Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2017	2017_526664_0006	006969-17	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

FAYLYN KERR-STEWART (664)

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): May 5, 8, 10, 16,18, 19, 2017.

During the course of the inspection, the inspector conducted a review of the resident's health records, incident investigation records, staff schedules, staff personal records, relevant policies and procedures and conducted staff interviews.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Interim Director of Care (I-DOC), Resident Care Coordinator (RCC), On-Call Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist and Personal Care Providers (PCPs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents are not neglected by the licensee or staff.

A Critical Incident System report (CIS) was submitted to the MOHLTC on an identified date in 2017, related to resident #029's falls with injury.

A review of the CIS report revealed that on an identified date, resident #029 had a fall that resulted in an injury and was taken to the hospital. The CIS further revealed that at the time of the incident, the resident sustained an injury and changes in his/her medical condition. The medical doctor was notified and an order was given for specified medication that was administered. The Substitute Decision Maker (SDM) was notified of the fall. The following morning, the resident was found unresponsive and was transferred to the hospital.

A review of resident #029's plan of care on a specified date, revealed the resident was at high risk for falls and required assistance with transfers. Staff were directed to do the following:
- provide supervision / cuing with one staff during transfers and to ensure the resident is using a specified ambulation device.
- Ensure the appropriate safety device is in use and ambulation device is within reach.
- Remind resident to call for assistance and wait before getting up.
- Remind resident to walk slowly and take their time getting to locations.

A review of resident #029's progress notes in PointClickCare (PCC), revealed the day before the fall at an identified time resident #029 was found on the floor inside his/her room and complained of pain to an identified area.
- The resident's gait was assessed after the fall, he/she was given a mobility device and was monitored by staff at the nursing station.
- In accordance with the home's policy, registered staff initiated a specified assessment after the fall.
- Later that day, resident #029 complained of pain and was given a medication.
-In comparison to previous recordings in the progress notes, the resident's medical condition worsened after the fall.

A further review of resident #029's progress notes in PCC, and the specified assessment flow sheets revealed that on an identified day in April 2017, at an identified time, resident #029 was exhibiting behaviours that required treatment.
- The resident sustained a second fall inside his/her room when the student PSW #141 assisted the resident to his/her room.
- Resident #029 sustained an injury; and later demonstrated a change in behaviour.

-Assessments completed after the fall indicated a deterioration in the resident's condition and the physician was notified, and a prescribed treatment was administered.
- Later that night, an entry in resident #029's medical record indicated the treatment was not effective in managing the resident's symptoms; however, a further review of the progress notes did not indicate whether the physician was notified that the prescribed treatment was ineffective in managing the resident's symptom.
-Though the specified assessment Flow Sheet indicated four types of assessments were to be completed at specified time intervals until 72 hours is reached, after the second fall, the specified assessments resumed, as directed by the home's policy and continued for one hour. Following this period, though assessments and monitoring indicated a further deterioration in resident #029's condition, at varying times during the next 24 hrs., specified assessments were not noted in the resident's file for up to six hours, or were not completed at all. Assessments and monitoring of resident #029 ceased after only four hrs. after the fall. Assessment and monitoring was not completed during the night shift. The following morning when resident #029 was found to be unresponsive, specified assessments were completed and showed significant changes in his/her condition. The resident was subsequently transferred to hospital.

In an interview with Registered Practical Nurses (RPN) #175, he/she acknowledged that resident #029 was not monitored during the night on a specified date; and stated he/she had not informed the physician that the prescribed treatment was not effective in managing the resident's symptom. RPN #175 further stated the home's expectation was to complete specified assessments in accordance with the home's policy, and in this case, he/she failed to do so.

Resident Care Coordinator (RCC) #160, in an interview, verified the home's expectation was for staff to complete specified assessments in accordance with the home's policy. RCC #160 further acknowledged that monitoring observed on the assessment forms on identified dates were incomplete, and was therefore, not in accordance with the home's policy.

In an interview with interim Director of Care (DOC) #172, he/she acknowledged that assessments had not been completed by RPN #175, and this was not in accordance with the home's Policy. DOC #172 affirmed that assessments were to be completed at the intervals noted on the assessment Flow Sheet for up to 72 hours post fall to assist staff in identifying changes in a resident's condition, and RPN #175 failed to do so.

Following the initial fall on the identified date, though resident #029 exhibited significant

changes in symptoms, staff took limited action in response to changes.

Resident #029 experienced a second fall a day later, and further deteriorated. Despite the significant deterioration, staff failed to closely monitor and take action in response to these changes.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date in2017, related to falls in which the resident sustained an injury.

A review of resident #029's progress notes revealed that on a specified date, the resident had an unwitnessed fall inside his/her room without a physical injury. Resident #029 complained of pain. Further review of the progress notes revealed registered nursing staff documented that the resident now required the use of an ambulation device, and other protective devices for safety, as new interventions.

A review of resident #029's plan of care on a specified date in 2017, revealed the resident was at high risk for falls and required assistance with transfers. Staff were directed to do the following:
- provide supervision / cuing with one staff during transfers and to ensure the resident is using his/her ambulation device.
- Ensure appropriate safety device is in use and the ambulation device is within reach.
- Remind resident to call for assistance and wait before getting up.
- Remind resident to walk slowly and take their time getting to locations.

A further review of resident #029's plan of care failed to include the use of the new ambulation device and other safety devices.

In an interview, RPN #149 stated that after the first fall, resident #029 required an ambulation device for safety including, close monitoring near the nursing station. RPN #149 confirmed that it was the home's expectation that the plan of care is to be updated when there is a significant change in the resident's condition.

Interviews with RPNs #140 and #174 also verified that the plan of care did not include the resident's use of a specified ambulation device. Both RPNs confirmed the home's expectation is to update the plan of care when there is a significant change in a resident's condition.

In an interview, RPN #173 acknowledged that the resident's plan of care was not reviewed and revised to reflect the significant change in the resident's condition. RPN #173 confirmed that updating the resident's plan of care would be important in communicating significant changes and care requirements to other staff.

Resident Care Coordinator (RCC) #160, in an interview, stated that the home's expectation was to revise the resident's plan of care, when there is a significant change in the resident's condition. He/she confirmed that resident #029's plan of care was not revised to include the resident's need for a new assistive device. [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that 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 that it is complied with.

A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date in 2017, related to falls in which the resident sustained injury.

A review of home's policy, #LTC-CA-WQ-200-07-04 with a revised date in 2014, directs registered staff to initiate specified assessments in four areas of focus that are to be compared with the resident's normal clinical status following injury to a specified body part, as a result of a fall. Once initiated, this assessment will continue for up to 72 hours (hrs.) unless it is ordered discontinued by the physician / nurse practitioner.

A review of resident #029's progress notes in PointClickCare (PCC), revealed the day before the fall, resident #029 was found on the floor inside his/her room and complained of pain to an identified area.
- In accordance with the home's policy, registered staff initiated a specified assessment after the fall.
-Though documentation related to resident #029 indicated there were changes in the resident's medical condition, at varying times throughout the 24 hrs. after the fall, specified assessments of resident #029 were not completed for up to six hours. Assessment and monitoring of the resident's condition ceased after 25 hrs.

A further review of resident #029's progress notes in PCC, and the specified assessment flow sheets in an identified month in 2017, revealed that on an identified day in 2017, resident #029 exhibited behaviours that required treatment.

- The resident sustained a second fall inside his/her room when the student PSW #141 assisted the resident to his/her room.
- Resident #029 sustained an injury; and later had a change in behaviour.

-A further review of specified assessments on an identified date, indicated the resident had a second fall and assessments resumed, as directed by the home's policy and continued for one hour though assessments and monitoring of resident #029's condition during that hour indicated a further deterioration in resident #029's condition.
- the physician was notified, and a prescribed treatment was administered, however, though an entry in the progress notes indicated the treatment was not effective in managing the resident's symptoms, there was no indication the physician was notified that the treatment was not effective in managing the resident's symptoms.
-During the night shift, there was no documentation observed on the assessment flow sheet or in the progress notes; and resident #029 was found to be unresponsive and an assessments completed at that time showed significant changes in his/her condition. The resident was subsequently transferred to hospital.

In an interview with Registered Practical Nurses (RPN) #175 he/she acknowledged that resident #029 was not monitored during the night on an identified date in 2017. RPN #175 stated the Home's expectation was to complete specified assessments in accordance with the policy, and in this case, he/she failed to do so.

Resident Care Coordinator (RCC) #160, in an interview, verified the Home's expectation was for staff to complete the specified assessments in accordance with the home's

policy. RCC #160 acknowledged that assessments and monitoring observed during an identified date range was incomplete, and was therefore, not in accordance with the Home's assessment policy.

In an interview with interim Director of Care (DOC) #172, he/she acknowledged that specified assessments had not been completed by RPN #175 and this was not in accordance with the home's policy. DOC #172 affirmed that specified assessments are to be completed at the intervals noted on the assessment Flow Sheet for up to 72 hours post fall to assist staff in identifying changes in the resident's condition, and RPN #175 failed to do so.

Resident #029 experienced significant changes in his/her condition following two falls in two consecutive months in 2017. The home's policy directed staff to initiate specified assessments after each fall, and to monitor and report changes in the resident's condition to the registered nurse in charge. RPN #175 failed to comply with the home's policy to monitor resident #029 after he/she fell and sustained injuries.

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 Fall Prevention Program's policy that is required by a long-term care home to the have, institute or otherwise put in place under section 30 (1) of the Regulation, the policy is complied with, to be implemented voluntarily.

Issued on this 21st day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FAYLYN KERR-STEWART (664)
Inspection No. / No de l'inspection :	2017_526664_0006
Log No. / No de registre :	006969-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 1, 2017
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Woodhaven Long Term Care Residence 380 Church Street, MARKHAM, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jason Gay

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Every licensee of a long-term care home shall ensure that residents are not neglected by the licensee or staff.

Upon receipt of this report, the licensee shall prepare, submit and implement a plan that includes but is not limited to:

1. Education of registered staff related to specified assessment of residents following an injury, or adverse event.
2. Documentation of specified assessments according to the home's policy.
3. Identification of changes in a resident's condition, or presence of new symptoms in comparison to the resident's previous baseline assessment.
4. Reporting changes in a resident's condition to the physician or nurse practitioner on duty.
5. Ongoing monitoring and evaluation of the effectiveness of prescribed treatment(s) by the registered staff, in accordance with the home's policy.
6. Notifying the physician or nurse practitioner on duty when a prescribed treatment is not effective in managing the resident's symptoms.
7. The plan will include an auditing system to ensure staff are compliant with items 1 through 6.
8. Please include the timeline and person responsible for the implementation and evaluation of the plan.

Please submit the plan to fay.kerr-stewart@ontario.ca, no later than August 14, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not neglected by the

licensee or staff.

A Critical Incident System report (CIS) was submitted to the MOHLTC on an identified date in 2017, related to resident #029's falls with injury.

A review of the CIS report revealed that on an identified date, resident #029 had a fall that resulted in an injury and was taken to the hospital. The CIS further revealed that at the time of the incident, the resident sustained an injury and changes in his/her medical condition. The medical doctor was notified and an order was given for specified medication that was administered. The Substitute Decision Maker (SDM) was notified of the fall. The following morning, the resident was found unresponsive and was transferred to the hospital.

A review of resident #029's plan of care on a specified date, revealed the resident was at high risk for falls and required assistance with transfers. Staff were directed to do the following:
- provide supervision / cuing with one staff during transfers and to ensure the resident is using a specified ambulation device.
- Ensure the appropriate safety device is in use and ambulation device is within reach.
- Remind resident to call for assistance and wait before getting up.
- Remind resident to walk slowly and take their time getting to locations.

A review of resident #029's progress notes in PointClickCare (PCC), revealed the day before the fall at an identified time resident #029 was found on the floor inside his/her room and complained of pain to an identified area.
- The resident's gait was assessed after the fall, he/she was given a mobility device and was monitored by staff at the nursing station.
- In accordance with the home's policy, registered staff initiated a specified assessment after the fall.
- Later that day, resident #029 complained of pain and was given a medication.
-In comparison to previous recordings in the progress notes, the resident's medical condition worsened after the fall.

A further review of resident #029's progress notes in PCC, and the specified assessment flow sheets revealed that on an identified day in April 2017, at an identified time, resident #029 was exhibiting behaviours that required treatment.
- The resident sustained a second fall inside his/her room when the student PSW #141 assisted the resident to his/her room.

- Resident #029 sustained an injury; and later demonstrated a change in behaviour.
-Assessments completed after the fall indicated a deterioration in the resident's condition and the physician was notified, and a prescribed treatment was administered.
- Later that night, an entry in resident #029's medical record indicated the treatment was not effective in managing the resident's symptoms; however, a further review of the progress notes did not indicate whether the physician was notified that the prescribed treatment was ineffective in managing the resident's symptom.
-Though the specified assessment Flow Sheet indicated four types of assessments were to be completed at specified time intervals until 72 hours is reached, after the second fall, the specified assessments resumed, as directed by the home's policy and continued for one hour. Following this period, though assessments and monitoring indicated a further deterioration in resident #029's condition, at varying times during the next 24 hrs., specified assessments were not noted in the resident's file for up to six hours, or were not completed at all. Assessments and monitoring of resident #029 ceased after only four hrs. after the fall. Assessment and monitoring was not completed during the night shift. The following morning when resident #029 was found to be unresponsive, specified assessments were completed and showed significant changes in his/her condition. The resident was subsequently transferred to hospital.

In an interview with Registered Practical Nurses (RPN) #175, he/she acknowledged that resident #029 was not monitored during the night on a specified date; and stated he/she had not informed the physician that the prescribed treatment was not effective in managing the resident's symptom. RPN #175 further stated the home's expectation was to complete specified assessments in accordance with the home's policy, and in this case, he/she failed to do so.

Resident Care Coordinator (RCC) #160, in an interview, verified the home's expectation was for staff to complete specified assessments in accordance with the home's policy. RCC #160 further acknowledged that monitoring observed on the assessment forms on identified dates were incomplete, and was therefore, not in accordance with the home's policy.

In an interview with interim Director of Care (DOC) #172, he/she acknowledged that assessments had not been completed by RPN #175, and this was not in

accordance with the home's Policy. DOC #172 affirmed that assessments were to be completed at the intervals noted on the assessment Flow Sheet for up to 72 hours post fall to assist staff in identifying changes in a resident's condition, and RPN #175 failed to do so.

Following the initial fall on the identified date, though resident #029 exhibited significant changes in symptoms, staff took limited action in response to changes.

Resident #029 experienced a second fall a day later, and further deteriorated. Despite the significant deterioration, staff failed to closely monitor and take action in response to these changes. (664)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Faylyn Kerr-Stewart

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