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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jun 1, 2018	2018_624196_0011	027501-17, 028248-17, 000220-18, 002672-18, 003265-18	Complaint

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Birchwood Terrace
237 Lakeview Drive, R.R. #1 KENORA ON P9N 4J7

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

LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)

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): April 23 - 27, 2018

The following intakes were inspected during this Complaint Inspection:
one intake related to staffing levels;
one intake related to 24 hour RN staffing; and
three intakes related to resident care concerns.

A Follow Up inspection #2018_624196_0012 and a Critical Incident System inspection #2018_624196_0013 was conducted concurrently with this Complaint inspection. Non-compliance related to LTCHA 2007, c.8, s.8. (3) identified during this Complaint inspection will be identified in the Follow Up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinator, Ward Clerk/Scheduler, residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health care records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

5 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	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A complaint was received by the Director related to the provision of personal support services to residents in the home. The complaint alleged that the home did not have sufficient staffing in the home on a specific date, with which to provide adequate personal support services to the residents in the home.

During an interview with PSW #103, they reported that, on a specific date in 2018, they had been the only PSW on the day shift on the floor providing care to approximately 40 residents. They added that there were 13 residents that required a particular type of assistance with an activity of daily living, and four residents that required a different type of assistance with an activity of daily living. They further reported that they had been unable to provide specific aspects of resident care. In addition, they stated resident #015 was not provided with a specific type of assistance and resident #004 was not provided with a specific type of care for the entire day shift despite a physician's order that specified the care was to be provided. PSW #103 added that an Activation staff member had assisted with an aspect of resident care and the RPN, RN, and one of the Quality Assistants had provided additional support to the residents.

During an interview with the Office Manager, they reported that they were the "Manager in Charge" (MOC) on a specific weekend in 2018, and came into the home at 0730 to 1130 hours (hrs) on both days. They stated, at approximately 0800hrs, on one of the days, the kitchen staff had told them the home was short PSWs. They added that they were aware that, on both of these days the home was short PSWs, but they were not

sure of the numbers of staff short, but knew it was less than three PSWs per floor.

During an interview with the Ward Clerk/Scheduler, after a review of PSW schedules with Inspector #196, they confirmed the PSW staffing levels on three specific day shifts.
- on the day shifts of two specific dates in 2018, there was one PSW on both of the floors; and
- on the day shift of another specific date in 2018, there were two PSWs on one floor and one PSW on the other floor.

During an interview with the DOC, they reported there had been shifts in which there had been only one PSW working on a floor providing care to approximately 40 residents and that a particular aspect of resident care was not always being done. They confirmed that when there was only one PSW working on a floor, the staff were not able to provide all of the required care to the residents as indicated in their plans of care. They further reported that on each floor, normally, there were three PSWs scheduled on the day and evening shifts; the home's census was less than full and the use of agency staff was no longer an option as it was cost prohibitive.

During an interview with the Administrator, they reported that they were the MOC on a specific weekend in 2018, and acknowledged that there had been one PSW on the one of the floors on the day shift; that the Activation staff had assisted with an aspect of resident care; that they had assisted in the dining room; and that they thought the home had managed to get the resident care done. In addition, they stated they had attempted to call staff in to work but had been unable to replace the staff. They also reported that the use of agency staff had been financially difficult for the home. [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 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 the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #687 reviewed a complaint that was reported to the Director in 2017 related to resident #001's fall incidents.

According to the complaint report, resident #001's Substitute Decision Maker (SDM) stated that the resident sustained five fall incidents starting in the fall of 2017. The SDM further stated that on a specific date in 2017, resident #001 fell and sustained an injury which resulted in immediate transfer to the hospital despite strategies that were implemented by the home to minimize the resident's fall incidents.

Inspector #687 reviewed resident #001's progress notes from the date of the fall in 2017, and identified that resident #001 fell during an activity of daily living. The progress notes also described that the resident's injury prevention device were not in place.

Inspector #687 reviewed resident #001's care plan, which identified that the resident was at risk for falls characterized by a particular action. Resident #001's fall interventions were to ensure that the injury prevention device were placed on both sides of the bed.

Inspector #687 reviewed the home's policy titled "Care Planning" last updated April 2017, which indicated that the resident plan of care, which included the care plan, served as a communication tool which promoted safe and effective resident care. The care plan provided documentation which identified immediate risk to safety and care needs of a resident and allowed the care team to implement strategies to mitigate risk and provide appropriate care to the resident.

Inspector #687 interviewed RPN #105 and RN #107, who verified that residents who were at risk for falls, would have the risk identified in their care plan and their falls interventions would be individualized.

Inspector #687 interviewed the Director of Care (DOC), who indicated that it was their expectation that all their staff were to follow the falls interventions as stated in the resident's care plan. [s. 6. (7)]

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 that ensures that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the programs referred to in clauses (1) (a) and (b).

A complaint was submitted to the Director regarding the nursing and personal support worker (PSW) staffing levels in the home.

During a record review, Inspector #196 could not locate a copy of the home's written staffing plan for the nursing and personal support services program.

During an interview with the Administrator, the Inspector requested a copy of the home's written staffing plan for the nursing and personal support services.

During an interview with the DOC, they reported that the Administrator had requested a copy of the home's written staffing plan for nursing and personal support services and they were unable to find one.

During a follow up interview with the Administrator, they reported to Inspector #196, that they could not provide a written staffing plan and they were making a written staffing plan for nursing and personal support services at that time. [s. 31. (2)]

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 that ensures there is a written staffing plan for the programs referred to in clauses (1) (a) and (b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with PSW #112 on a day during the inspection, they reported that the baths/showers had not been done on the day shift due to short staffing of PSWs.

During an interview with RN #104, they reported that staff had not communicated any missed baths to them.

The floor "resident care and bath list" was reviewed and indicated residents #016, #017, #018, #019, and #020, were scheduled to have a bath on the day shift on that particular day.

A review of the Point of Care charting was conducted by the Inspector with the RAI Coordinator. The RAI Coordinator confirmed that the bathing activity on that date, was documented as "Activity did not occur" for all five identified residents. A further review indicated that resident #016, #017, #018, #019, and #020, had not had a bath documented for one full week previous to this date.

The Ward Clerk/Scheduler reported that PSW #112 and PSW #113 worked both the day and evening shifts on the floor on this date, and they were unaware whether baths had been done the day before, on either the day or evening shifts.

During a follow up interview with PSW #113 on the following day, they reported that there were no extra staff brought in on the evening shift the day previous to complete the missed baths and the baths were not provided.

During an interview with the Administrator, they reported they were aware that on that specific date, the floor had two PSWs working the day shift. They added that staff were to postpone bathing until the next shift if needed and then they were to provide the missed baths if the staff were unable to get the baths done. They indicated that it was up to the registered staff to inform the management if they were having difficulty with providing resident care. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the care plan identified the resident and included, at a minimum, the following with respect to the resident: Known health conditions, including allergies and other conditions of which the licensee should have been aware upon admission, including interventions.

Inspector #687 reviewed a complaint that was reported to the Director in 2017, related to resident #001's roommate who had a specific medical diagnosis.

According to the complaint report, resident #001's Substitute Decision Maker (SDM) felt that resident #001 acquired a medical condition from their roommate, resident #008.

In a record review of resident #001's progress notes dated on a date in 2017, the resident was admitted to a room, where resident #008 was also a resident.

In a record review conducted by Inspector #687 with resident #008's New Admission

Information Form and Interfacility Transfer form on a particular date in 2017, indicated that resident #008 had an admitting diagnoses and required a type of medical treatment.

Inspector #687 conducted a record review of the home's policy titled "Care Planning" last updated on April 2017, where it indicated that the nurse was responsible for completing a 24 hours Admission Care Plan that was to be developed immediately after admission, based on information obtained during the admission process.

Inspector #687 conducted a record review of resident #008's admission care plan and identified that resident #008 did not have any focus for the specific type of medical treatment. This was further verified by the Inspector on the resident's resolved care plan; the care plan was not updated to reflect the resident's admission diagnosis and the type of medical treatment.

In an interview with PSW #106, registered practical nurse (RPN) #105 and registered nurse (RN) #104, they all stated that when residents were identified with a type of medical treatment, the resident's care plan would be updated to reflect this.

In an interview with Inspector #687, the Director of Care (DOC) stated that it was their expectation that registered staff would ensure that during the resident's admission process, the type of medical treatment would be identified and be incorporated into the resident's care plan immediately. This was to ensure that an appropriate intervention was posted for staff and others so that they could follow appropriate medical care. [s. 24. (2) 6.]

Issued on this 12th day of June, 2018

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) :	LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2018_624196_0011
Log No. / No de registre :	027501-17, 028248-17, 000220-18, 002672-18, 003265-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 1, 2018
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pat Stephenson

To CVH (No. 2) LP, 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must comply with s. 8 (1) of the Long-Term Care Homes Act, 2007.

(a) The licensee shall ensure there is an organized program of personal support services for the home to meet the assessed needs of the residents.

(b) The licensee shall ensure that there is a written staffing plan for the programs referred to in clauses (1)(a) and (b). O. Reg. 79/10, s.31 (2).

(c) The licensee shall ensure that the staffing plan is developed and implemented in consideration of O. Reg. 79/10, s. 31 (3)(4).

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A complaint was received by the Director related to the provision of personal support services to residents in the home. The complaint alleged that the home did not have sufficient staffing in the home on a specific date, with which to provide adequate personal support services to the residents in the home.

During an interview with PSW #103, they reported that, on a specific date in 2018, they had been the only PSW on the day shift on the floor providing care to

approximately 40 residents. They added that there were 13 residents that required a particular type of assistance with an activity of daily living, and four residents that required a different type of assistance with an activity of daily living.They further reported that they had been unable to provide specific aspects of resident care. In addition, they stated resident #015 was not provided with a specific type of assistance and resident #004 was not provided with a specific type of care for the entire day shift despite a physician's order that specified the care was to be provided. PSW #103 added that an Activation staff member had assisted with an aspect of resident care and the RPN, RN, and one of the Quality Assistants had provided additional support to the residents.

During an interview with the Office Manager, they reported that they were the Manager in Charge (MOC) on a specific weekend in 2018, and came into the home at 0730 to 1130 hours (hrs) on both days. They stated, at approximately 0800hrs, on one of the days, the kitchen staff had told them the home was short PSWs. They added that they were aware that, on both of these days the home was short PSWs, but they were not sure of the numbers of staff short, but knew it was less than three PSWs per floor.

During an interview with the Ward Clerk/Scheduler, after a review of PSW schedules with Inspector #196, they confirmed the PSW staffing levels on three specific day shifts.
- on the day shifts of two specific dates in 2018, there was one PSW on both of the floors; and
- on the day shift of another specific date in 2018, there were two PSWs on one floor and one PSW on the other floor.

During an interview with the DOC, they reported there had been shifts in which there had been only one PSW working on a floor providing care to approximately 40 residents and that a particular aspect of resident care was not always being done. They confirmed that when there was only one PSW working on a floor, the staff were not able to provide all of the required care to the residents as indicated in their plans of care. They further reported that on each floor, normally, there were three PSWs scheduled on the day and evening shifts; the home's census was less than full and the use of agency staff was no longer an option as it was cost prohibitive.

During an interview with the Administrator, they reported that they were the MOC on a specific weekend in 2018, and acknowledged that there had been

one PSW on the one of the floors on the day shift; that the Activation staff had assisted with an aspect of resident care; that they had assisted in the dining room; and that they thought the home had managed to get the resident care done. In addition, they stated they had attempted to call staff in to work but had been unable to replace the staff. They also reported that the use of agency staff had been financially difficult for the home.

The decision to issue this Compliance order was due to the severity of this issue which was a level 2 as there was minimum risk or a potential for actual harm to the residents. The scope was a level 2, a pattern of staffing shifts. The compliance history was a level 3, with previous non-compliance issued in a similar area of the legislation that included:
- A Compliance Order (CO) made under s. 8 (3) of the Long-Term Care Homes Act, 2007, August 3, 2017, (#2017_652625_0010) with a compliance due date of September 4, 2017;
- A CO made under s. 8 (3) of the Long-Term Care Homes 2007, March 8, 2017, (#2017_246196_0009) with a compliance due date of March 22, 2017;
- A Voluntary Plan of Correction (VPC) made under s. 8 (3) of the Long-Term Care Homes Act, 2007, July 12, 2016 (#2017_2466196_0009); and
- A VPC made under s. 8 (3) of the Long-Term Care Homes Act, 2007, January 21, 2016, (#2016_339617_0004). (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

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