Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 15, 2019	2019_671684_0015	031948-18, 006897-19, 007232-19, 007249-19	Complaint

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

Waters Edge Care Community
401 William Street NORTH BAY ON P1A 1X5

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

SHELLEY MURPHY (684)

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): April 8 - 12, 2019.

The following areas were inspected during this Complaint Inspection:

Two intakes related to no hot water in the home.

One Critical Incident System intake related to the same issue (no hot water), was inspected during the Complaint inspection.

One intake related to reporting and complaints.

A Critical Incident Inspection #2019_671684_0016 was conducted concurrently with this inspection.

The inspector(s) also conducted daily tours of the resident care areas, reviewed residents health care records, home policies and procedures, observed resident rooms, observed resident common areas, and observed the provision of care and services to residents, including resident to staff interactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager, Director of Environmental Services (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Personal Support Services
Reporting and Complaints

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure as part of the organized program of maintenance services under clause 15 (1) c of the Act, that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

A Critical Incident (CI) report was submitted on a specified day in 2019, to the Director related to breakdown of major equipment (Central hot water boiler) for the entire facility.

Inspector #684 observed a Memo posted in the elevator which stated the following:
Re: No Hot Water
We are working to fix this issue as soon as possible.
Where: Entire Building
When: As of March 29, 2019
Time to be restored: To be determined (TBD)
Residents' showers/bath will be rescheduled till further notice.

Inspector #684 interviewed two Personal Support Workers (PSWs) regarding hot water availability for the provision of resident baths and showers. PSW #112 stated the showers had no hot water. PSW #104 stated the home had hot water connected to the tub and that the shower was not connected.

During an interview with PSW #104 they informed Inspector #684 that they had a ten gallon hot water tank to shower residents, but, staff had to put the resident in the tub, as they could not put hot water in the tub, then staff wet the resident, turned the water off, lathered the resident all over, then rinsed the resident.

Inspector #684 and Environmental Service Manager (ESM) filled the bath tub on one area as it would be filled to provide a tub bath with approximately 40 gallons of water.

The water temperature once the tub was filled was 18 degrees Celsius, as confirmed by the ESM. The ESM and Inspector #684 then tested the water temperature of the shower on a second area in the shower stall. The water temperature was 20.4 degrees Celsius coming from shower head, as verified by the ESM.

Inspector #684 interviewed the DOC and clarified that the home currently had hot water coming from the mini hot water tanks which supplied the tubs for the staff to be able to provide residents quick showers while seated in the tub. DOC responded "yes" that was correct and there was hot water being brought to the units in the thermal jugs that staff can use to bring hot water to the resident rooms as needed and requested. Inspector #684 asked prior to the boiler breaking down did the home have hot water to both the tub and the shower stalls in the tub/shower rooms on all of the units. The DOC replied yes the boiler served the entire home for hot water. [s. 90. (2) (i)]

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. 6. Plan of care

Specifically failed to comply with the following:

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 provision of the care set out in the plan of care was documented.

A Complaint was submitted to the Director on a specified date in 2019, regarding no hot water and a specific intervention not being completed for resident #002.

Inspector #684 reviewed the "Documentation Survey Report V2" for three residents. Resident #002 was missing documentation on a specified day in 2019, related to a specific care intervention, resident #005 was missing documentation for a specific intervention on four different days in 2019; and, resident #006 was missing documentation on four different days in 2019.

Inspector #684 reviewed with Personal Support Worker (PSW) #118 the "Documentation Survey Report V2" for residents #002, 005 and 006 and asked if there should there ever be blanks in charting. PSW #118 stated no, staff should be documenting that the intervention was completed or that the intervention had not occurred there should not be blanks.

Inspector #684 reviewed the "Documentation Survey Report V2" with Registered Practical Nurse (RPN) #119 for resident #002, 005 and 006, they indicated that there should never be blanks in documentation, as the PSWs should be documenting something.

Inspector #684 reviewed the home's policy titled "Documentation – Plan of Care" VII-C-10.80-SSLI, last revised April 2018. In the procedure section it stated "The PSW will document on the care provided as specified in the plan of care".

During an interview with the DOC, Inspector #684 reviewed the "Documentation Survey Report V2" for resident #002, 005 and 006, the DOC verified that there was missing documentation for the above noted residents. The DOC stated when there were blanks in Plan of Care (POC) documentation "the assumption to me was that it wasn't done". The DOC identified that even if it didn't occur they should utilize Activity Did not Occur. [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 ensuring that the following is documented; the provision of the care set out in the plan of care, to be implemented voluntarily.

WN #3: 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 each resident of the home was 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.

Inspector #684 reviewed a complaint submitted to the Director on a specified day in 2019, regarding the Long Term Care home not having hot water for an identified period of time, and resident #002 having missed their bathing choice. A second complaint was submitted to the Director on specified day in 2019, regarding a resident not receiving their specified bathing choice; and, a CI report was submitted to the Director on a specified date in 2019, related to equipment failure of the hot water boiler.

During an interview with resident #002, Inspector #684 asked resident #002 if they had been receiving their bathing choice as scheduled, resident #002 stated "no" . When asked if they had missed receiving their bathing choice they stated "many".

Inspector #684 interviewed resident #005 regarding their bathing choice. Resident #005 stated they have not received their bathing choice for a specified time period. They then stated that they were bathed in a method that was contrary to their choice. Inspector

#684 asked, if the resident was able to have their preferred bathing choice, and the resident responded "no I was not".

Inspector #684 interviewed resident #006 and asked if staff offered a bathing choice. Resident #006 responded “No".

Inspector #684 interviewed PSW #111, on how they knew when a resident was to be bathed, they stated there was a list that informed them of the resident's bathing choice. They informed Inspector #684 that since the hot water went off, there was a period of time where a resident's bathing choice was not provided. Inspector #684 asked if the residents were still being offered their bathing choice, PSW #111 replied, no.

PSW #112 was interviewed by Inspector #684 and asked if residents were still being offered their bathing choice, they provided the Inspector the reason why resident's were not receiving their bathing choice.

Inspector #684 reviewed "Documentation Survey Report V2" for a specified time frame, and noted that the resident's bathing choice was being documented as "Activity Did Not Occur" for resident #002 on two specified dates in 2019, resident #005 on two specified dates in 2019 and resident #006 on a specified date in 2019.

Inspector #684 reviewed the homes’ policy titled “Documentation-Plan of Care”, VII-C-10.70-SSLI, which was last revised April 2018, the policy section stated “A plan of care will be developed and maintained that reflects assessed resident needs according to choice”.

During an interview held with Director of Environmental Services, they stated to Inspector #684, that resident's bathing choices were not occurring, that alternate interventions were being offered to the residents.

During an interview with Inspector #684 the DOC was asked if the residents were still offered a bathing choice. The DOC responded, the home had an issue so they are only able to provide alternative interventions. Inspector #684 asked the DOC when "Activity Did Not Occur" was charted,what did this mean, the DOC responded, “It didn’t happen and I would expect progress notes to be in there to explain what happened”. [s. 33. (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 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, to be implemented voluntarily.

WN #4: 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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): an incident that caused an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the residents' health condition.

Inspector #684 reviewed a complaint which was submitted to the Director on a specified date in 2018, in relation to a incident which resulted in an injury, not being submitted to the Director.

Inspector #684 reviewed resident #001's progress notes regarding the incident. Inspector #684 noted in a progress note, that resident #001 had a change in condition. The next progress note indicated that resident #001 was to receive a number of interventions, to be completed by staff post incident.

Inspector #691 interviewed RN #114 regarding reporting requirements for critical incidents. RN #114 stated for any incident with injury, which the resident had gone to hospital, they follow an algorithm. RN #114 stated they then call the manager on call, discuss the situation, gather all the information and investigate. The home had guidelines, as to what is reportable, and "we can call into the action line and report if in doubt". The DOC submits reports to the MOHLTC.

Inspector #684 reviewed the home's policy titled "MOHLTC-Critical Incident Reporting", XXIII-C-10.90, last revised August 2018. Under the procedure section it stated "The Director of Care will ensure all required documentation is completed within expected timelines in the CIS portal as per MOH standards."

During an interview with Inspector #684 the DOC stated that if an incident occurred after hours the manager on call was notified of the incident and the RN on shift will call the after hours MOH report line if necessary. The call between the RN and manager gives the managers awareness for when they were back in the office to submit report to MOH. The DOC then stated in regards to the incident involving resident #001, they thought they were looking at a significant change as it may have related to a change in assistance required for ADLs, they should have considered that resident #001 had a change in condition related to the incident. Inspector #684 asked if they felt this should have been reported to the MOH, the DOC replied "for sure". [s. 107. (3) 4.]

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHELLEY MURPHY (684)
Inspection No. / No de l'inspection :	2019_671684_0015
Log No. / No de registre :	031948-18, 006897-19, 007232-19, 007249-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 15, 2019
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 :	Waters Edge Care Community 401 William Street, NORTH BAY, ON, P1A-1X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hoss Notarkesh

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be in compliance with r. 90(2) (i) of the LTCHA, 2007.

The licensee shall prepare, submit, and implement a plan to ensure that the organized program of maintenance services under clause 15 (1) c of the Act, ensures that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

The plan must include, but is not limited to, the following:

1. Ensuring that hot water is restored and functioning to meet the required minimum temperature of 40 degree Celsius.

2. Ensuring that all residents receive their bathing choice within the first four days of hot water restoration.

3. Develop an auditing process to ensure that residents received their choice of bath or shower at least twice a week, identify who will be responsible for the audit and maintain records of the audits.

The plan must be emailed to the attention of LTCH Inspector Shelley Murphy @ SudburySAO.moh@ontario.ca The plan is due April 18, 2019, and the order is to be complied by April 26, 2019.

Grounds / Motifs :

1. The licensee has failed to ensure as part of the organized program of maintenance services under clause 15 (1) c of the Act, that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

A Critical Incident (CI) report was submitted on a specified day in 2019, to the Director related to breakdown of major equipment (Central hot water boiler) for the entire facility.

Inspector #684 observed a Memo posted in the elevator which stated the following:
Re: No Hot Water
We are working to fix this issue as soon as possible.

Where: Entire Building
When: As of March 29, 2019
Time to be restored: To be determined (TBD)
Residents' showers/bath will be rescheduled till further notice.

Inspector #684 interviewed two Personal Support Workers (PSWs) regarding hot water availability for the provision of resident baths and showers. PSW #112 stated the showers had no hot water. PSW #104 stated the home had hot water connected to the tub and that the shower was not connected.

During an interview with PSW #104 they informed Inspector #684 that they had a ten gallon hot water tank to shower residents, but, staff had to put the resident in the tub, as they could not put hot water in the tub, then staff wet the resident, turned the water off, lathered the resident all over, then rinsed the resident.

Inspector #684 and Environmental Service Manager (ESM) filled the bath tub on one area as it would be filled to provide a tub bath with approximately 40 gallons of water. The water temperature once the tub was filled was 18 degrees Celsius, as confirmed by the ESM. The ESM and Inspector #684 then tested the water temperature of the shower on a second area in the shower stall. The water temperature was 20.4 degrees Celsius coming from shower head, as verified by the ESM.

Inspector #684 interviewed the DOC and clarified that the home currently had hot water coming from the mini hot water tanks which supplied the tubs for the staff to be able to provide residents quick showers while seated in the tub. DOC responded "yes" that was correct and there was hot water being brought to the units in the thermal jugs that staff can use to bring hot water to the resident rooms as needed and requested. Inspector #684 asked prior to the boiler breaking down did the home have hot water to both the tub and the shower stalls in the tub/shower rooms on all of the units. The DOC replied yes the boiler served the entire home for hot water. [s. 90. (2) (i)]

The severity of the issue was determined to be a level two, as there was a risk of minimal harm or potential for actual harm. The scope of the issue was level three as it was widespread affecting all residents. The home had a level two compliance history, as they had previous unrelated non-compliance. (684)

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2019

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 15th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shelley Murphy

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