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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Jan 6, 2021	2020_821640_0026	020397-20, 021282-20, 022910-20, 024449-20	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

Fairview Nursing Home
14 Cross Street Toronto ON M6J 1S8

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

HEATHER PRESTON (640)

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): December 10, 11, 14, 16 and 17, 2020.

During the course of the inspection, the Long-Term Care Homes (LTCH) Inspector toured the home, observed the provision of care, reviewed clinical records, policy and procedure and conducted interviews.

The following Follow-Up Inspection was conducted:
Log # 021282-20 related to Compliance Order (CO) #001 from inspection #2020_650565-0010 related to resident to resident abuse.

The following Critical Incident (CI) reports were reviewed:
Log #019350-20 (no CI report submitted) related to resident to resident physical abuse
CI #2723-000026-20, Log #020397-20 related to resident to resident physical abuse
CI #2723-000029-20, Log #022910-20 related to a fall with injury and transfer to hospital
CI #2723-000030-20, Log #024449-20 related to medication error

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behaviour Support Ontario (BSO) Lead, Manager of Clinical Informatics, Environmental Services, Neighbourhood Coordinator, Associate Director of Care (ADNC), The Corporate Senior Nurse Consultant and the General Manager (GM).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing
Training and Orientation

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

- **9 WN(s)**
- **3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_650565_0010	640

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Director of Nursing Care (DNC) worked regularly in that position, on site at the home at least 35 hours per week.

The Long-Term Care Homes (LTCH) Inspector was informed that the DNC was not available for interview. There was no Acting DNC in place. The Associate DNC, an RPN, was in charge of the nursing department during the DNC's absence.

The General Manager (GM) said the DNC was going to be away for a one month period, followed by two weeks of self-isolation. They said that a Senior Nurse Consultant had been attending the home one day per week dependent upon their schedule.

The risk to the resident was no on-site Registered Nursing direct support of the operations of the nursing and personal care services.

Sources: Observation and interview with the ADNC, the GM and other staff. [s. 213. (1)]

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. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their training and orientation program, under sections 76 and 77 of the Act, was implemented for a registered nurse (RN).

A RN was scheduled to work at the home on a regular basis, from the home's contracted agency.

They had made three medication errors during a one month period that negatively affected a resident.

The GM and the ADNC said they did not know if the RN had completed all required training as they did not keep a record of training and orientation for agency staff.

The risk to residents was staff not being trained and aware of the licensee's programs, protocols and policies that directly affect resident care.

Sources: CI report, medication incident reports, clinical records, interview with the GM, ADNC and other staff. [s. 216. (1)]

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was protected from abuse by another resident.

Physical abuse is defined in O. Reg. 79/10 as: the use of physical force by a resident that causes physical injury to another resident.

Staff heard screaming and found a resident holding another resident's hands tightly. The resident would not let the other resident's hands go. After they were able to release the resident's grip they noted redness and a scratch on the other resident's hands.

During a second incident, the same resident hit the same resident on their head and forehead resulting in bruises and a bump on the resident's head.

There was risk of further physical abuse and injury to residents.

Sources: CI report, residents' clinical records, progress notes and assessments, interviews with the GM and other staff. [s. 19. (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 resident #006 is protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every incident of alleged, witnessed or suspected abuse of a resident by anyone, was immediately investigated.

An incident of alleged resident to resident abuse resulted in harm to one of the resident's.

There was no investigation conducted in relation to the incident.

There was no direct risk to the resident.

Sources: ltchomes.net, interview with the GM and other staff. [s. 23. (1) (a)]

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 every incident of abuse of a resident by anyone, is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for that resident.

A resident returned to the home following hospitalization.

The re-admission medication reconciliation orders directed that a medication was to be discontinued and that the resident was allergic to the medication.

The medication continued to be administered for more than five days.

There was risk to the resident that the medication may have caused an allergic reaction.

Sources: CI report, medication administration record, hospital reports and medication orders, interview with the RN, ADNC and other staff. [s. 131. (1)]

2. The licensee failed to ensure that a drug was administered to a resident in accordance with directions for use as specified by the prescriber.

A resident returned to the home following hospitalization. They had a history of a specified condition.

The medication orders directed that a medication be given for the specified condition.

The medication was not given and on five occasions after the resident returned from hospital they exhibited signs that the specified condition was not being well manged.

Sources: CI report , medication administration record, hospital reports and medication orders, vital signs tab in PCC, interview with the RN, ADNC and other staff. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for that resident and in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

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 failed to ensure that a written complaint concerning care of a resident was immediately forwarded to the Director.

One of the home's physician's, emailed the General Manager with two concerns related to a registered staff not completing a medication reconciliation correctly and not following through on a written order left by the physician for a resident. The concern had a negative impact on the resident.

The written complaint was not forwarded to the Director.

There was no direct risk to the resident.

Sources: Progress notes and the MAR, e-mail, interview with the GM and other staff. [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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written complaint made to the licensee or staff member, concerning the care of a resident, had a response made to the complainant indicating what the licensee had done to resolve the complaint.

A physician sent an email to the GM outlining two concerns related to a registered staff's completion of medication reconciliation and not carrying out a written order for a resident. The concern resulted in a negative impact to a resident..

The physician did not receive a response from the GM regarding the resolution of the complaint.

There was no direct risk to the resident.

Sources: Medication incident review, written complaint, interview of the GM and the ADNC and other staff. [s. 101. (1) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every incident of abuse of a resident by anyone, was submitted in writing to the Director.

A resident injured another resident during an altercation

The reporting website was reviewed, and this incident had not been reported in writing to the Director. A registered staff had called the Info-line but the home did not follow-up with a written report of the alleged physical abuse.

There was no direct risk to the resident.

Sources: ltchomes.net,home report, interview with the GM and other staff. [s. 104. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident where a resident was taken to the hospital which resulted in a significant change in status within one business day after the occurrence of the incident.

A resident was taken to hospital, assessed and returned to the home the following day with a significant change in condition.

The Director was not notified until 8 days later.

There was no direct risk to the resident.

Sources: CI report, progress notes and incident note, interview with the ADNC and other staff. [s. 107. (3)]

Issued on this 22nd day of March, 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

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

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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2020_821640_0026
Log No. / No de registre :	020397-20, 021282-20, 022910-20, 024449-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 6, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	Fairview Nursing Home 14 Cross Street, Toronto, ON, M6J-1S8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Saurabh Bhatnagar

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

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. 213. (1) Every licensee of a long-term care home shall ensure that the home’s Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee must be compliant with s. 213 (1) of O. Reg. 79/10.

Specifically the licensee must:

Ensure that when the DNC is not available on site, except as provided for in the LTCHA, a temporary RN is appointed as the Acting DNC.

Grounds / Motifs :

1. The licensee failed to ensure that the home’s Director of Nursing Care (DNC) worked regularly in that position, on site at the home at least 35 hours per week.

The Long-Term Care Homes (LTCH) Inspector was informed that the DNC was not available for interview. There was no Acting DNC in place. The Associate DNC, an RPN, oversaw the nursing department during the DNC’s absence.

The General Manager (GM) said the DNC was going to be away for a one month period, followed by two weeks of self-isolation. They said that a Senior Nurse Consultant had been attending the home one day per week dependent upon their schedule.

The risk to the resident was no on-site Registered Nursing direct support of the operations of the nursing and personal care services.

Sources: Observation and interview of the ADNC, the GM and other staff.

A compliance order was made taking the following into account:

Severity: All residents were at risk during the period of time without the DNC on site at the home.

Scope: As all residents were affected, the scope was widespread.

Compliance history: The CH was previous non-compliance in other sections of the LTCHA in the previous 36 months.
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 16, 2021

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

Order / Ordre :

The licensee must be compliant with s.216(1) of O. Reg. 79/10.

Specifically the licensee must;

1) Develop and implement required training and orientation for all agency staff prior to being scheduled to work at the home, including training related to medication administration for registered agency staff,
2) Keep a record of the training provided agency staff and,
3) Ensure that the record is kept at the home.

Grounds / Motifs :

1. The licensee failed to ensure that their training and orientation program, under sections 76 and 77 of the Act, was implemented for a registered nurse (RN).

A RN from the home's contracted agency was scheduled to work at the home on a regular basis.

They made three medication errors during a one month period that negatively affected a resident.

The GM and the ADNC said they did not know if the RN had completed all required training as they had not kept a record of training and orientation for agency staff.

The risk to residents was staff not being trained and aware of the licensee's programs, protocols and policies that directly affect resident care.

Sources: CI report, medication incident reports, clinical records, interview with the GM, ADNC and other staff.

A compliance order was made taking the following into account:

Severity: The severity of this issue was determined to be minimal risk/harm. The negative outcome was related to medication incidents with no home specific or other training related to medication administration in the home being provided to an agency RN.

Scope: The scope was determined to be pattern as three of seven medication incidents in 17 days, were related to one agency nurse.

Compliance history: The CH was determined to be previous non-compliance in other sections of the LTCHA in the previous 36 months.
(640)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 16, 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 6th day of January, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Heather Preston

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