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 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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2018	2018_674610_0016	019185-17, 022549-17, 026016-17, 028727-17, 000866-18, 007282-18, 007497-18, 008590-18, 009140-18, 009751-18, 010716-18, 011230-18, 017557-18, 020851-18, 024530-18, 025256-18, 026877-18, 027282-18	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

Elmwood Place
46 Elmwood Place West LONDON ON N6J 1J2

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

NATALIE MORONEY (610), HELENE DESABRAIS (615)

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): September 28, 2018,

October 1, 2, 3, 4, 5, 9, 10, 11, 12, and 15, 2018

The following intakes were inspected concurrently while in the home completing critical incident inspections:

Log #006139-18, related to a follow up to Compliance Order #001 issued in Resident Quality Inspection #2017_508137_0022 regarding O. Reg. 79/10, s.8.(3) 24/7 Registered Nurse coverage in the home.
Log #006140-18, 006141-18, 006142-18, 006138-18 related to a follow-up to Compliance Order #002, #003, #004, #005 issued in Resident Quality Inspection #2017_508137_0022 regarding O. Reg. 79/10, related to medication management.

Log# 020270-18 Inspection #2018_674610_0018 Complaint Info-line #58692 IL-58805 related to care concerns.

Log #019185-17 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #022549-17 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #028727-17 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #000866-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #007282-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #008590-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #009140-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #009751-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #010716-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #011230-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #017557-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #020851-18 Critical Incident #2018_674610_0016 related to alleged staff to

resident abuse.
Log #024530-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #025256-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #027282-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #026016-17 Critical Incident #2018_674610_0016 related to falls.
Log #007497-18 Critical Incident #2018_674610_0016 related to infection prevention and Control.
Log #026877-18 Critical Incident #2018_674610_0016 related to safe and secure missing resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Co-Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario Personal Support Worker, Dietary Aides, Regional Manager, Clinical Consultant Pharmacist, Recreational Therapist Manager, Social Worker, family members and residents.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meals, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
3 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The home submitted submitted CIS report #2662-000025-18 to the MOHLTC, related to allegations of abuse to a specific resident related wound management.

The home submitted CIS report #2662-000034-18 to the MOHLTC, related to a nurse not providing wound management to a specific resident

The Ontario Regulation 79/10 defines “neglect” as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.”.

Review of the home's policy "Resident non-abuse Program" stated in part that the home had a zero tolerance for abuse and neglect and any form of abuse or neglect by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated".

Review of the home's policy showed that routine skin care would be be provided to maintain skin integrity and prevent wounds.

Review of the home's policy said that the "Setup Treatment Observation Record was to be "Ongoing Weekly Wound Assessment".

Record review for the specific resident stated that the resident was presenting impaired skin integrity related to a wound.

A review of the home's on going wound assessment for a specific resident, showed there was no completed documentation for weekly wound assessments for four weeks.

A review of a specific resident's documentation showed that the resident's wound care was not completed as per the physician's order.

A review of staffs disciplinary notice stating in part that they neglected a resident wound care order.

During an interview, the DOC said that there had been issues with the wound program and was lacking for some time and that education was provided to registered staff. DOC acknowledged that the wound got worse as a result of not providing wound care and not assessing.

During interviews, the DOC , ADOC, and Wound Champion concurred and a specific resident had not received weekly wound assessments.

B) A review of the a specific resident's clinical record showed that a specific resident was presenting a wound.

A review of the specific resident's "Ongoing Wound Assessment - Treatment observation Record" showed no documentation on identified dates for wound care.

During an interview the DOC stated that the specific resident did not receive weekly wound assessments and that they would expect registered staff to complete weekly wound assessments.

The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 2 as it related to two of three residents reviewed. Compliance history was a level 2 as there was unrelated noncompliance. [s. 19. (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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

CIS #2662-000020-18 submitted to MOHLTC was related to allegation of staff to resident abuse.

A specific resident had been refusing an activity of daily living (ADL) relating to feeding assistance. The Behavioural Support Nurse (BSO) had sent an email to the recreation manager stating that staff were not following the interventions with the specific resident even thought the resident had refused.

The Plan of care for the specific resident showed that the level of assistance for eating was independent with setup help and may require supervision as needed.

Further review of the plan of care showed that the information provided for intervention were not specified and did not provide clear direction to the front line staff on how to

intervene when resident was having identified triggered behaviours.

The Minimal Data Set (MDS) Quarterly review assessment in showed the specific resident required limited assistance with one staff physical assist with eating.

During an interview staff said that the resident required total feeding assistance by one staff member with fluids, meals and deserts and had been receiving that level of assistance for some time.

The DOC said that the plan of care should provide clear direction to staff to and others who provide direct care to the specific resident and had not.

The licensee has failed to ensure that there was a written plan of care for the resident that set out, clear directions to staff and others who provide direct care. [s. 6. (1) (c)]

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

The home submitted CIS report #2662-000012-18 to the MOHLTC related to a specific resident who was identified as a missing resident

Documentation for the identified resident showed that the resident had been located. Further review of documentation showed that the resident had a fall. The plan was to monitor the residents outings closely.

Review of the resident's plan of care showed that the ADOC updated the plan of care for the specific resident for tracking and use of a log to sign in and out of the home,

Review of the log book showed that over six months the log book documentation of the resident were not documented and was incomplete for days the resident had been out.

During an interview with the resident they acknowledged they were aware of needing to use the log book when going out and returning.

The DOC said that staff need to ensure that the resident was using the log out book when leaving the home. The DOC said that the expectation was that the plan of care would be provided as specified.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

A) The home submitted Critical Incident #2662-000022-17 to the MOHLTC regarding a specific resident for allegations physical abuse from resident to resident

A review of the specific resident's documentation stated their was no documented evidence if the registered staff reported the abuse to the home's management.

A review of the home's policy "Mandatory Reporting of Resident Abuse or Neglect" stated in part "Where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately verbally report the suspicion and the information upon which it is based to the person in charge (i.e. the nurse on

duty). They will then together immediately report this to their legislative Authority as per legislation. (Ont - Director of the MOHLTC in accordance with Critical Incident Reporting Requirements). Following this, the Nurse will document the suspicion in the chart of each resident involved: confirmed abuse or neglect of Residents".

During interviews, staff had stated they would report abuse or neglect to their registered staff who would report to the management and the Ministry.

During an interview, the DOC stated that the incident was abuse and that staff should of reported it immediately to management and the MOHLTC.

B) The home submitted to MOHLTC CIS report #2662-000016-17, related to allegation of physical abuse by staff to resident. The internal investigation notes showed that a visitor in the home told the Recreational Therapist Manager about the incident of allegations of physical abuse to a specific residents.

The Recreational Therapist Manager said that they were the first aware of the incident and thought that they reported immediately to Executive Director.

Executive Director said the expectation was that any suspicion or allegation of abuse or neglect was reported immediately to the Director.

C) The home submitted to the MOH CIS report #2662-000020-18 with allegation of physical abuse by staff to a specific resident submitted to MOHLTC.

The internal investigation showed the Recreational Therapist Manager received an email related to allegations of abuse related to a specific resident.

The Recreational Therapist Manager said they had received an email as they were concerned about abuse from staff to resident with feeding assistance.

The DOC said that the expectation is that all staff report any suspicion of abuse or neglect immediately to the manger or the Director.

D) The home submitted CI #2662-000016-18/ related to improper/incompetent treatment of a specific resident.

A review of the specific resident's progress notes showed that the staff would speak with

a management tomorrow and will investigate the situation". The suspected abuse was not reported to the management of the home.

The DOC agreed that the nurse had not immediately report the suspected abuse to management nor the MOH and would expect any person to immediately report suspected abuse.

The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with. [s. 20. (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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, 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, a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital.

The home submitted CIS report #2662-000012-18 to the MOHLTC related to a specific resident.

Review of record documentation showed that a specific resident was missing form the home and had been found at a hospital.

The homes policy Skin and Wound LTC- Procedures Steps: Prevention of skin breakdown reviewed March 31, 2018, states:
All residents will have a Head to Toe assessment “upon return from the hospital”.

Further review of documentation records showed that the specific resident did not have a head to toe skin assessment completed upon return to the home.

The DOC stated that all resident that return from hospital would have a head to toe skin assessment completed would be completed and they had not completed the skin assessment.

The licensee has failed to ensure that, the resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital. [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, a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital, to be implemented voluntarily.

Issued on this 25th day of October, 2018

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

Original report signed by the inspector.

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

Ministére 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) : NATALIE MORONEY (610), HELENE DESABRAIS (615)

Inspection No. / No de l'inspection : 2018_674610_0016

Log No. / No de registre : 019185-17, 022549-17, 026016-17, 028727-17, 000866-18, 007282-18, 007497-18, 008590-18, 009140-18, 009751-18, 010716-18, 011230-18, 017557-18, 020851-18, 024530-18, 025256-18, 026877-18, 027282-18

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 23, 2018

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Elmwood Place
46 Elmwood Place West, LONDON, ON, N6J-1J2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lisa Maynard

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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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Specifically, the licensee shall ensure the following:
1.That the two identified resident's and all residents, when exhibiting altered skin integrity, if clinically indicated, are reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments, and the assessment is documented.

2. The plan of care related to altered skin integrity for two identified resident's and all other residents with impaired skin integrity, will provide clear direction to staff regarding the specific treatment, the specific area and location, and the dates and times that the treatment is to be provided.

3. Treatments and care related to altered skin integrity for two identified resident's, and all other residents exhibiting altered skin integrity, are completed as planned and documented.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The home submitted submitted CIS report #2662-000025-18 to the MOHLTC, related to allegations of abuse to a specific resident related wound management.

The home submitted CIS report #2662-000034-18 to the MOHLTC, related to a nurse not providing wound management to a specific resident

The Ontario Regulation 79/10 defines “neglect” as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.”.

Review of the home's policy "Resident non-abuse Program" stated in part that the home had a zero tolerance for abuse and neglect and any form of abuse or neglect by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated".

Review of the home's policy showed that routine skin care would be be provided to maintain skin integrity and prevent wounds.

Review of the home's policy said that the "Setup Treatment Observation Record was to be "Ongoing Weekly Wound Assessment".

Record review for the specific resident stated that the resident was presenting impaired skin integrity related to a wound.

A review of the home's on going wound assessment for a specific resident, showed there was no completed documentation for weekly wound assessments for four weeks.

A review of a specific resident's documentation showed that the resident's wound care was not completed as per the physician's order.

A review of staffs disciplinary notice stating in part that they neglected a resident wound care order.

During an interview, the DOC said that there had been issues with the wound program and was lacking for some time and that education was provided to registered staff. DOC acknowledged that the wound got worse as a result of not providing wound care and not assessing.

During interviews, the DOC , ADOC, and Wound Champion concurred and a specific resident had not received weekly wound assessments.

B) A review of the a specific resident's clinical record showed that a specific

resident was presenting a wound.

A review of the specific resident's "Ongoing Wound Assessment - Treatment observation Record" showed no documentation on identified dates for wound care.

During an interview the DOC stated that the specific resident did not receive weekly wound assessments and that they would expect registered staff to complete weekly wound assessments.

The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 2 as it related to two of three residents reviewed. Compliance history was a level 2 as there was unrelated noncompliance (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	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 23rd day of October, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Natalie Moroney

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