted with a different dessert instead. The FSA further stated that any revision of the Therapeutic Menu production sheet was done by the FSM.

During an interview with the FSM, they indicated that for any menu substitution, the FSM would be consulted prior to any menu changes and direction would be provided to their staff. The FSM further stated that any menu change would be communicated verbally to their staff as they do not document this in a paper format. The FSM acknowledged that they were not aware of the Therapeutic Menu substitution for the modified texture dessert on the specified dates. [s. 72. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system provides for documentation on the production sheet of any menu substitutions, to be implemented voluntarily.

WN #4: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service which included communication of the seven-day and daily menus to residents.

A complaint was submitted to the Director which indicated an alleged incident of uncooked food served by the home.

During observations conducted by Inspector #687, the Inspector identified that in three specified home areas, the “Regular Week at a Glance” food menu was different from the posted Daily Menu.

In a subsequent observation conducted by Inspector #687, the Inspector identified that in a specified home area, the dinner Daily Menu was not posted.

Furthermore, Inspector #687 identified that in a specific home area, the “Regular Week at a Glance” food menu continued to be posted different than the Daily Menu.

An interview was conducted by Inspector #687 with resident #008, #009, #011, #014, #015, #016, and #017, the residents all indicated that they were not aware of the Daily Menu. Resident #015 further stated that “It would be nice to know ahead of time”.

During an interview with Personal Care Assistant (PCA) #118 and 119, the PCAs both identified and verified that the “Regular Week at a Glance” food menu in the specified home area was different than the posted Daily Menu.

Inspector #687 interviewed RPN #110, the RPN stated that the posted Daily Menu for the specified home area was completely incorrect for the specified date.

During an interview with the FSA #117, the FSA stated that the “Regular Week at a Glance Menu” was different than the posted Daily Menu. The FSA further stated that the Regular Week at a Glance menu was supposed to be changed by the specified FSA staff on a specified date, but this did not occur.

In an interview with the FSM, they acknowledged that the posted Daily Menu was different than the “Regular Week at a Glance” menu in the specified dining room. The FSM further stated that the posted Daily Menu and the “Regular Week at a Glance” menu were supposed to be changed by the specified staff at a specified schedule to ensure that the up-to-date menu was posted in the dining room. The FSM stated that the staff members would be informed about this incident. [s. 73. (1) 1.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

During an observation conducted by Inspector #687 in the specified dining room area, resident #012 was observed with a specified meal in front of them but no staff was available to assist them. Ten (10) minutes later, the Inspector observed PCA #113 had returned to the dining room to assist resident #012 with their meal.

In a review of resident #012’s electronic care plan record in effect at that time, Inspector #687 identified that resident #012 required total dependence from staff for nutrition and

hydration.

Inspector #687 reviewed the home's policy titled "Meal Service – Villas" last reviewed date August 12, 2019, which indicated that residents who needed assistance would not be served their meal until staff were seated and ready to assist.

In an interview with PCA #113, they stated that they were not there to assist resident #012 when the specified meal was served to the resident.

Inspector #687 conducted an interview with RPN #112, the RPN stated that the specified meal was served to resident #012 before the PCA was available to assist them.

In an interview conducted by Inspector #687 with the Director of Care (DOC), the DOC indicated that for residents who required total assistance with their meal, a staff member must be present in the dining room prior to serving the food to the resident. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home had a dining and snack service that includes communication of the seven-day and daily menus to residents, and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

Issued on this 21st day of July, 2020

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) :	LOVIRIZA CALUZA (687)
Inspection No. / No de l’inspection :	2020_679687_0007
Log No. / No de registre :	009068-20, 010187-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 16, 2020
Licensee / Titulaire de permis :	St. Joseph's Health Centre of Sudbury 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	St. Gabriel's Villa of Sudbury 4690 Municipal Road 15, Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Ray Ingriselli

To St. Joseph's Health Centre of Sudbury, 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. 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 O. Reg 79/10.

1. Specifically, the licensee must:

a) Ensure that all registered staff review the home's policy titled ”Narcotic – Missing”, last revised date December 7, 2018. This process should be documented to include; the dates of the review, the names and classifications of the staff who completed the review, the content of the review, and any other pertinent documents.

b) Ensure that any discrepancy in the narcotic count, the Registered Nurse (RN) is notified and search is conducted for a possible cause of the discrepancy.

2. In addition, the licensee must:

a) Ensure that the food and fluid temperatures are taken in each dining room servery by the Food Service Assistants (FSAs) prior to serving meals to residents;

b) Document and maintain an accurate record of the food and fluid temperatures in the dining room servery, and

c) Develop and conduct weekly audits to ensure that food and fluid temperatures are within the recommended temperatures by the Sudbury & District Health Unit for the next three months, and to maintain a record of the conducted audits.

Grounds / Motifs :

1. The licensee has failed to ensure that, where Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the home's ”Narcotic – Missing” policy,

last revised date December 7, 2018, which indicated that when there was a discrepancy in the narcotic count, the Registered Practical Nurse (RPN) would notify the Registered Nurse (RN) and a search would be conducted for a possible cause for the discrepancy.

The home submitted a Critical Incident (CI) report to the Director related to resident #001's missing narcotic medication.

Inspector #687 conducted a review of resident #001's electronic progress notes and identified that RPN #107 had documented that the resident's narcotic medication was missing.

In an interview with RPN #110 and #116, they both stated that when a registered staff received a report or discovered a missing narcotic medication from a resident, this would be reported immediately to the RN for further direction.

During an interview conducted by Inspector #687 with RN #106, the RN stated that they were not aware of resident #001's missing narcotic medication. The RN further stated that when the resident's narcotic medication was noted missing by RPN #107, the RPN was expected to notify them immediately according to the home's Missing Narcotic policy.

In an interview with the Assistant Director of Care (ADOC), they stated that when resident #001's narcotic medication was noted missing by RPN #107, the RN was supposed to be notified immediately. The ADOC further stated that they had spoken to RPN #107 about this incident and was provided with education regarding missing and monitoring of narcotic medications.
(687)

2. In accordance with O. Reg 79/10, s 68 (2) (c), as part of the organized program of nutrition care and dietary services required under clause 11 (2) of the Act, the licensee must ensure that the program included the implementation of interventions to mitigate and manage those risks.

Specifically, the staff did not comply with the home's "Food Service Temperatures" last reviewed March 7, 2019, which indicated that temperatures would be recorded for each dining room and that Food Service staff would be

accountable for accurate recording to ensure that all food items were safe for consumption and to prevent the growth of and/or toxin production by pathogens in potentially hazardous food.

A complaint was submitted to the Director which indicated an alleged incident of uncooked food served by the home.

During an observation in a specified dining room, Inspector #687 observed that Food Service Assistant (FSA) #129 had not taken the food/fluid temperatures prior to serving meals to two residents.

In another observation conducted by Inspector #687, it was observed that FSA #136 had not taken the food/fluid temperatures prior to serving meals to eleven residents.

In a record review of the Daily Food/Fluid Temperatures from the specified home area for the month of May 2020, Inspector #687 identified that the food/fluid temperatures were not taken 19 days and was only partially taken three days out of 28 days.

Inspector #687 conducted an interview with FSA #129 and they stated that they should have had taken the food/fluid temperatures prior to serving meals to residents in the dining room and that they were sorry.

In an interview with the Food Service Manager (FSM), they stated that food temperatures were taken initially in the kitchen and prior to the FSA serving the food in the dining room home areas. The FSM further stated that the food temperature check was important for the resident's health and safety. The FSM acknowledged that they had identified and investigated this incident in the past and re-educated the staff member.

The severity of this issue was determined to be a level two, as there was a minimal risk or harm to a number of residents. The scope of the issue was a level three as it was determined to be widespread. The home had a level three compliance history, as they had non-compliance to the same subsection in the previous 36 months under O. Reg. 79/10, which included:

- Voluntary Plan of Correction (VPC) issued February 25, 2019, in inspection report #2019_655679_0005;

- VPC issued December 3, 2019, in inspection report #2019_671684_0040;

- Written Notification (WN) issued February 25, 2019, in inspection report #2019_655679_0006, and

- Compliance Order (CO) issued October 24, 2017, in inspection report #2017_668543_0004.
(687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 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 16th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Loviriza Caluza

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