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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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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
Nov 16, 2021	2021_805638_0021	012513-21, 012643-21, 013111-21, 013557-21, 014085-21, 014090-21	Complaint

Licensee/Titulaire de permis

F. J. Davey Home
733 Third Line East Sault Ste. Marie ON P6A 7C1

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

F.J. Davey Home
733 Third Line East Sault Ste. Marie ON P6A 7C1

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

RYAN GOODMURPHY (638), LISA MOORE (613)

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): September 27 - 29, October 1, 4 - 8, 2021.

The following intakes were inspected upon during this Complaint inspection;
-One log related to visitor screening concerns;
-One log related to staffing levels impacting care, wound management, housekeeping services, infection prevention and control (IPAC), as well as nutrition concerns;
-Two logs related to wound management and IPAC concerns;
-One log related to alleged financial abuse; and
-One log related to fall management.

Critical Incident System inspection #2021_805638_0020 was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Care (EDOC), Directors of Care (DOC), Infection Prevention and Control (IPAC) Manager, Social Worker, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), screening staff, housekeeping staff, accounting staff, residents and their families.

The Inspector(s) also conducted daily tours of resident care areas, reviewed relevant health care records, internal investigation notes, policies and procedures, observed staff to resident interactions, the implementation of infection prevention and control practices, as well as the provision of care to residents and services within the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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,
(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; O. Reg. 79/10, s. 50 (2).

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 a resident received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A resident was sent to hospital and returned on a specific date. There was no assessment of the resident's skin integrity upon their return to the home. The resident was later assessed for skin integrity concerns.

Failure of the registered staff to complete a skin assessment on return from hospital put the resident at risk of not receiving treatment and worsening skin integrity.

Sources: Resident's progress notes, assessments, census record; Skin and Wound Program: Prevention of Skin Breakdown – RC-23-01-01 December 2020; interviews with DOC #121 and other staff. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments as well as received immediate treatment and interventions to reduce or relieve pain, promote healing and prevention infection, as required.

A resident was identified as having an area of altered skin integrity. The RPN requested that it be assessed on the following shift. There was no assessment, treatment or interventions initiated in relation to the area of altered skin integrity. Staff said the usual practice for a new wound was to assess and document on the area, send a referral to the dietitian and leave a note for the Nurse Practitioner or Physician to determine a treatment.

Failure of the registered staff to complete a skin assessment and implement immediate treatment put the resident at risk of worsening altered skin integrity.

Sources: Resident's progress notes, assessments, orders; Skin and Wound Program: Wound Care Management – RC-23-01-02 December 2020; interviews with DOC #121 and other staff. [s. 50. (2) (b)]

3. The licensee has failed to ensure that a resident received a weekly wound assessment by a member of the registered nursing staff, if clinically indicated.

A resident was assessed as having a new skin issue on a specific date. There was no reassessment of the area until 14 days after being identified. Upon reassessment the area was noted to be deteriorating. A RPN identified that resident wounds were assessed weekly or on wound days depending on the timing of the wound care.

The licensee failed to ensure that the resident received a weekly wound assessment, which put the resident at risk related to provision of appropriate treatment and a lack of monitoring wound progression.

Sources: Resident's progress notes, assessments; Skin and Wound Program: Wound

Care Management – RC-23-01-02 December 2020; interviews with DOC #121 and other staff. [s. 50. (2) (b) (iv)]

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 :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, outlined that homes must ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, including for outdoor visits. Staff and visitors must be actively screened once per day at the beginning of their shift or visit.

When an Inspector entered the home, there was no one present at the entrance to conduct screening and the Inspector was able to access the home. The Inspector paged a RN on two occasions and they did not attend the entrance to ensure screening was completed. Screener #101 came in at a later time and identified that although the doors were unlocked at a specified time, they did not start their day until two hours later.

The EDOC acknowledged that without someone at the entrance, visitors could enter the home and not be screened. By not ensuring active screening occurred, the home did not ensure there was a safe and secure environment, which put the residents at risk of potential respiratory infection.

Sources: Inspector observations; Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Effective Date of Implementation: July 16, 2021; interviews with the EDOC and other staff. [s. 5.]

2. A family member was not actively screened by a screener and was permitted entry into the home. The screener failed to ask the family member to demonstrate proof of their vaccination status or Polymerase Chain Reaction (PCR) results.

Failure of the screener not actively screening visitors put the residents at risk of transmission of infection.

Sources: Complainant; Investigation file, Memo; interviews with the IPAC Manager and RN #103. [s. 5.]

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 all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, to be implemented voluntarily.

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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the resident's plan of care related to wound care was provided to the resident as specified in the plan.

A resident required a specific wound care treatment. During one treatment a RPN completed the resident's treatment without using one of the required supplies as they did not have any available. The wound dressing list identified that the unit was restocked with the specific product prior to the treatment and additional supplies were stocked in the storage area as well.

Failure of registered staff to obtain wound care supplies and provide the resident with their specified wound treatment put the resident at risk of worsening wounds.

Sources: Review of the resident's progress notes, wound care orders, weekly dressing list record; observations of the product supply; interviews with DOC #121 and other staff.

[s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the resident's plan of care related to wound care was provided to the resident as specified in the plan.

A resident required wound care at a specified interval using specific products. During wound care the RPN completed the resident's treatment without all of the supplies required and identified they would call for more supplies the next day.

Failure of registered staff to obtain wound care supplies and provide the resident with their specified wound care put the resident at risk of worsening wounds.

Sources: Review of the resident's progress notes, wound care orders; observations of the product supply; interviews with RPN #120 and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

a) Resident care records related to bathing on one unit over a seven day period revealed that six of 30 residents did not have care documented for one of their scheduled baths for the week.

b) Resident care records related to bathing on a second unit over a seven day period revealed that eight of 32 residents did not have care documented for one of their scheduled baths for the week and one resident did not have either of their scheduled baths documented.

c) Resident care records related to bathing on a third unit over a seven day period revealed that 11 of 32 residents did not have care documented for one of their scheduled baths for the week and another five residents did not have either of their scheduled baths documented.

Staff identified that bathing was recorded on paper records. A PSW outlined that if care was not documented, they could not tell if the resident received their bath. Failure of staff to document care on resident bathing records put the residents at risk of missing care due to an inability to determine what care had been provided.

Sources: Bathing records on three units over a seven day period; interviews with the

EDOC and other staff. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of care is documented and that all wounds are treated as per their prescribed treatment orders, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008, #009 and #010, were bathed, at a minimum, twice a week by the method of their choice.

a) Resident #008's care record identified they were provided a bed bath on a specific date instead of their preferred method. There was no record or notation identifying that the resident requested a bed bath on that date.

b) Resident #009's care record identified they were provided a bed bath on a specific date instead of their preferred method. There was no record or notation identifying that the resident requested a bed bath on that date.

c) Resident #010's care record identified they were provided a bed bath on a specific date instead of their preferred method. There was no record or notation identifying that the resident requested a bed bath on that date.

Two PSWs identified that at times when they worked short staffed they would provide bed baths as an alternative to their preferred method. A RN identified that when they were short staffed, bathing was impacted and staff would complete bed baths instead of their preferred method because there was no time. Failure of staff providing residents with a bath by the method of their choice twice a week impacted the residents' rights.

Sources: Resident #008, #009 and #010, plan of care, progress notes and HCA Charting Record; interviews with RN #126 and other staff. [s. 33. (1)]

Issued on this 16th day of November, 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) :	RYAN GOODMURPHY (638), LISA MOORE (613)
Inspection No. / No de l’inspection :	2021_805638_0021
Log No. / No de registre :	012513-21, 012643-21, 013111-21, 013557-21, 014085-21, 014090-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 16, 2021
Licensee / Titulaire de permis :	F. J. Davey Home 733 Third Line East, Sault Ste. Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F.J. Davey Home 733 Third Line East, Sault Ste. Marie, ON, P6A-7C1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Connie Lee

To F. J. Davey Home, 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

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. 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 :

The licensee must comply with s. 50 (2) of Ontario Regulation 79/10.

Specifically, the licensee must:
1. Designate a lead to oversee the skin and wound program;

2. Perform weekly audits, to ensure that residents who have been identified as having altered skin integrity are; assessed using a clinically appropriate tool designed for skin and wound; receive immediate treatment and intervention; assessed by a registered dietitian; and re-assessed at least weekly;

3. Continue the audits until 100 per cent compliance is maintained for at least two consecutive weeks; and

4. Maintain a record of the weekly completed audits.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A resident was sent to hospital and returned on a specific date. There was no assessment of the resident's skin integrity upon their return to the home. The resident was later assessed for skin integrity concerns.

Failure of the registered staff to complete a skin assessment on return from hospital put the resident at risk of not receiving treatment and worsening skin integrity.

Sources: Resident's progress notes, assessments, census record; Skin and Wound Program: Prevention of Skin Breakdown – RC-23-01-01 December 2020; interviews with DOC #121 and other staff. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments as well as received immediate treatment and interventions to reduce or relieve pain, promote healing and

prevention infection, as required.

A resident was identified as having an area of altered skin integrity. The RPN requested that it be assessed on the following shift. There was no assessment, treatment or interventions initiated in relation to the area of altered skin integrity. Staff said the usual practice for a new wound was to assess and document on the area, send a referral to the dietitian and leave a note for the Nurse Practitioner or Physician to determine a treatment.

Failure of the registered staff to complete a skin assessment and implement immediate treatment put the resident at risk of worsening altered skin integrity.

Sources: Resident's progress notes, assessments, orders; Skin and Wound Program: Wound Care Management – RC-23-01-02 December 2020; interviews with DOC #121 and other staff. [s. 50. (2) (b)]

3. The licensee has failed to ensure that a resident received a weekly wound assessment by a member of the registered nursing staff, if clinically indicated.

A resident was assessed as having a new skin issue on a specific date. There was no reassessment of the area until 14 days after being identified. Upon reassessment the area was noted to be deteriorating. A RPN identified that resident wounds were assessed weekly or on wound days depending on the timing of the wound care.

The licensee failed to ensure that the resident received a weekly wound assessment, which put the resident at risk related to provision of appropriate treatment and a lack of monitoring wound progression.

Sources: Resident's progress notes, assessments; Skin and Wound Program: Wound Care Management – RC-23-01-02 December 2020; interviews with DOC #121 and other staff.

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

Severity: A resident did not have any assessment or treatment implemented on identification of a new area of altered skin integrity. There was actual risk to the

resident who developed new areas of altered skin integrity.

Scope: This was a pattern as two residents out of three reviewed were determined to have non compliance related to wound management.

Compliance History: One written notification was issued to the home related to the same sub-section of the legislation within the past 36 months. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 11, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ryan Goodmurphy

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