Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
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Téléphone: (888) 432-7901
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Amended Public Copy/Copie modifiée 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
Dec 03, 2021	2021_922119_0002 (A1)	009008-21, 009048-21, 010719-21, 014250-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Barnswallow Place Care Community
120 Barnswallow Drive Elmira ON N3B 2Y9

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

Amended by JANIS SHKILNYK (706119) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Home requested an extension to the compliance due date. Inspection #2021_922119_0002. New compliance due date January 31, 2022.

Issued on this 3 rd day of December, 2021 (A1)

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

Original report signed by the inspector.

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

Division des opérations relatives aux soins de longue durée
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Barnswallow Place Care Community
120 Barnswallow Drive Elmira ON N3B 2Y9

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

Amended by JANIS SHKILNYK (706119) - (A1)

Amended 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): October 15, 19-22, 2021.

The following intakes were completed within the critical incident inspection:

Log #010719-21, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status;

Log #009048-21, related to improper/incompetent treatment of a resident that resulted in harm or risk to a resident;

Log # 014250-21, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status;

Log #009008-21, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status;

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Director of Care (DOC), Associate Director of Care (ADOC)-IPAC Lead, Personal Support Workers (PSW), Housekeeping, Registered Practical Nurses (RPN), Care Support Assistant (CSA), and Lift and Transfer Lead.

During this inspection, inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, relevant policies, and infection prevention and control practices.

Inspector Jessica Bertrand was present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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 transferring techniques when they completed a transfer for a resident.

The home submitted a critical incident (CI) report to the Ministry of Long Term Care (MLTC) that identified a resident was injured during a transfer.

While the resident was lifted, an improper lifting transfer was completed by staff resulting in multiple injuries to a resident.

Staff believed that the lifting equipment was not attached per the home's policy and procedure prior to transferring the resident.

Policy #VII-G-20.30(I) stated that team members must check that the appropriate sling is utilized for the lifts and that loops are fitted safely over the appropriate crossbars.

The staff not confirming the process outlined in the home's policy and procedure prior to the transfer may have lead to unsafe lifting and transferring procedures which caused actual harm to the resident.

Sources: resident's progress notes, assessments, risk management, and post fall assessments, home’s investigation notes, interview with PSW's, RPN, lift and transfer lead, and ADOC. Policy # VII-G-20.30(I) – Mechanical lifting and sling safety protocol. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 failed to ensure that the head injury routine (HIR) policy included in the required falls prevention and management program was complied with for two residents.

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

O. Reg. 79/10, s 49 (2) requires that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, the staff did not comply with the home's policy and procedure "Head Injury Routine", VII-G-30-20, dated January 2021.

The Head Injury Routine policy #VII-G-30.20 dated January 2021, stated that a head injury routine would be initiated on any resident who sustained or was suspected of a head injury to be completed as per the schedule outlined, or as ordered by the physician.

A) A resident fell sustaining an injury to their head. The head injury routine

assessment was not completed during specific times indicated on the HIR form. Documentation stated that the resident was sleeping or was missed. When the resident was not assessed for a head injury during the times initiated on the head injury form, it posed a risk that any neurological injury may not have been identified.

Sources: record review of resident progress notes, head injury routine form, interview with ADOC and policy # VII-G-30.20, The Head Injury Routine policy current revision: January 2021.

B) A resident had an unwitnessed fall. The head injury routine assessment was to be completed per the schedule outlined on the monitoring record form #VII-G-30.20(a). The head injury routine form documented the resident was sleeping and a full assessment was not completed.

The resident was not assessed for a head injury on the head injury form. There was no documentation for the coma scale, pupil scale, and limb movement posing a risk that any neurological deficit may not have been identified.

Sources: interview with RPN, record review of the head injury record form VII-G-30-20(a), head injury routine policy #VII-G-30.20. [s. 8. (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 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, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home’s safe resident handling program assessment and sling selection for three residents was documented.

The home’s policy #VII-G-20.301 of 1, Safe Resident Handling, current revision April 2019, stated that the director of care was to ensure that the interprofessional team was engaged in the process of sling selection and usage to meet the individual residents’ needs and included in their plan of care. The nurse or designate was to conduct an initial assessment and reassessment when there was a change in condition and the assessment was to be documented in the home’s electronic lift and transfer assessment.

A review of the plan of care for three residents did not show what size or type of sling the residents had been assessed for, and there was no documentation to communicate the appropriate slings for staff to use when they were completing a mechanical lift transfer.

A PSW was the lead for lift and transfers and was responsible for the assessment of residents for appropriate sling type/size. They did not document the assessment in the plan of care or in the lift and transfer assessment. They stated that the slings had the residents name on them and they were kept in their room, but there was no communication to the staff on what size or type of sling to use. If the sling was missing or in the laundry, staff would just borrow a co-resident sling.

The home not ensuring that a sling size/type assessment was documented in the residents lift and transfer assessment or in the plan of care, put three residents at risk for improper sling selection and use, with the potential for an unsafe transfer.

Sources: Observations of three residents, record review of lift and transfer assessments, plan of care, physio assessments, and transfer logos for three identified residents, Interviews with PSW, RPN, Lift and Transfer lead and ADOC, review of policy #VII-G-20.301 of 1, Safe Resident Handling, current revision April 2019. [s. 30. (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 every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs, where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition., 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,
(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).

Findings/Faits saillants :

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

A) A resident sustained an unwitnessed fall. The progress notes documented an alteration in skin integrity as a result of the fall. The resident was transferred and admitted to hospital for assessment. When they were readmitted from hospital they did not have a skin assessment completed.

Sources: Resident's progress notes, assessments, and readmission checklist, interview's with RPN and the Acting Director of Care.

B) A resident fell which resulted in significant injuries that included alteration in skin integrity. A change in health status resulted in them being admitted to the hospital. A skin assessment was not completed upon return from hospital which may have led to a delay in the resident receiving treatment.

Sources: resident's assessment and progress notes, resident's return from hospital checklist, interviews with the ADOC and RPN.

C) A resident was admitted to hospital and returned to the home one month later. A skin assessment was not completed upon return which may have led to a delay in the resident receiving treatment.

Sources: resident's assessments and progress notes, interview with the Acting Director of Care. [s. 50. (2) (a) (ii)]

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 licensee of a long-term care home shall ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had pain as a result of a fall, that an assessment using a clinically appropriate assessment instrument specifically designed for pain was completed.

A resident fell and sustained multiple injuries. On initial assessment the resident was assessed to have pain and refused pain medication when offered.

The home completed post fall assessments for the resident for nine consecutive shifts and during the assessment period they did not document the monitoring or assessment of pain on five out of the nine shifts. Staff identified on the head injury routine monitoring form that the resident had localized pain and withdrew from pain on eight occasions during the time they were assessed.

The ADOC said they expected that pain assessments would have been completed due to the severity of the incident and the injuries obtained. They expected that interventions would have been put in place to assess and manage resident's pain.

When the resident exhibited pain, they were not assessed using a clinically appropriate assessment designed for pain, and interventions were not implemented until three days after the incident.

Sources: progress notes, post fall assessments, pain assessment, risk management, HIR, and electronic medication administration record (eMAR), interview with PSW, RPN, ADOC, Pain and Symptom Management policy #VII-G-30.30. [s. 52. (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 every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the home's infection control program. Staff did not perform hand hygiene for residents before or after their nourishment and snack service.

Staff were observed on four occassions offering residents food and fluids from the snack cart, and did not perform or offer hand hygiene to the residents.

The risk of harm to residents may occur from the potential spread of infection related to not washing or hand sanitizing residents hands before or after nourishment.

Sources: observations of nourishment cart pass, PSW interviews. [s. 229. (4)]

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 licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section, specifically related to all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 3 rd day of December, 2021 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JANIS SHKILNYK (706119) - (A1)
Inspection No. / No de l'inspection :	2021_922119_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009008-21, 009048-21, 010719-21, 014250-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 03, 2021(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Barnswallow Place Care Community 120 Barnswallow Drive, Elmira, ON, N3B-2Y9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Catherine Schalk

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, 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. 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 must comply with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:

A) Ensure that the identified resident and all residents in the home who utilize a mechanical lift for transfers are reassessed by members of the home's lift and transfer team that have received individualized training on safe lifting techniques. The reassessment must include and identify the appropriate sling size, and type to be used with the appropriate mechanical lift.

B) The reassessment of sling size and type for each identified resident must include the date of reassessment and the person completing the assessment. The sling size and type must be documented in the residents plan of care, and be easily accessible to all staff.

C) Re-educate each resident care staff member on the safe handling and lifting techniques. The education must be documented, and include the date and the staff member who provided the education. A copy of the education is to be kept in the home.

D) Develop and implement an audit to ensure that all residents using a lift are in the correct sling size/style, and the information is included in the residents' plan of care. The audit must include the person completing the audit, the date the audit was completed and any corrective actions in place as a result of identified deficiencies.

E) Develop and implement an audit to ensure that staff are observed performing safe lift and transferring techniques for residents. Auditing must occur until compliance is demonstrated for three months. This process must include the date and documentation of observation, and of actions taken to address unsafe practices if observed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when they completed a transfer for a resident.

The home submitted a critical incident (CI) report to the Ministry of Long Term Care (MLTC) that identified a resident was injured during a transfer.

While the resident was lifted, an improper lifting transfer was completed by staff resulting in multiple injuries to a resident.

Staff believed that the lifting equipment was not attached per the home's policy and procedure prior to transferring the resident.

Policy #VII-G-20.30(I) stated that team members must check that the appropriate sling is utilized for the lifts and that loops are fitted safely over the appropriate crossbars.

The staff not confirming the process outlined in the home's policy and procedure prior to the transfer may have lead to unsafe lifting and transferring procedures which caused actual harm to the resident.

Sources: resident's progress notes, assessments, risk management, and post fall assessments, home's investigation notes, interview with PSW's, RPN, lift and transfer lead, and ADOC. Policy # VII-G-20.30(I) – Mechanical lifting and sling safety protocol. [s. 36.]

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

Severity: Unsafe practice resulted in harm to the resident.

Scope: The scope of this non-compliance was isolated as one resident was injured during an unsafe lift and transfer procedure.

Compliance History: Three written notifications (WNs) and two voluntary plans of correction (VPCs) were issued to the home related to different sections of the legislation in the past 36 months.

(729)

Jan 31, 2022(A1)

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

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

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 3 rd day of December, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by JANIS SHKILNYK (706119) - (A1)

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