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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2022	2022_947752_0003	012316-21, 013582-21, 013640-21, 013718-21, 018212-21	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street Markham ON L6B 1E1

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

LUCIA KWOK (752)

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): February 7, 8, 9, 10, 11, 14, 15, and 16, 2022.

A follow up log to Compliance Order (CO) #001, O. Reg. 79/10, s. 49. (3), related to availability of fall prevention equipment, issued under inspection #2021_598570_0017 on August 26, 2021, with a compliance due date of November 26, 2021;
Log #012316-21, log #001918-22, log #013582-21, and log #013718-21 related to alleged staff to resident abuse;
Log #018212-21 related related to a significant change in condition.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 19 (1) and a Voluntary Plan of Correction (VPC) related to O. Reg. 79.10, s. 36, were identified in this inspection and has been issued in a concurrent inspection, #2022_892762_0004, dated February 24, 2022.

During the course of the inspection, the inspector(s) spoke with residents, the Adminstrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager, Director of Social Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), and housekeeper.
The inspector conducted a tour of the home, observed the provision of care, and resident and staff interactions. The inspector reviewed pertinent clinical records, and relevant policies and procedures, and other pertinent documents.

Inspector #735818 was also present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 49. (3)	CO #001	2021_598570_0017	752

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically, the appropriate use of

personal protective equipment (PPE), staff hand hygiene (HH) practices, availability of PPE, the disposal of soiled linen.

The Director of Care (DOC) confirmed the Long-Term Care Home (LTCH) was in a COVID-19 outbreak at the time of the inspection and staff were to follow droplet/contact precautions for PPE practices. The Assistant Director of Care (ADOC), the home's IPAC lead, stated the expectation during outbreak was for staff and visitors to adhere to universal eye protection and surgical masking when they were in resident home areas (RHA).

During the inspection, the following IPAC observations were noted:

a) Staff HH practices
- On two occasions, after providing direct care to residents, a staff did not conduct HH after doffing their soiled gloves and prior to donning new gloves.

b) Availability of PPE and supplies
- The PPE caddie outside of a resident room and a staff break room did not have sanitizing wipes.
- The PPE caddie outside of a resident room did not have surgical masks.

The ADOC stated the expectation was for PPE caddies to be stocked with gowns, gloves, sanitizing wipes, surgical masks and when there was a positive COVID-19 case, N95 respirators were stocked as well.

c) Appropriate use of PPE
- On multiple occasions in different resident home areas (RHA), staff were providing direct care and/or interacting with residents and/or in close proximity with residents/other staff without wearing their eye protection.
- On one occasion, a visitor was in a RHA without wearing their eye protection.
- On one occasion, a staff exited resident's room with their soiled gown and walked into the nursing station where other staff and residents were congregated.
- On multiple occasions in different RHAs, staff did not replace their soiled surgical masks and/or respirators and did not sanitize their soiled face shield upon exiting a droplet/contact precautions room.
- On two occasions, a staff sanitized their soiled face shield and donned it back immediately. The staff acknowledged that they did not wait for the one minute contact time.

Registered Practical Nurse (RPN) #104 stated that the they were instructed to only replace their N95 respirators when exiting COVID-19 positive resident rooms. PSW #130 stated that the LTCH directed staff to change their N95 respirator when they were soiled.

The ADOC shared that the expectation was for staff to doff their soiled surgical mask/ N95 respirators and replace with a cleaned one when they exit a droplet/contact precautions room.

d) Disposal of soiled linen
- On one occasion, a soiled clothing protector was left on the hand rail by a resident room.
- On one occasion, a bag of soiled laundry was left outside of the mud room. An agency staff shared that they did not have keys to the mud room, the practice was to leave soiled laundry by the door and wait for the LTCH's staff for disposal.

The ADOC shared that the expectation was for staff to dispose of soiled linen into the laundry bin in the mud room and not leave them by the door.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations conducted throughout inspection; Interviews with DOC, ADOC, and staff; LTCH's IPAC policies and procedures; Public Health Unit IPAC reports/checklists. [s. 229. (4)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to report two alleged staff to resident abuse incidents to the Director immediately.

a) A critical incident system (CIS) was submitted to the Ministry of Long-Term Care (MLTC) related to an alleged staff to resident abuse incident five days after the incident. The DOC acknowledged that the unit RPN did not report the alleged staff to resident abuse immediately.

b) A CIS report was first submitted to the MLTC related to an alleged resident abuse incident. The DOC confirmed the incident was reported to the management team two days after the occurrence.

PSW #116 stated that staff were to report the suspected or witnessed abuse incidents to their direct supervisor and/or management team immediately.

There was no risk to the residents when the abuse incidents were not reported immediately.

Sources: Interviews with PSW #116, DOC, and other staff; LTCH's investigation records, CIS reports, residents' progress notes. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019. 2007, to be implemented voluntarily.

WN #3: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were at risk of altered skin integrity received a skin assessment when they returned from the hospital.

Two residents' care plan documented that they were at risk of altered skin integrity. Both residents were transferred to the hospital for treatments. When both residents returned from hospital, their areas of altered skin integrity were not assessed and documented on readmission.

The LTCH's wound care nurse, Registered Practice Nurse (RPN) #114 stated that the expectation was for registered staff to complete and document all areas of altered skin integrity on the initial skin and wound assessment for readmission residents.

As a result, the residents were at risk of not receiving treatment and monitoring of their altered skin areas in a timely manner.

Sources: Interview with RPN #114; Residents' care plan, electronic Treatment Administration Record (eTAR), skin and wound assessments, progress notes, LTCH's Skin Care Policy #LTC-CA-WQ-200-08-03, last revised December 2017. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that residents' areas of altered skin integrity were re-assessed weekly by a registered staff member.

a) A CIS report was submitted to the MLTC related to a resident's injury resulting in significant change in condition and altered skin integrity. There were no documentation of an initial and subsequent weekly skin assessments for the area of altered skin integrity.

b) A resident was admitted to hospital for treatment. The resident returned home with altered skin integrity. There were no documentation of an initial and subsequent weekly skin assessments for the area of altered skin integrity.

RPN #114 stated that a weekly skin assessment should be completed for all areas of altered skin integrity until the area has resolved.

As a result of the lack of weekly assessments on areas of altered skin integrity, the residents were at risk of not receiving treatment in a timely manner.

Sources: Interview with RPN #114; Residents' care plan, eTAR, skin and wound assessments, progress notes, CIS reports, LTCH's Skin Care Policy #LTC-CA-WQ-200-08-03, last revised December 2017. [s. 50. (2) (b) (iv)]

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) 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;and (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure proper techniques were used to assist residents with eating who required assistance.

On two occasions, Inspector #752 observed two different staff standing upright and not at the resident's eye level while providing feeding assistance to residents in their room. One resident had to stretch their neck upwards to eat. The other resident was coughing when the staff fed them fluids. RPN #116 stated that staff should provide feeding assistance to residents in seated position and at the resident's eye level.

By not adhering to proper techniques when providing feeding assistance, residents were at risk for choking.

Sources: Observations (Feb 7, and 15, 2022); Interview with RPN #116. [s. 73. (1) 10.]

Issued on this 11th day of March, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LUCIA KWOK (752)
Inspection No. / No de l'inspection :	2022_947752_0003
Log No. / No de registre :	012316-21, 013582-21, 013640-21, 013718-21, 018212-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 24, 2022
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Woodhaven Long Term Care Residence 380 Church Street, Markham, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andre Dwyer

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

2. Ensure caddies with personal protective equipment (PPE) are fully stocked at all times.

3. Conduct audits to ensure staff's compliance to proper techniques for donning and doffing PPE and hand hygiene (HH). Keep a documented record of the audits conducted, including the date and location of the audit, the person who conducted the audit, and the person who was audited. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH.

4. Conduct audits to ensure staff's compliance to proper soiled linen disposal process. Keep a documented record of audits conducted, including the date and location of the audit, the person who conducted the audit, and the person audited.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically, the appropriate use of personal protective equipment (PPE), staff hand hygiene (HH) practices, availability of PPE, the disposal of soiled linen.

The Director of Care (DOC) confirmed the Long-Term Care Home (LTCH) was in a COVID-19 outbreak at the time of the inspection and staff were to follow droplet/contact precautions for PPE practices. The Assistant Director of Care (ADOC), the home's IPAC lead, stated the expectation during outbreak was for staff and visitors to adhere to universal eye protection and surgical masking when they were in resident home areas (RHA).

During the inspection, the following IPAC observations were noted:

a) Staff HH practices
- On two occasions, after providing direct care to residents, a staff did not conduct HH after doffing their soiled gloves and prior to donning new gloves.

b) Availability of PPE and supplies
- The PPE caddie outside of a resident room and a staff break room did not have sanitizing wipes.
- The PPE caddie outside of a resident room did not have surgical masks.

The ADOC stated the expectation was for PPE caddies to be stocked with gowns, gloves, sanitizing wipes, surgical masks and when there was a positive COVID-19 case, N95 respirators were stocked as well.

c) Appropriate use of PPE
- On multiple occasions in different resident home areas (RHA), staff were providing direct care and/or interacting with residents and/or in close proximity with residents/other staff without wearing their eye protection.
- On one occasion, a visitor was in a RHA without wearing their eye protection.
- On one occasion, a staff exited resident's room with their soiled gown and walked into the nursing station where other staff and residents were congregated.
- On multiple occasions in different RHAs, staff did not replace their soiled surgical masks and/or respirators and did not sanitize their soiled face shield upon exiting a droplet/contact precautions room.
- On two occasions, a staff sanitized their soiled face shield and donned it back immediately. The staff acknowledged that they did not wait for the one minute contact time.

Registered Practical Nurse (RPN) #104 stated that the they were instructed to only replace their N95 respirators when exiting COVID-19 positive resident rooms. PSW #130 stated that the LTCH directed staff to change their N95 respirator when they were soiled.

The ADOC shared that the expectation was for staff to doff their soiled surgical mask/ N95 respirators and replace with a cleaned one when they exit a droplet/contact precautions room.

d) Disposal of soiled linen
- On one occasion, a soiled clothing protector was left on the hand rail by a resident room.
- On one occasion, a bag of soiled laundry was left outside of the mud room. An agency staff shared that they did not have keys to the mud room, the practice was to leave soiled laundry by the door and wait for the LTCH's staff for disposal.

The ADOC shared that the expectation was for staff to dispose of soiled linen into the laundry bin in the mud room and not leave them by the door.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations conducted throughout inspection; Interviews with DOC, ADOC, and staff; LTCH's IPAC policies and procedures; Public Health Unit IPAC reports/checklists. [s. 229. (4)]

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

Severity: There was actual risk of harm to the residents because there was actual risk of transmission of infectious agents due to the staff and visitors not participating in the implementation of the IPAC program and PPE not being fully stocked outside of resident rooms.

Scope: The scope of this non-compliance was patterned because the IPAC

related concerns were identified during the inspection and from observations throughout multiple resident home areas.

Compliance History: In the past 36 months, one voluntary plan of correction (VPC) and a compliance order (CO), which had been compiled, were issued to the same subsection of the legislation.

(752)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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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 24th day of February, 2022

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Lucia Kwok

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