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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Oct 14, 2020	2020_780699_0013 (A1)	011720-20, 012008-20	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Compliance due date extended to December 11, 2020.

Issued on this 14th day of October, 2020 (A1)

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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5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 16-19, 22-26, and 30, July 2-3, 6-9, 2020. Off-site inspection dates July 15, and 17, 2020.

The following complaint logs were inspected during this inspection:

-Log # 011720-20 and 012008-20 related to suspected neglect of resident #011.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Dietitian (RD), Registered Practical Nurse (RPN), Personal support workers (PSW), power of attorney (POA), family members (FM), and residents.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(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 resident #011's identified altered skin integrity was assessed weekly as required.

Record review of resident #011's progress notes indicated that the resident had a hospital admission and returned to the home on a specific date with an area of altered skin integrity.

A referral was made to the skin and wound specialist four weeks later, as the altered skin integrity was not healing. Review of the skin and wound specialist's consultation notes indicated that the area surrounding the altered skin integrity appeared bright red. They stated that if the area surrounding the altered skin integrity was indeed bright red, warm and worsening, then the altered skin integrity needed to be treated with an identified intervention as soon as possible.

Review of resident #011's skin and wound assessments in PointClickCare (PCC), indicates that there were no weekly wound assessments completed for the resident's altered skin integrity for approximately two weeks.

In an interview with the skin and wound lead #169, they indicated that the expectation for altered skin integrity is that they would be assessed weekly, utilizing the Skin and Wound assessment tool in PCC.

Review of the home's policy titled "Skin and Wound Care Management Protocol", policy number VII-G-10.90, last revised April 2019, indicated the following:
-initiate and complete electronic weekly skin and wound assessment for residents exhibiting altered skin integrity.

In an interview with DOC #102, they indicated that the weekly skin assessments should have been completed for resident #011.

Additional Required Actions:

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

(A1)
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 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 resident #011 was protected or free from neglect by the licensee or staff in the home.

The Ministry of Long-term Care (MLTC) received complaints alleging suspected neglect of resident #011.

As per O. Reg. 79/10, s. 5, the definition of "'neglect" means 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.

Record review of resident #011's progress notes indicated that the resident had a hospital admission and returned to the home on a specific date with an area of altered skin integrity.

Resident #011 was started on an identified medication 11 days after readmission for one week for an altered skin integrity infection. Further review of the resident's progress notes, plan of care and clinical health record did not indicate that the resident's infection was reassessed to determine if the medications were effective after the course of medication was completed. Review of resident #011's skin and wound assessments in PCC, indicated there were no weekly skin and wound

assessments completed for the resident's altered skin integrity from an identified time period. Please see WN #1 related to non compliance under r. 50 (2)(b)(iv).

A referral was made to the skin and wound specialist four weeks later, as the altered skin integrity was not healing. Review of the skin and wound specialist's consultation notes indicated that the area surrounding the altered skin integrity appeared bright red. They stated that if the area surrounding the altered skin integrity was indeed bright red, warm and worsening, then the altered skin integrity needed to be treated with an specified intervention as soon as possible and a swab needed to be collected. The consult notes also stated to ensure pain management was in place prior to dressing changes and as needed, if the resident was noted to be in discomfort. The skin and wound nurse sent the consultation notes to the home on the same date as the referral.

Two days after the skin and wound specialist's recommendations were sent back to the home, the new dressing orders recommended were initiated, however, there was no indication that an assessment of the resident's area surrounding the altered skin integrity for the presence of infection was done. A note requesting the physician to review the recommendations was left in the physician communication book. Further review of the progress notes and skin assessments did not show any indication that the altered skin integrity was assessed or reassessed for a possible infection over the next nine days.

The physician ordered a specific diagnostic test. The resident was again started on a specific medication for 10 days for an infection, 11 days after the assessment. Review of the skin and wound assessments over the next 12 days, did not indicate that the altered skin integrity was assessed for presence of an infection or if the medications were effective.

Review of the skin and wound assessments from over the next two weeks, showed that the resident's altered skin integrity size improved. The altered skin integrity then worsened again approximately two months after readmission. Review of the progress notes, clinical health record and care plan did not indicate that the wound was reassessed, or that the physician was notified. Three weeks later, resident #011's altered skin integrity again worsened, and the resident had developed a second area of altered skin integrity to an identified area of the body. A referral was sent to the skin and wound specialist again.

Review of the skin and wound nurse's consultation notes for resident #011 altered

skin integrity, indicated the following:
-resident needs pressure relief, this is caused from sitting or lying in the same position and unable to reposition self;
-monitor closely for infection, treat as soon as possible as patient is very high risk; and -please re-send a new picture for consult to be completed.

Three months after readmission, resident #011 's diagnostic test came back positive for an infection and was started on identified treatment for 10 days. Review of the progress notes indicated that the resident was not monitored for their infection for seven shifts. Please see WN #3 related under r. 229 (5)(a) for further details.

Review of resident #011's medication administration record (MAR) for the above three months, indicated that an identified medication was ordered for pain control. Further review of the MARs for all three months showed that the resident was not provided any pain medication. A review of the plan of care did not indicate that there was pain management in place for the resident's altered skin integrity.

Review of the progress notes and care plan with full revision history showed that the resident's skin and wound interventions were not reassessed when the altered skin integrity worsened.

Review of resident #011's skin assessments from an identified period, did not indicate that a skin and wound assessment was completed for the altered skin integrity or monitored for infection.

A review of an email chain between ED #100 and DOC #102, indicated that the family was concerned that the altered skin integrity was worsening and may lead to an identified condition. The DOC indicated in the email response to the ED that resident #011 was at high risk for the specified condition. There was no evidence to support that this was communicated to the nursing staff, or a plan of care was developed to monitor the resident for the specified condition.

Review of a progress note indicated resident #011 was sent out to hospital five days following the email communication due to a change of condition. Review of the hospital medicine consult notes indicated the reason for consult was related to several factors including the above specified condition.

In an interview with RPN #164, they indicated if an altered skin integrity was

worsening, new referrals would be made to the interdisciplinary team, and the resident's plan of care related to the altered skin integrity would be reassessed and updated.

In an interview with skin and wound specialist #170, they indicated in their experience, residents who have a specific altered skin integrity exhibit pain during treatments; and they had added pain management for resident #011 in their recommendations so that the home knew the altered skin integrity could be painful.

In an interview with physician #129, they indicated that they should have been informed the resident's altered skin integrity was worsening. They further indicated that they were not aware that of the severity and that the resident should have been on a scheduled analgesic to start and increase if required for pain management. Physician #129 acknowledged that resident #011 was not provided the care they required.

In an interview with DOC #102, they indicated they would have expected resident #011's plan of care to be reassessed when the altered skin integrity was worsening. The DOC stated that they would have expected the infection to be reassessed after an identified therapy to determine if it was effective; and a plan of care should have been in place for pain management.

This non compliance is additional evidence for a compliance order issued in inspection report #2020_780699_0014, that was inspected concurrently with this inspection.

WN #3: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored resident #011 for symptoms of infection on every shift in accordance with evidence-based practices.

On an identified date, resident #011's diagnostic test came back positive for an infection and they were started on treatment for 10 days.

Review of resident #011 's progress notes and vital sign assessments in PointClickCare (PCC) indicated that over the following days, the resident was not monitored for signs and symptoms of infection for seven shifts.

In an interview with RPN #173, they indicated that if a resident has an infection, they would be monitored for vital signs, fever, respiratory status and temperature. They indicated that this should occur on every shift.

In an interview with DOC #102, they indicated that they would expect a comprehensive assessment of the resident's infection symptoms on every shift.

This non compliance is additional evidence for a compliance order issued in inspection report #2020_780699_0014, that was inspected concurrently with this inspection.

Issued on this 14th day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2020_780699_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011720-20, 012008-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 14, 2020(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kerri Judge

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 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;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with s. 50. (2) of O.Reg. 79/10.

Specifically, the licensee must ensure:
1. Any resident exhibiting altered skin integrity, is reassessed at least weekly by
a member of the registered staff, if clinically indicated, utilizing the home's electronic skin and wound assessment tool outlined in the policy.
2. The development and implementation of a monthly audit to monitor the completion of skin assessments for all residents who exhibit altered skin integrity. The audit is to include but not limited to the following information: unit name, date of audit, person completing the audit, resident name, outcome of audit, follow up actions; and other relevant information.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

1. The licensee has failed to ensure that resident #011's identified altered skin integrity was assessed weekly as required.

Record review of resident #011's progress notes indicated that the resident had a hospital admission and returned to the home on a specific date with an area of altered skin integrity.

A referral was made to the skin and wound specialist four weeks later, as the altered skin integrity was not healing. Review of the skin and wound specialist's consultation notes indicated that the area surrounding the altered skin integrity appeared bright red. They stated that if the area surrounding the altered skin integrity was indeed bright red, warm and worsening, then the altered skin integrity needed to be treated with an identified intervention as soon as possible.

Review of resident #011's skin and wound assessments in PointClickCare (PCC), indicates that there were no weekly wound assessments completed for the resident's altered skin integrity for approximately two weeks.

In an interview with the skin and wound lead #169, they indicated that the expectation for altered skin integrity is that they would be assessed weekly, utilizing the Skin and Wound assessment tool in PCC.

Review of the home's policy titled "Skin and Wound Care Management Protocol", policy number VII-G-10.90, last revised April 2019, indicated the following:
-initiate and complete electronic weekly skin and wound assessment for residents exhibiting altered skin integrity.

In an interview with DOC #102, they indicated that the weekly skin assessments should have been completed for resident #011.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Written Notification (WN) issued July 30, 2018, 2018_420643_0012. (699)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 11, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 14th day of October, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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