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
Feb 16, 2021	2021_678590_0002	026052-20, 026081-20, 000715-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Tecumseh
2475 St. Alphonse Street Tecumseh ON N8N 2X2

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

ALICIA MARLATT (590)

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): January 11 - 15, 18 - 22, 25, 26 and 29, 2021.

The following intakes were inspected concurrently during this complaint inspection:

Log #026052-20 with associated Critical Incident report #2904-000036-20 was related to falls prevention and management;
Log #026081-20 was related to falls prevention and complaints process;
Log #000715-21 was related to falls prevention and complaints process.

During the course of the inspection, the inspector(s) spoke with the Regional Director for Extendicare Tecumseh, the Administrator, the Director of Care (DOC), one Assistant Director of Care (ADOC), one Office Manager, one Registered Nurse (RN), two Registered Practical Nurses (RPN) and one Personal Support Worker (PSW).

During the course of the inspection, the inspector(s) reviewed one residents clinical record, policies relevant to inspection items, Critical Incident System reports, LTCH's internal investigation notes, email communications and correspondence between the licensee and family members. The inspector(s) observed one residents' room for falls interventions to be in place.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transfer techniques when assisting resident #001.

Resident #001 had a care plan which identified that for transferring purposes, they required extensive assistance transferring with limited assistance using their assistive device for mobility. PSW #102 was assisting resident #001 when they fell. In an interview with the PSW, they said that they had assisted the resident but that they did not have their assistive device in reach at the time of the fall as the resident often got confused. The PSW shared that they had assisted the resident to use their assistive device to and from the bathroom but for the last couple feet had placed it to the side and walked with the resident, side by side. The PSW further shared that when their attention was diverted momentarily, the resident had lost their balance and fell. As a result of these actions resident #001 lost their balance and fell. The resident was transferred to the hospital with a significant change in their health care status.

In an interview with the DOC they said that the PSW did not use safe transferring techniques when they did not follow the resident's plan of care related to transferring. The DOC further said that resident #001 should have their assistive mobility device in their reach at all times when ambulating.

Sources: Resident #001’s progress notes, care plan and post-fall assessment; Long Term-Care Homes (LTCH) investigative notes; interviews with PSW #102 and other staff members, Critical Incident System report. [s. 36.]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Falls Prevention and Management procedures included in the required Falls Prevention and Management Program were complied with, for resident #001.

O. Reg. 79/10, s. 48. (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10, s, 49. (1) requires that the falls prevention and management program must, at a minimum, provide strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management Program", last updated in December 2019. The policy directs that the Program will engage resident, family/Substitute Decision Maker (SDM) and the interdisciplinary team to proactively identify and address individual and environmental risk factors and causes of falls. Further the policy directs to create an individualized plan addressing identified fall causes and risk factors such as, but not limited to:

a. History of falls and/or fractures;
b. Recent hospitalization or acute illness;
c. Medications;
d. Gait, balance and mobility;
e. Transfer;
f. Sensory and neurological impairments;

g. Muscle strength;
h. Heart rate and rhythm;
i. Postural hypotension and hypoglycemia;
j. Feet and footwear;
k. Environmental hazards;
l. Use of restraints and assistive devices;
m. Behavioural factors; and
n. Disrupted sleep.

Resident #001 fell and sustained injuries. Review of the completed falls risk assessments showed that the most recent falls risk assessment was completed a year prior to this fall and it had identified the resident as a high fall risk. Since the most recent fall risk assessment dated approximately a year ago, this resident had experienced three falls and had also been admitted to the hospital. When the resident returned from the hospital their daily dose of medications had been increased, thus increasing their risk for falls.

In an interview with the DOC they stated that the expectation was that falls risk assessments were completed per the homes' policy which was upon admission and with a change in a residents' condition. The DOC verified that the most recent falls risk assessment was completed approximately a year ago. The DOC further verified that the resident had been hospitalized within the year, which resulted in a reported significant change in the residents' condition and should have had a falls risk assessment completed at that time.

Sources: Resident #001's fall risk assessments, continence assessments, care plan and electronic Medication Administration Records (eMAR's), Multiple Data Set (MDS) assessment; LTCH policy Falls Prevention and Management Program, RC-15-01-01 (last updated December 2019); interviews with DOC #101 and another staff member. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the Falls Prevention and Management procedures are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was dressed appropriately for the weather and in keeping with their preferences.

Resident #001 was prepared for an outing by a staff member and brought down to the front of the building to wait for their pick up. The resident was wearing what was described as a large zipped hoodie or zipped sweater with clothing layered underneath. The SDM reported their concerns to the staff member and the Regional Director, that the resident was waiting for pick up with no winter coat present to wear.

In an interview with the staff member involved they shared that the SDM had expressed concern that there was no winter coat present. The staff member told the inspector during the interview that it had not been a particularly cold day outside and thought what they were wearing was acceptable.

In an interview with the Administrator they shared that they were not aware of any incidents occurring that day until the Regional Director contacted them.

In an interview with the Regional Director they shared that a resident should be assisted to wear their winter coat if going outside this time of year.

Sources: Interviews with Regional Director and other staff members; resident #001's progress notes; LTCH's investigative notes. [s. 40.]

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 residents are dressed appropriately for the weather and in keeping with their preferences, to be implemented voluntarily.

WN #4: 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,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's area of chronic impaired skin integrity was assessed on a weekly basis.

Resident #001 had an area of impaired skin integrity that required medical intervention. The Substitute Decision Maker (SDM) for resident #001 contacted the Ministry of Long-Term Care (MLTC) expressing concern about how the area had been monitored prior to the area being addressed.

Review of the completed skin assessments for the time frame of a four month period in 2020, showed that there were missing weekly assessments. In the review, the first Skin - Weekly Impaired Skin Integrity Assessment assessment that was completed documented a red and inflamed area of skin integrity. The assessment documented that the resident reported pain when the area was palpated. After this first assessment in this review, weekly assessments were completed for approximately two more months, but for the next month and a half after that, there were no further completed Skin - Weekly Impaired Skin Integrity assessments until the area was medically addressed.

The LTCH's policy titled 'Skin and Wound Program: Wound Care Management', RC-23-01-02, directed that a resident exhibiting any form of altered skin integrity would be reassessed at least weekly by a nurse, if clinically indicated. The resident had a known area of impaired skin integrity that was documented as being inflamed and painful that required medical intervention months later. The area of altered skin integrity should have been re-assessed weekly until it was medically addressed, as the area had the potential to worsen at any time.

Registered Practical Nurses (RPN) #104 and #107 both stated in interviews that areas of impaired skin integrity, including areas such as resident #001 had, should be assessed weekly using the Weekly Skin Assessment tool and should include a description of the area. The DOC stated that the homes policy should have been followed, the area should have been assessed weekly and that the assessments that had been done were not completed appropriately in full to include a description of the area.

Sources: Resident #001's skin assessments; the LTCH's policy titled 'Skin and Wound Program: Wound Care Management', RC-23-01-02 (December 2019); and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)]

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 ensure that all areas of impaired skin are assessed weekly, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 was based on the resident's preferences.

The SDM for resident #001 had submitted a written request and had a verbal conversation with the Regional Director requesting that PSW #102 no longer provide care the resident moving forward. The SDM reported to the inspector over three weeks later, that no follow-up had been completed with them about their request or concerns submitted previously. After the request had been made, resident #001 was being cared for by PSW #102 when they fell. The fall resulted in injuries and subsequent hospitalization.

In an interview with Administrator #100 they shared that they were aware of the request for PSW #102 to no longer provide care to resident #001 but could not recall when they were made aware of the request. The Administrator could also not recall if they informed anyone else of the request for the plan of care to be updated appropriately.

Sources: LTCH investigative notes; resident #001's Point Of Care (POC) records; interview with the Administrator and other staff members. [s. 6. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints that had been received concerning the care of a resident or the operation of the home was reported to the Director.

The SDM for resident #001 contacted the Regional Director via email reporting concerns about a specific staff members' conduct towards themselves and care towards resident #001 and requested to speak with them about the events which transpired. The SDM reported to the Regional Director verbally that day, that the specific staff member had not dressed the resident in appropriate clothing. They further shared that the resident was not wearing the appropriate undergarments or continence products.

In an interview with the Administrator they shared that they had not reported the incident because at the LTCH there was no written or verbally submitted complaint. When asked about the incident the Administrator stated that the SDM for resident #001 never contacted them about any events which transpired that day. They further shared that they had discovered the SDM's concerns when they were contacted by the Regional Director about them.

In an interview with the Regional Director they shared that after the discussion with the SDM, it should have been reported to the MLTC, but the LTCH was in a COVID-19 outbreak and had resources directed towards other emergent issues.

Sources: LTCH's Complaints and Customer Service policy, RC-09-01-04, June 2020; Administrator's notes; email communications between staff members; interviews with the Regional Director, the Administrator and other staff members. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

A complaint was received by the MLTC from the SDM of resident #001 who shared that they had not yet received a response from the LTCH about concerns they had identified approximately two weeks prior. The SDM shared that they had identified concerns in an email and further had a discussion with the Regional Director on a specific day in 2020, about events which had transpired the same day at the LTCH. In an interview with the SDM over three weeks later after they talked with the Regional Director, they shared that they still had not been contacted.

In an interview with Regional Director #108 they shared that they had received a written email from the SDM of resident #001 which identified concerns about a staff members treatment of the resident and conduct towards themselves. They shared that they also had a conversation that day with the SDM about the identified concerns. Further the Regional Director said that this concern had not been handled appropriately or within the time frames due to the LTCH being in a COVID-19 outbreak and having resources directed towards other emergent issues.

Sources: LTCH’s investigation notes; LTCH’s Complaints and Customer Service policy, RC-09-01-04, June 2020; Administrator’s notes; email communications between staff members; interviews with the Regional Director, the Administrator and other staff members. [s. 101. (1) 1.]

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

Issued on this 24th 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) :	ALICIA MARLATT (590)
Inspection No. / No de l'inspection :	2021_678590_0002
Log No. / No de registre :	026052-20, 026081-20, 000715-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 16, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tecumseh 2475 St. Alphonse Street, Tecumseh, ON, N8N-2X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Wilson

To Extendicare (Canada) 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 :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall comply with s. 36 of O. Reg 79/10.

Specifically, the licensee shall ensure that staff use safe transfer techniques when transferring resident #001, with special attention given to the placement of the assistive device in relation to the resident's position and location.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff used safe transfer techniques when assisting resident #001.

Resident #001 had a care plan which identified that for transferring purposes, they required extensive assistance transferring with limited assistance using their assistive device for mobility. PSW #102 was assisting resident #001 when they fell. In an interview with the PSW, they said that they had assisted the resident but that they did not have their assistive device in reach at the time of the fall as the resident often got confused. The PSW shared that they had assisted the resident to use their assistive device to and from the bathroom but for the last couple feet had placed it to the side and walked with the resident, side by side. The PSW further shared that when their attention was diverted momentarily, the resident had lost their balance and fell. As a result of these actions resident #001 lost their balance and fell. The resident was transferred to the hospital with a significant change in their health care status.

In an interview with the DOC they said that the PSW did not use safe transferring techniques when they did not follow the resident's plan of care related to transferring. The DOC further said that resident #001 should have their assistive mobility device in their reach at all times when ambulating.

Sources: Resident #001's progress notes, care plan and post-fall assessment; Long Term-Care Homes (LTCH) investigative notes; interviews with PSW #102 and other staff members, Critical Incident System report. [s. 36.]

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

Severity: Resident #001 experienced serious injuries as a result of this fall and required hospitalization and further acute care monitoring.

Scope: This was an isolated incident as no other residents have been injured as a result of unsafe transferring techniques.

Compliance History: In the last 36 months, the licensee was found to be non-complaint with O. Reg 79/10 and a Voluntary Plan of Correction (VPC) was issued to the home.
(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 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 16th day of February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

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