Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 21, 2021	2021_555506_0015	006622-21, 008292-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Brierwood Gardens
425 Park Road North Brantford ON N3R 7G5

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

LESLEY EDWARDS (506)

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): June 2, 3, 4, 8, 9 and 10, 2021.

This inspection was completed related to the following intakes:

006622-21- for Critical Incident System (CIS) 2678-000014-21 for fall and unexpected death; and
008292-21- for CIS 2678-000016-21 for unexpected death.

Inspector Jennifer Allen was shadowing for parts of this inspection.

During the course of the inspection, the inspector(s) spoke with Interim Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Infection Control Manager, Regional Manager, Environmental Service Manager (ESM), maintenance staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, security guard, Brantford Public Health, Minimum Data Set Resident Assessment Instrument Co-ordinator (RAI), Physician and residents.

During the course of the inspection, the inspector completed an Infection Prevention and Control (IPAC) checklist, cooling requirements, observed resident care, meal and snack service, medication pass, reviewed resident health records, conducted interviews, reviewed investigation notes and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home

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

4 WN(s)
1 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed in accordance with prevailing practices, to minimize risk to residents.

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The guide is cited in a document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards", March 2008. The Health Canada guide was identified by the Director of the Ministry of Long Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety. According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape." Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident in their bed mobility activities, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk related hazards associated with the application of one or more bed rails. The Clinical Guidance document emphasizes the importance of establishing procedures and processes for bed safety monitoring. Monitoring includes but is not limited to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored for while the resident is in bed with one

or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails.

The home's procedure required the bed rail risk assessment, bed rail and bed safety risk assessment to be completed and document the results on the Zones of Entrapment excel document.
The procedure also required that a sleep observation study would be completed upon admission, with any change in a bed system, annually, and if there was no change in the bed system within the year. If there was a change in a resident's condition the DOC or delegate would complete a bed rail risk assessment and if there was a change in bed system as a result of the bed rail risk assessment the ESM or delegate would repeat a bed safety risk assessment and document on the zones of entrapment excel document.

i. The clinical record for resident #002 included a physician’s order.
A review of the clinical record and interviews with the DOC and Regional Manager confirmed that the three assessments were not conducted as per the home's procedures.

The clinical record identified that on an identified date in May 2021, a change was made to resident #002's bed system.
If a resident used a particular bed system, additional precautions should be put in place to mitigate the risk of entrapment, an identified risk assessment was to be completed and the plan of care would address interventions to mitigate the risk of entrapment.

The DOC and Regional Manager confirmed that additional precautions were not in place nor did the plan address interventions to mitigate any risks related to entrapment for resident #002 when a change was made to their bed system.

An internal investigation completed by the home identified that the resident’s bed system was inconsistent with the specified bed system recorded on their zones of entrapment form.

ii. Observations of resident #003 and #004's bed systems, on an identified date in June, 2021, identified that their bed systems were not consistent with the specific information recorded on the zones of entrapment form.

Discussion with the ESM identified that during the past year surfaces and bed frames had been changed and there was a process in place to notify the maintenance person of changes to ensure proper testing and documentation was completed; however, this was

not taking place.

iii. A review of resident #003's clinical record included an assessment completed on identified dates in May 2021, identified that they were at risk and directed staff to follow the instructions for high risk.
Interviews with the DOC, Regional Manager and the RAI co-ordinator were unable to identify or provide the instructions to be followed when a resident was identified at high risk.

iv. Resident #003 and #004's clinical record were reviewed and an assessment was completed and identified that alternatives were not trialled.

Interview with the DOC and Regional Manager confirmed that the home's policy does not include which alternatives that could be used in order to mitigate the risk of entrapment and the bed rail assessment does not include the names of the interdisciplinary team members who participated in assessing the resident.

The licensee has failed to ensure that where the specified interventions were used, the resident was assessed and their bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident.

2. The licensee has failed to ensure that other safety issues related to the use of the specified intervention were addressed for resident #003 and #004.

i. On an identified date in June 2021, the bed system of resident #003 was observed and a safety issue was identified.

ii. On an identified date in June 2021, the bed system of resident #004 was observed and a safety issue was identified.

The Regional Manager confirmed the safety issue, on identified date in June 2021, and directed the ESM to correct the safety issue.

Safety issues related to the use of the specified intervention were not addressed.

Sources: review of resident #002, #003 and #004's clinical records, bed rail safety assessments, sleep observations, bed safety risk assessment, zones of entrapment excel document , staff interviews, Clinical Guidance Document and discussion with

Environmental Consultant. [s. 15. (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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence based hand hygiene program, "Just Clean Your Hands" related to staff assisting residents with hand hygiene before and after snacks.

On an identified date in June 2021, during a nourishment snack pass residents were observed to be served and or assisted with a beverage and or a muffin without immediate prior assistance with hand hygiene.

Interviews with PSW #108 confirmed that assistance with resident hand hygiene was not completed prior to the distribution of the snacks on an identified date in June 2021, as they were unaware of this expectation.

The home's hand hygiene procedure, referred to staff hand hygiene and not resident hand hygiene. The home did not have a written program for resident hand hygiene.

The Just Clean Your Hands program required that staff assist residents to clean their hands before and after snacks.

Failure to have a hand hygiene program in place in accordance with evidenced based practices presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents during the nourishment snack pass, interviews with PSW and other staff and review of the home's hand hygiene procedure and Just Clean Your Hands program resources. [s. 229. (9)]

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 a hand hygiene program was in place in accordance with the Ontario evidence based hand hygiene program, "Just Clean Your Hands" related to staff assisting residents with hand hygiene before and after snacks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home (LTCH) was a safe and secure environment for its residents.

On an identified date in June 2021, the LTCH Inspector observed several tools, such as wrenches, ratchets and an exacto knife with the blade exposed, left on the floor across from the nursing station unattended. Upon further inspection it was also noted that a ladder was leaning up against the fire doors with ceiling tiles all over the area and exposed tubing.

Upon speaking with staff, they confirmed that the home had contractors in completing work and confirmed that they should not have left the area unattended with the above items out as there were residents in the area.

After 10 minutes, the LTCH inspector informed the DOC who stayed in the area to ensure that the residents were kept safe and secure and asked staff to call the Environmental Manager.

The potentially dangerous items being left unattended posed a risk to residents of causing harm to themselves or others.

Sources: observation of the area and staff interviews. [s. 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperatures required to be measured, including in two residents bedrooms in different parts of the home were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

It was identified during an interview with the DOC on an identified date in June 2021, that nursing staff check and record the temperatures of five areas in the home three times a day; however, these areas do not include two resident bedrooms.

The temperatures were not measured and documented as required.

Sources: A review of the humidex heat stress recording form and interview with the DOC. [s. 21. (2) 1.]

Issued on this 21st day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LESLEY EDWARDS (506)
Inspection No. / No de l’inspection :	2021_555506_0015
Log No. / No de registre :	006622-21, 008292-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 21, 2021
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Brierwood Gardens 425 Park Road North, Brantford, ON, N3R-7G5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Amanda Kopitan

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall be compliant with s.15 (1) (a) and (c) of O. Reg. 79/10.

Specifically, the licensee must:

1. Reassess any resident in the home that uses the specified intervention to ensure:
a) Specified intervention risk assessment is completed and documented;
b) A sleep observation study is completed and documented;
c) Specified intervention and bed safety risk assessment zones of entrapment is completed and documented;
d) Alternatives that were trialled prior to the application of one or more specified intervention and document whether the alternatives were effective during the specified period of use or if no alternatives were trialled, document why they were not trialled; and
e) Include the names of the interdisciplinary team members who participated in assessing the resident.

2. Develop or revise procedures that encompasses resident assessments and bed system
evaluations. The procedures shall include but not be limited to the following guidance:

a) PSW role in bed safety monitoring for residents with the specified intervention applied and the safety risks
that need to be monitored for; and
b) Registered staff role in bed safety monitoring for residents with the specified intervention applied and assessing residents where the specified intervention have been requested or indicated for use;
c) Substitute Decision Maker's role in making decisions about the application of specified intervention;
d) Maintenance staff role in ensuring that the bed systems are evaluated as per Health
Canada guidelines;
e) The role of any other selected interdisciplinary members involved in the resident
assessments;
f) The available alternatives to the specified intervention and the accessories that are available to mitigate
any identified risks or hazards;
g) The process for recognizing and reporting bed system deficiencies;
h) The process for reporting bed system changes to management staff (i.e. mattress
exchanges);
i) Guidance for the assessors in being able to make clear decisions based on the data
acquired by the various team members and to conclude and document the risk versus the
benefits of the application of one or more specified interventions for residents.

3. All bed systems shall be re-evaluated using the methods and processes described in
the Health Canada guidelines and each bed frame and mattress is to be labelled with the
same identifier. The results of the evaluation shall be documented.

4. All registered and non-registered staff shall be informed about the bed safety procedures and be provided with face to face education about bed system hazards (zones of entrapment and other injuries), regulatory requirements in Ontario regarding adult hospital beds, the risks and benefits of specified

intervention use, resident risk factors associated with increased risk of injury related to specified intervention use, how to identify and report bed system deficiencies and any other relevant information identified in the prevailing practices. The Education materials and evidence that staff have been trained on the above shall be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed in accordance with prevailing practices, to minimize risk to residents.

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The guide is cited in a document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards", March 2008. The Health Canada guide was identified by the Director of the Ministry of Long Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety. According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape." Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident in their bed mobility activities, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk related hazards associated with the application of one or more bed rails. The Clinical Guidance document emphasizes the importance of establishing procedures and processes for bed safety monitoring. Monitoring includes but is not limited to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored for while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails.

The home's procedure required the bed rail risk assessment, bed rail and bed

safety risk assessment to be completed and document the results on the Zones of Entrapment excel document.
The procedure also required that a sleep observation study would be completed upon admission, with any change in a bed system, annually, and if there was no change in the bed system within the year. If there was a change in a resident's condition the DOC or delegate would complete a bed rail risk assessment and if there was a change in bed system as a result of the bed rail risk assessment the ESM or delegate would repeat a bed safety risk assessment and document on the zones of entrapment excel document.

i. The clinical record for resident #002 included a physician's order.
A review of the clinical record and interviews with the DOC and Regional Manager confirmed that the three assessments were not conducted as per the home's procedures.

The clinical record identified that on an identified date in May 2021, a change was made to resident #002's bed system.
If a resident used a particular bed system, additional precautions should be put in place to mitigate the risk of entrapment, an identified risk assessment was to be completed and the plan of care would address interventions to mitigate the risk of entrapment.

The DOC and Regional Manager confirmed that additional precautions were not in place nor did the plan address interventions to mitigate any risks related to entrapment for resident #002 when a change was made to their bed system.

An internal investigation completed by the home identified that the resident's bed system was inconsistent with the specified bed system recorded on their zones of entrapment form.

ii. Observations of resident #003 and #004's bed systems, on an identified date in June, 2021, identified that their bed systems were not consistent with the specific information recorded on the zones of entrapment form.

Discussion with the ESM identified that during the past year surfaces and bed frames had been changed and there was a process in place to notify the maintenance person of changes to ensure proper testing and documentation

was completed; however, this was not taking place.

iii. A review of resident #003's clinical record included an assessment completed on identified dates in May 2021, identified that they were at risk and directed staff to follow the instructions for high risk.
Interviews with the DOC, Regional Manager and the RAI co-ordinator were unable to identify or provide the instructions to be followed when a resident was identified at high risk.

iv. Resident #003 and #004's clinical record were reviewed and an assessment was completed and identified that alternatives were not trialled.

Interview with the DOC and Regional Manager confirmed that the home's policy does not include which alternatives that could be used in order to mitigate the risk of entrapment and the bed rail assessment does not include the names of the interdisciplinary team members who participated in assessing the resident.

The licensee has failed to ensure that where the specified interventions were used, the resident was assessed and their bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident.

2. The licensee has failed to ensure that other safety issues related to the use of the specified intervention were addressed for resident #003 and #004.

i. On an identified date in June 2021, the bed system of resident #003 was observed and a safety issue was identified.

ii. On an identified date in June 2021, the bed system of resident #004 was observed and a safety issue was identified.

The Regional Manager confirmed the safety issue, on identified date in June 2021, and directed the ESM to correct the safety issue.

Safety issues related to the use of the specified intervention were not addressed.

Sources: review of resident #002, #003 and #004's clinical records, bed rail

safety assessments, sleep observations, bed safety risk assessment zones of entrapment excel document , staff interviews, Clinical Guidance Document and discussion with Environmental Consultant.

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

Severity: was identified as actual risk.
Scope: three out of three residents were reviewed as part of the inspection to determine scope of NC.
Compliance History:a level 2 compliance history with previous non compliance issued, however
to a different section.
(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 23, 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 21st day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

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