Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2020_814501_0016	013808-20, 014176-20, 015268-20, 015953-20, 016788-20, 017058-20, 017132-20, 019355-20, 019647-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

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

SUSAN SEMEREDY (501), MOSES NEELAM (762)

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): December 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 29, 30, 31, 2020 and January 4, 5, 6, 7, 2021.

The following intakes were inspected in this complaint inspection:
#013808-20 and #017058-20 related to nutrition and hydration, personal support services and reporting and complaints;
#014176-20, #019647-20 #017132-20 related to sufficient staffing;
015268-20 and #016788-20 related to abuse and neglect;
015953-20 related to admission and discharge; and
019355-20 related to safe transferring.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 6(7) was identified in a concurrent inspection #2020_784762_0026 (Log #026112-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Food and Nutrition Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), substitute decision-makers, family members and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 and #007 during an outbreak in the home.

The Long-Term Care Home (LTCH) was in an outbreak and for the initial two weeks the home had staffing shortages. According to the home's staffing levels, one of the units was to have one RPN and 4 PSWs for both the day and evening shifts. Review of the actual staffing levels indicated that there was on average one RPN and 2 PSWs for both day and evening shifts.

According to regular day staff working on the above noted unit, there was not enough time to provide care and services to all residents. The evening staff consisted mostly of newly hired temporary staff and the regular staff indicated evening shifts often had less staff. As a result, the day staff would not get all residents out of bed because they knew the evening staff could not manage to get them back to bed.

As a result of this staffing shortage, basic care including bathing/showering (including bed baths), oral hygiene, nail care, assistance with eating and drinking and fall prevention monitoring was not provided.

According to resident #007's plan of care, the resident was to be provided a type of hygiene care twice a week. Documentation and interviews indicated the resident was not provided this for over a week as the staff did not have time.

Failing to provide resident #007 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #007's written care plan and documentation survey report and interviews with staff. [s. 6. (7)]

2. During the outbreak resident #007 was not provided assistance with eating and drinking adequate food and fluids as required by the plan of care. This contributed towards weight loss.

Failing to provide assistance with eating and drinking put resident #007 at risk for weight loss and dehydration.

Sources: Point of Care documentation by PSWs, clinical assessments, care plan and staff interviews [s. 6. (7)]

3. Resident #005 was known to wander and be at high risk for falls. The plan of care

indicated the resident was to be checked for safety and be reminded to use the toilet.

During the outbreak, the resident had two falls when the unit was short staffed. Staff indicated they were unable to provide resident #005 with monitoring and toileting which may have contributed to resident #005's increased falls.

By failing to follow the plan of care, resident #005 was at a high risk for injury from falls.

Sources: Resident #005's care plan, post fall assessments, progress notes and staff interviews. [s. 6. (7)]

4. Resident #005 was to be assisted with hygiene and grooming. Documentation indicated the resident did not receive this assistance consistently during the outbreak. Staff interviews indicated there was not enough time to provide such assistance.

Failing to provide resident #005 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #005's care plan, progress notes, physical chart records and staff interviews. [s. 6. (7)]

5. Staff indicated resident #005 needed more assistance with eating and drinking during the outbreak. Records indicated the resident had significant weight loss. Staff indicated resident #005 was encouraged but could not always be assisted to eat and drink due to staffing shortages.

Failing to assist resident #005 with eating and drinking as their level of care increased put them at risk for weight loss and dehydration.

Sources: Resident #005's progress notes, documentation survey report, fluid intake report, and weight reports and staff interviews. [s. 6. (7)]

6. The licensee has failed to ensure that resident #012 was wearing a protective device according to the plan of care.

The resident had a fall that led to a significant change in status. As a result of this fall, many interventions were put in place, including a protective device to be worn at all times. During an observation, it was noted by inspector #762 that the resident was not

wearing this device.

Failing to apply a protective device put the resident at risk for further injury if a fall occurred.

Sources: Observation, care plan and staff interviews. [762] [s. 6. (7)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 was repositioned every two hours or more frequently as required, when the resident was unable to reposition themselves, leading to the worsening and creation of new wounds.

When the home was in outbreak, resident #007 was not repositioned at least every two hours due to the LTCH's staffing shortage. As a result, the resident developed four areas of altered skin integrity.

Failing to reposition resident #007 put the resident at risk for developing wounds.

Sources: Clinical assessments, Point of Care documentation by PSWs and staff interviews. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The license has failed to ensure that an RPN treated resident #004 with courtesy and respect in a way that fully recognized the resident's individuality and respected their dignity.

While providing resident #004 with care, an RPN made a derogatory comment to the resident. The RPN had indicated that this was meant to be a joke, however, acknowledged that it was inappropriate. This remark was considered disrespectful and the RPN was provided with a discipline letter.

This verbal exchange put the resident at risk of diminishing their well-being, dignity and self-worth.

Sources: The LTCH investigative notes and interview with the DOC. [s. 3. (1) 1.]

Issued on this 4th day of February, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SUSAN SEMEREDY (501), MOSES NEELAM (762)
Inspection No. / No de l’inspection :	2020_814501_0016
Log No. / No de registre :	013808-20, 014176-20, 015268-20, 015953-20, 016788-20, 017058-20, 017132-20, 019355-20, 019647-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 27, 2021
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, Pickering, ON, L1V-3R6
	Jason Gay

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

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

Order / Ordre :

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

The licensee shall ensure that resident #005, #007 and #012 receive the care as set out in their plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 and #007 during an outbreak in the home.

The Long-Term Care Home (LTCH) was in an outbreak and for the initial two weeks the home had staffing shortages. According to the home's staffing levels, one of the units was to have one RPN and 4 PSWs for both the day and evening shifts. Review of the actual staffing levels indicated that there was on average one RPN and 2 PSWs for both day and evening shifts.

According to regular day staff working on the above noted unit, there was not enough time to provide care and services to all residents. The evening staff consisted mostly of newly hired temporary staff and the regular staff indicated evening shifts often had less staff. As a result, the day staff would not get all residents out of bed because they knew the evening staff could not manage to get them back to bed.

As a result of this staffing shortage, basic care including bathing/showering (including bed baths), oral hygiene, nail care, assistance with eating and drinking and fall prevention monitoring was not provided.

According to resident #007's plan of care, the resident was to be provided a type

of hygiene care twice a week. Documentation and interviews indicated the resident was not provided this for over a week as the staff did not have time.

Failing to provide resident #007 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #007's written care plan and documentation survey report and interviews with staff. (501)

2. During the outbreak resident #007 was not provided assistance with eating and drinking adequate food and fluids as required by the plan of care. This contributed towards weight loss.

Failing to provide assistance with eating and drinking put resident #007 at risk for weight loss and dehydration.

Sources: Point of Care documentation by PSWs, clinical assessments, care plan and staff interviews. (762)

3. Resident #005 was known to wander and be at high risk for falls. The plan of care indicated the resident was to be checked for safety and be reminded to use the toilet.

During the outbreak, the resident had two falls when the unit was short staffed. Staff indicated they were unable to provide resident #005 with monitoring and toileting which may have contributed to resident #005's increased falls.

By failing to follow the plan of care, resident #005 was at a high risk for injury from falls.

Sources: Resident #005's care plan, post fall assessments, progress notes and staff interviews. (501)

4. Resident #005 was to be assisted with hygiene and grooming. Documentation indicated the resident did not receive this assistance consistently during the outbreak. Staff interviews indicated there was not enough time to provide such

assistance.

Failing to provide resident #005 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #005's care plan, progress notes, physical chart records and staff interviews.
(501)

5. Staff indicated resident #005 needed more assistance with eating and drinking during the outbreak. Records indicated the resident had significant weight loss. Staff indicated resident #005 was encouraged but could not always be assisted to eat and drink due to staffing shortages.

Failing to assist resident #005 with eating and drinking as their level of care increased put them at risk for weight loss and dehydration.

Sources: Resident #005's progress notes, documentation survey report, fluid intake report, and weight reports and staff interviews.

Sources: Resident #005's progress notes, documentation survey report, fluid intake report, and weight reports and interview with RPN #112 and other staff.
(501)

6. The licensee has failed to ensure that resident #012 was wearing a protective device according to the plan of care.

The resident had a fall that led to a significant change in status. As a result of this fall, many interventions were put in place, including a protective device to be worn at all times. During an observation, it was noted by inspector #762 that the resident was not wearing this device.

Failing to apply a protective device put the resident at risk for further injury if a fall occurred.

Sources: Observation, care plan and staff interviews.

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

Severity: Failing to provide resident #005, #007 and #012 with the care set out in the plan of care put them at risk for actual harm.

Scope: The scope of this non-compliance was a pattern because a total of eleven residents were reviewed for three different care areas and there were findings for the plan of care not being provided for a total of six residents.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with LTCHA s.6(7) and five Written Notifications (WNs), four Voluntary Plans of Correction (VPCs) and one Compliance Order (C) were issued to the home.
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

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

The licensee must compliant with s. 50(2) of the LTCHA.

Specifically, the licensee must:

Develop a plan to ensure residents that are unable to reposition themselves are repositioned at least ever two hours during any type of staffing shortage. This plan must be implemented for resident #007 and any other resident that requires repositioning during such circumstances.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

1. The licensee has failed to ensure that resident #007 was repositioned every two hours or more frequently as required, when the resident was unable to reposition themselves, leading to the worsening and creation of new wounds.

When the home was in outbreak, resident #007 was not repositioned at least every two hours due to the LTCH's staffing shortage. As a result, the resident developed four areas of altered skin integrity.

Failing to reposition resident #007 put the resident at risk for developing wounds.

Sources: Clinical assessments, Point of Care documentation by PSWs and staff interviews.

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

Severity: There was actual harm to resident #007 as they developed four pressure ulcers due to not being repositioned.

Scope: The scope of this non-compliance was isolated because the repositioning of the resident every two hours was not completed for one of the three residents reviewed during this inspection.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with O.Reg. 79/10 s. 50(2) and two Written Notifications (WNs) and two Voluntary Plans of Correction (VPCs) were issued the home. (762)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 22, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

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 27th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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