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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 30, 2021	2021_643111_0008	000614-21, 002129-21, 002130-21	Critical Incident System

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

LYNDA BROWN (111), CHANTAL LAFRENIERE (194)

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): April 13 to 16, 2021.

The following inspections were completed concurrently during this inspection:
-Log #002129-21 for a follow up related to compliance order #001 for plan of care.
-Log #002130-21 for a follow up related to compliance order #002 for skin and wound care.
-Log #000614-21 for a critical incident (CIR) related to a fall with an injury.

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), Housekeeping (HSK), Infection Control Practitioner (ICP), Behavioural Support Ontario (BSO) staff and residents.

During the course of the inspection, the inspector(s): toured the home, reviewed resident health records, active screening records, and reviewed Infection, Prevention and Control (IPAC) policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #002	2020_814501_0016	111
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_814501_0016	111

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff implemented the infection, prevention and control program (IPAC) related to isolation precautions and personal protective

equipment (PPE).

The following IPAC concerns were identified on a specified date:
-resident #001, #002 and #004 had specified precaution signage posted on their door, but there was no PPE available for staff use.
-resident #003 had specified precautions signage posted on their door with PPE available and at a specified time, an RPN was observed entering and exiting the resident's room, without completing appropriate donning and doffing of their PPE.
-resident #013 and #014 had specified precautions signage posted on their door with PPE available for staff use and at a specified time, a PSW was observed returning the resident back to their room, without appropriate donning and doffing of PPE and did not complete hand hygiene as required. The PSW was also unaware of why the resident was on precautions. An RPN confirmed that all residents on specified isolation precautions should have had PPE available. Failing to ensure that staff have the appropriate PPE available for use with residents on isolation precautions and staff failing to complete appropriate IPAC practices related to donning and doffing of PPE, places residents and staff at risk for transmission of infections. (#111)

2. The licensee failed to ensure that staff were participating in implementation of the Infection Prevention and Control Program for resident #008 related to donning and doffing of PPE.

Resident #008 returned from the hospital and was placed on isolation precautions for COVID-19, for 14 days and PPE was available for staff use. On a specified day and time, Inspector #194 observed an RPN enter the resident’s room carrying a meal tray, without completing hand hygiene, or donning the required PPE. The RPN then exited the resident’s room without completing appropriate doffing of PPE. Another PSW entered the resident’s room to assist with meal set up, without donning the appropriate PPE and then exited the room without doffing their PPE as required. The RPN confirmed awareness of the resident's isolation precautions but thought they were only for 10 days. The PSW indicated no awareness that resident #008 was still on isolation precautions despite the signage indicating they were. Staff failing to ensure that the appropriate PPE are donned and doffed while assisting the resident and being aware of isolation precaution procedures, places the staff and resident at risk for the transmission of infection.

Sources: observations throughout the home, resident #008’s progress notes, observation of resident #008 during meal service and interviews with staff. (#194)

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for residents related to not following Directive #3, for active screening for COVID-19.

Review of the visitor active screening for COVID-19 for a specified period, had no documented evidence that a number of visitors had passed the active screening, or had COVID-19 testing completed on a number of dates. A PSW confirmed when they completed the active screening of all visitors, they are required to mark off whether visitors pass or fail the active screening for COVID-19 on the visitor active screening log and based on the results of the rapid antigen COVID-19 testing. The IPAC lead confirmed that staff should be marking off on the active screening of all visitors log whether the visitor passed or failed the COVID-19 testing. Failing to identify that visitors are actively screened for COVID-19 may lead to possible COVID-19 infections into the home. Review of resident active screening for COVID-19 logs for a specified period, indicated that a number of residents did not receive the twice daily active screening for COVID-19 completed on identified dates and units. Review of the staff active screening for COVID-19 logs for a specified period, indicated a number of staff did not complete active screening for COVID-19, at the beginning or the end of their shift as required on a number of dates. Failing to actively screen residents and staff for COVID-19 may lead to possible COVID-19 infections through the home.

Sources: observations of screening, review of , staff and resident active screening logs for COVID-19 and the PanBio COVID-19 results logs, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (updated April 7, 2021), Homes Visitor Policy during COVID-19 and interview with staff. (#194 and #111).

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. 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 failed to ensure that clear direction was provided in the plan of care for resident #008 related to Infection, Prevention and Control Practices and wandering behaviour.

Resident #008 returned from hospital and placed in isolation for COVID-19 with specified precautions, for 14 days. During that period, Inspector #194 observed the resident outside of their room, without a mask. An RPN redirected the resident back to their room, without assisting the resident with hand hygiene or donning a mask and indicated the resident was non-compliant with donning of a mask. The RPN also confirmed that the resident had attended the dining room for meals on a number of occasions, while being on isolation precautions. The plan of care did not have any clear direction related to resident #008's responsive behaviours or how to manage those behaviours while the resident was on isolation precautions. Failing to provide clear direction in the plan of care for resident's responsive behaviours while on isolation for COVID-19 precautions, places other residents and staff at increased risk of transmissions of infections.

Source: Resident #008's care plan and progress notes, observation of resident #008, and interview of staff.(#194)

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 provides clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: 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. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

The licensee failed to ensure that the admission care plan for resident #003 set out clear directions to staff and others who provide direct care to resident for a specified medical procedure.

Resident #003 was admitted with a specified medical procedure. Observation of the resident confirmed they used the specified medical procedure with the door left open. The signage on the door indicated the door was to be closed when medical procedure was in use. A number of RPN's confirmed the resident used the specified medical procedure independently and the door should have been closed. The resident's admission care plan indicated the RPN was to assist with application/removal of the medical procedure. There was no clear direction that the resident applied the device independently or that the door was to be closed while in use. Failing to ensure there is clear direction related to the use of a specified medical procedure can lead to improper care provided.

Sources: observation of resident #003, care plan of resident #003 and interview of staff.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee failed to ensure that resident #008 was provided appropriate equipment, including a table at an appropriate height, to meet the needs of the resident for dining purposes.

Resident #008 returned from hospital on a specified date and placed on isolation precautions for COVID-19 for 14 days, requiring the resident to have their meals in their room. A number of days later, Inspector #194 observed an RPN place the resident's meal on their mobility aid, as there was no over-bed table available and the resident was struggling to access their meal. A number of RPNs confirmed that the resident required an over-bed table to consume their meals and provided the resident with an over bedside table as a result of the inspection. As a result, the resident was not able to consume their meal for a period of time. Failing to provide the resident with an over-bed table for a number of days, at an appropriate height to meet the need of the resident, minimized the resident's ability to comfortably consume their meals.

Source: Observation of resident #008's room, progress notes for resident #008 and interview of staff. (#194).

Issued on this 7th day of May, 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) :	LYNDA BROWN (111), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2021_643111_0008
Log No. / No de registre :	000614-21, 002129-21, 002130-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 30, 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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	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

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:

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 229(4).

Specifically the licensee must do the following:
1. Ensure there is proper PPE available for staff use, for all residents on isolation precautions.
2. Ensure there is proper signage posted at the resident doorway, for any resident with an AGMP in place upon admission or readmission from hospital, according to PH guidelines.
3. Ensure all staff are donning and doffing the appropriate PPE for any residents on isolation precautions and IPAC lead to continue providing on the spot training for those staff who are not compliant and continue to identify the training on the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff implemented the infection, prevention and control program (IPAC) related to isolation precautions and personal protective equipment (PPE).

The following IPAC concerns were identified on a specified date:
-resident #001, #002 and #004 had specified precaution signage posted on their door, but there was no PPE available for staff use.
-resident #003 had specified precautions signage posted on their door with PPE available and at a specified time, an RPN was observed entering and exiting the resident's room, without completing appropriate donning and doffing of their PPE.
-resident #013 and #014 had specified precautions signage posted on their door with PPE available for staff use and at a specified time, a PSW was observed returning the resident back to their room, without appropriate donning and

doffing of PPE and did not complete hand hygiene as required. The PSW was also unaware of why the resident was on precautions. An RPN confirmed that all residents on specified isolation precautions should have had PPE available. Failing to ensure that staff have the appropriate PPE available for use with residents on isolation precautions and staff failing to complete appropriate IPAC practices related to donning and doffing of PPE, places residents and staff at risk for transmission of infections (#111).

2. The licensee failed to ensure that staff were participating in implementation of the Infection Prevention and Control Program for resident #008 related to donning and doffing of PPE.

Resident #008 returned from the hospital and was placed on isolation precautions for COVID-19, for 14 days and PPE was available for staff use. On a specified day and time, Inspector #194 observed an RPN enter the resident's room carrying a meal tray, without completing hand hygiene, or donning the required PPE. The RPN then exited the resident's room without completing appropriate doffing of PPE.Another PSW entered the resident's room to assist with meal set up, without donning the appropriate PPE and then exited the room without doffing their PPE as required. The RPN confirmed awareness of the resident's isolation precautions but thought they were only for 10 days. The PSW indicated no awareness that resident #008 was still on isolation precautions despite the signage indicating they were. Staff failing to ensure that the appropriate PPE are donned and doffed while assisting the resident and being aware of isolation precaution procedures, places the staff and resident at risk for the transmission of infection (#194).

Sources: observations throughout the home, resident #008's progress notes, observation of resident #008 during meal service and interviews with staff.

An order was made by taking the following factors into account:
-Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.
-Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations on multiple home areas, and the noncompliance has the potential to affect a large number of the LTCH's

residents.

Compliance History: the home has had non-compliance to the same subsection in the past 36 months as follows:
-issued a Voluntary Plan of Correction (VPC) on September 28, 2020 during inspection #2020_603194_0016. A VPC was issued on September 28, 2020 during inspection #2020_598570_0006. A VPC was issued to O.Reg.79/10, s.229(3) on December 3, 2020. A VPC was issued to O.Reg. 79/10, s. 229(5) on January 27, 2020. (111)

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

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.5.

Specifically, the licensee shall complete the following:
1.Actively screen staff and visitors for COVID-19 as directed with Directive #3.
2.Ensure residents are screened twice daily for acute respiratory illness-COVID-19, as per Directive #3.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for residents related to not following Directive #3, for active screening for COVID-19.

Review of the visitor active screening for COVID-19 for a specified period, had no documented evidence that a number of visitors had passed the active screening, or had COVID-19 testing completed on a number of dates. A PSW confirmed when they completed the active screening of all visitors, they are required to mark off whether visitors pass or fail the active screening for COVID-19 on the visitor active screening log and based on the results of the rapid antigen COVID-19 testing. The IPAC lead confirmed that staff should be marking off on the active screening of all visitors log whether the visitor passed or failed the COVID-19 testing. Failing to identify that visitors are actively screened for COVID-19 may lead to possible COVID-19 infections into the home. Review of resident active screening for COVID-19 logs for a specified period, indicated that a number of residents did not receive the twice daily active screening for COVID-19 completed on identified dates and units. Review of the staff active screening for COVID-19 logs for a specified period, indicated a number of staff did not complete active screening for COVID-19, at the

beginning or the end of their shift as required on a number of dates. Failing to actively screen residents and staff for COVID-19 may lead to possible COVID-19 infections through the home.

Sources: observations of screening, review of , staff and resident active screening logs for COVID-19 and the PanBio COVID-19 results logs, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (updated April 7, 2021), Homes Visitor Policy during COVID-19 and interview with staff. (#194 and #111). (111)

2. An order was made by taking the following factors into account:
-Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to staff, visitors and residents not having active COVID-19 screening completed, as per Directive #3.

-Scope: The scope of this non-compliance was widespread because the active screening was not being completed with staff, residents and visitors as per the Directive.and the noncompliance has the potential to affect all residents within the LTCH.
-Compliance History: the home has had non-compliance to the same subsection in the past 36 months as follows:issued a Voluntary Plan of Correction (VPC) on December 2, 2020 during inspection #2020_598570_0013. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 30th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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