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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 20, 2022	2022_673672_0008 (A3)	011703-21, 012506-21, 012757-21, 012891-21, 000736-22, 001295-22, 001606-22, 004891-22, 005067-22	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 Wynfield Long Term Care Residence
451 Woodmount Drive Oshawa ON L1G 8E3

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

Amended by JENNIFER BATTEN (672) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended at the request of the Licensee, in order to extend the Compliance Due Date (CDD) until June 9, 2022.

Issued on this 20th day of May, 2022 (A3)

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

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

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Long-Term Care Inspections Branch

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

Amended by JENNIFER BATTEN (672) - (A3)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 23, 24, 25, 28, 29, 30, 31 and April 1, 2022

A Follow-Up inspection (inspection #2022_673672_0007) and a Complaint inspection (inspection #2022_673672_0009) were conducted concurrent to this inspection and findings of non-compliance were issued within those reports.

The following intakes were completed during this inspection:

One intake related to improper/incompetent care of a resident which resulted in harm and/or risk of harm to the resident.

One intake related to an injury to a resident as a result of an unknown cause.

Three intakes related to allegations of staff to resident abuse.

Four intakes related to allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, IPAC Lead, Behavioural Support Ontario Lead (BSO RPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCPs), Nursing Unit Clerk, Physiotherapists (PT) and physio assistants (PTA), Housekeepers,

screeners, students and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Skin and Wound Care, Nutrition and Hydration and Medication Administration. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
- 2 WN(s)
- 0 VPC(s)
- 2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #018,

so that their assessments were integrated, consistent with and complemented each other.

A Critical Incident Report (CIR) was submitted to the Director related to an incident of incompetent/improper care of resident #018, which resulted in harm to the resident. The CIR indicated resident #018 had lab work taken and results were delivered to the home three days later. The results included critical results. The lab results were placed into the responsible physician's book without being reviewed and/or signed by the charge nurse, which left the results untreated until the physician returned from vacation more than 10 days later. Upon review by the physician, resident #018 was transferred to hospital for further assessment and returned to the home after being deemed as palliative. Resident #018's Substitute Decision Maker (SDM) was upset regarding the incident and lack of care provided.

Record review indicated resident #018 passed away in the home. Review of the progress notes indicated resident #018 did present with signs and symptoms which could have been related to the critical lab values, but the team did not appear to have collaborated or refer to anyone else from the multidisciplinary team such as a physician or nurse practitioner during that time period. Once resident #018's physician returned to the home, they noted the resident's health was declining and located their lab results in the communication book. Resident #018's SDM was immediately notified, and it was agreed that the resident would be transferred to hospital for further assessment and treatment. While in hospital, resident #018 was declared palliative and returned to the LTCH for end-of-life care.

During separate interviews, RN #122, the DOC and the Administrator indicated the expectation in the home was for the Registered Nurse (RN) on duty to accept delivery of the lab values when they were delivered to the home by the lab. Once the results were received, the RN was expected to review each of the reports for any critical and/or time sensitive values and immediately report to the responsible physician. Each lab report was expected to be signed and dated to indicate the report had been reviewed and then placed into the physician's communication book for review by the physician the next time they were in the home. The Administrator further indicated this process had not been followed when resident #018's lab results were received by the home.

By not ensuring that staff and others involved in the different aspects of resident

#018's care collaborated with each other, the resident was left untreated with critical lab values for a period of 10 days, which had significant negative effects on their health.

Sources: Identified Critical Incident Report; resident #018’s progress and hospital notes; resident #018’s identified lab reports; resident #018’s PPS and Corresponding Interventions form; interviews with RN #122, the DOC and the Administrator. [s. 6. (4) (a)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector observed multiple medicated treatment creams in residents #007, #008, #010, #012 and #019’s bathrooms and bedrooms. Some of the residents were in shared bedrooms or bathrooms and there were co-residents wandering on the RHA.

During separate interviews, resident #008 indicated they always had their medicated treatment creams stored in their bathroom, as they applied the treatments independently. Resident #008 further indicated they had not been provided a locked drawer or box to store the medicated treatment creams in and had not been informed the medicated treatments could not be left out in the open, as they may be accessed by other residents on the RHA. Resident #010 indicated they were unsure if their medicated treatment creams were routinely stored in their bathroom or if they applied the treatments independently.

RPNs #107 and #109 indicated residents #010 and #012 did not self administer the medicated treatment creams found in the residents’ bedrooms and/or bathrooms and that they should not have been stored outside of the secured treatment cart or medication room. RPNs #107 and #109 further indicated they would immediately remove the medicated treatments from the residents’

bedrooms and/or bathrooms. PSW #111 indicated resident #007 also did not self administer medicated treatment creams and was unaware of the medicated treatment cream which was found in the resident’s bathroom. The label on the bottle indicated it was from a local hospital and PSW #111 indicated they were unsure if the resident had been independently administering the medication but would immediately remove the medicated treatment from the resident’s bathroom.

On an identified date, Inspector observed the medication carts on specified resident home areas were parked in the common area outside of the dining rooms and had been left unattended and unlocked. This allowed the medications for each of the residents on the unit to be accessed, as Inspector was able to open each of the drawers to the medication carts without being observed or questioned. After standing with the medication cart drawers open for several minutes, Inspector closed and locked the cart and went to search for the Registered staff. During separate interviews, the RPNs responsible for the medication carts indicated they were assisting with meal services in the dining room and had forgotten to lock the medication cart(s) before they walked away from the area. The RPNs verified the expectation in the home was for medication carts to be kept secured and locked at all times when not being utilized or able to be observed and indicated they could not see Inspector accessing and opening the drawers of the medication cart.

On an identified date, Inspector observed multiple medicated treatment creams on resident #019’s bedside table. During an interview, RPN #124 indicated they were unfamiliar with resident #019 therefore was unsure if the resident self administered the medicated treatment creams and left them on the resident’s bedside table. Inspector also observed residents #008 and #010 continued to have the medicated treatment creams present in their bedrooms and/or bathrooms as well.

During separate interviews, ADOC1, ADOC2 and the Administrator verified the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times when not being utilized by staff.

By not ensuring that drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with residents #008 and #010, PSW #111, RPNs #107, #109, #124, ADOC1, ADOC2 and the Administrator. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

Issued on this 20th day of May, 2022 (A3)

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

Original report signed by the inspector.

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A3)
Inspection No. / No de l’inspection :	2022_673672_0008 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011703-21, 012506-21, 012757-21, 012891-21, 000736-22, 001295-22, 001606-22, 004891-22, 005067-22 (A3)
Type of Inspection / Genre d’inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 20, 2022(A3)
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 Wynfield Long Term Care Residence 451 Woodmount Drive, Oshawa, ON, L1G-8E3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Debbie Mccance

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with section s. 6 (4) (a) of the LTCHA.

Specifically, the licensee must:

1. Educate all Registered staff on the expectation in the home related to the process regarding lab reports being received by the home. Have the staff sign off that they have received and understood the education and keep a documented record of the education completed to make available for Inspectors upon request.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #018, so that their assessments were integrated, consistent with and complemented each other.

A Critical Incident Report (CIR) was submitted to the Director related to an incident of incompetent/improper care of resident #018, which resulted in harm to the resident. The CIR indicated resident #018 had lab work taken and results were delivered to

the home three days later. The results included critical results. The lab results were placed into the responsible physician's book without being reviewed and/or signed by the charge nurse, which left the results untreated until the physician returned from vacation more than 10 days later. Upon review by the physician, resident #018 was transferred to hospital for further assessment and returned to the home after being deemed as palliative. Resident #018's Substitute Decision Maker (SDM) was upset regarding the incident and lack of care provided.

Record review indicated resident #018 passed away in the home. Review of the progress notes indicated resident #018 did present with signs and symptoms which could have been related to the critical lab values, but the team did not appear to have collaborated or refer to anyone else from the multidisciplinary team such as a physician or nurse practitioner during that time period. Once resident #018's physician returned to the home, they noted the resident's health was declining and located their lab results in the communication book. Resident #018's SDM was immediately notified, and it was agreed that the resident would be transferred to hospital for further assessment and treatment. While in hospital, resident #018 was declared palliative and returned to the LTCH for end-of-life care.

During separate interviews, RN #122, the DOC and the Administrator indicated the expectation in the home was for the Registered Nurse (RN) on duty to accept delivery of the lab values when they were delivered to the home by the lab. Once the results were received, the RN was expected to review each of the reports for any critical and/or time sensitive values and immediately report to the responsible physician. Each lab report was expected to be signed and dated to indicate the report had been reviewed and then placed into the physician's communication book for review by the physician the next time they were in the home. The Administrator further indicated this process had not been followed when resident #018's lab results were received by the home.

By not ensuring that staff and others involved in the different aspects of resident #018's care collaborated with each other, the resident was left untreated with critical lab values for a period of 10 days, which had significant negative effects on their health.

Sources: Identified Critical Incident Report; resident #018's progress and hospital notes; resident #018's identified lab reports; resident #018's PPS and Corresponding

Interventions form; interviews with RN #122, the DOC and the Administrator.

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

Severity: There was actual harm to resident #018 and risk of harm to the other residents in the home due to the lab results not being reviewed and acted upon as required by Registered staff.

Scope: The scope of this non-compliance was isolated, as only resident #018 was noted to have been affected by the process not being executed as required.

Compliance History: A Voluntary Plan of Correction was issued to the licensee during Critical Incident System inspection #2021_643111_0006 on April 30, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 2022(A3)

Order # / No d'ordre: 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with section s. 129. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1.Conduct weekly audits of the resident home areas until compliance is achieved, to ensure medications and medicated treatment creams are being stored in an appropriate area or the medication cart as outlined in the regulation. Audits are to also include review that medication carts are kept secured and locked when not being utilized and in sight of the responsible Registered staff member. Keep a documented record of the audits completed.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that drugs were stored in an area or medication

cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector observed multiple medicated treatment creams in residents #007, #008, #010, #012 and #019's bathrooms and bedrooms. Some of the residents were in shared bedrooms or bathrooms and there were co-residents wandering on the RHA.

During separate interviews, resident #008 indicated they always had their medicated treatment creams stored in their bathroom, as they applied the treatments independently. Resident #008 further indicated they had not been provided a locked drawer or box to store the medicated treatment creams in and had not been informed the medicated treatments could not be left out in the open, as they may be accessed by other residents on the RHA. Resident #010 indicated they were unsure if their medicated treatment creams were routinely stored in their bathroom or if they applied the treatments independently.

RPNs #107 and #109 indicated residents #010 and #012 did not self administer the medicated treatment creams found in the residents' bedrooms and/or bathrooms and that they should not have been stored outside of the secured treatment cart or medication room. RPNs #107 and #109 further indicated they would immediately remove the medicated treatments from the residents' bedrooms and/or bathrooms. PSW #111 indicated resident #007 also did not self administer medicated treatment creams and was unaware of the medicated treatment cream which was found in the resident's bathroom. The label on the bottle indicated it was from a local hospital and PSW #111 indicated they were unsure if the resident had been independently administering the medication but would immediately remove the medicated treatment from the resident's bathroom.

On an identified date, Inspector observed the medication carts on specified resident home areas were parked in the common area outside of the dining rooms and had been left unattended and unlocked. This allowed the medications for each of the residents on the unit to be accessed, as Inspector was able to open each of the drawers to the medication carts without being observed or questioned. After standing with the medication cart drawers open for several minutes, Inspector closed and locked the cart and went to search for the Registered staff. During separate interviews, the RPNs responsible for the medication carts indicated they were

assisting with meal services in the dining room and had forgotten to lock the medication cart(s) before they walked away from the area. The RPNs verified the expectation in the home was for medication carts to be kept secured and locked at all times when not being utilized or able to be observed and indicated they could not see Inspector accessing and opening the drawers of the medication cart.

On an identified date, Inspector observed multiple medicated treatment creams on resident #019's bedside table. During an interview, RPN #124 indicated they were unfamiliar with resident #019 therefore was unsure if the resident self administered the medicated treatment creams and left them on the resident's bedside table. Inspector also observed residents #008 and #010 continued to have the medicated treatment creams present in their bedrooms and/or bathrooms as well.

During separate interviews, ADOC1, ADOC2 and the Administrator verified the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times when not being utilized by staff.

By not ensuring that drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with residents #008 and #010, PSW #111, RPNs #107, #109, #124, ADOC1, ADOC2 and the Administrator.

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

Severity: There was actual risk of harm to the residents as residents had access to medications and medicated treatment creams.

Scope: The scope of this non-compliance was widespread, as there were several resident rooms affected and there were multiple observations of the medication room being left unlocked.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 2022(A3)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of May, 2022 (A3)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by JENNIFER BATTEN (672) - (A3)

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