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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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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
Aug 26, 2020	2020_782736_0017	013021-20	Critical Incident System

Licensee/Titulaire de permis

The Ontario Mission of the Deaf
2395 Bayview Avenue NORTH YORK ON M2L 1A2

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

Bob Rumball Home for The Deaf
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

AMANDA BELANGER (736)

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): August 19-21, 2020.

During the course of the inspection, the following log was inspected:
-one log related to report submitted to the Director, by the home, for an allegation of staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager (NM), Registered Nurse(s) (RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), and residents.

The Inspector(s) conducted daily tours of the resident home area, and observed staff to resident interactions as well as the provisions of care, reviewed relevant resident records, internal investigation notes, relevant licensee policies and programs.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 a resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) A Critical Incident (CI) report was submitted to the Director related to a neglect allegation of resident #001, as the resident had impaired skin integrity that had not been reassessed for approximately six months. The CI report further indicated that the impaired skin integrity to the resident should have been noted, as another area of impaired skin integrity was being assessed, and a specified treatment was signed for twice weekly by the Registered Practical Nurses (RPNs) for a one month time frame.

Inspector #736 reviewed resident #001's charting, and noted documents related to impaired skin integrity. The Inspector noted that during 2019, the resident had the impaired skin integrity assessed, but failed to be completed on a weekly basis. The Inspector also noted that for a period of six months, there was no indication in the resident's chart that the impaired skin integrity had been assessed.

In separate interviews with Registered Nurse (RN) #103 and RN #104, who was also the lead for the Skin and Wound Program, they both indicated to the Inspector that any kind

of rashes, skin tears, bruising, pressure ulcers or scratches, qualified as altered skin integrity for a resident, and therefore, should have been assessed at a minimum weekly, by the registered staff. RN #104 further indicated that they were aware that impaired skin integrity assessments were not being completed on a regular basis for resident #001 for a length of time.

The licensee's internal policy, titled "Skin and Wound Care", number NUR-III-02, last reviewed August 2018, indicated that altered skin integrity was "potential or actual disruption of epidermal or dermal tissue". The licensee's policy provided direction to registered staff related to assessment, and reassessment, as well as documentation.

In an interview with the Director of Care (DOC), they indicated to the Inspector that impaired skin integrity included rashes, skin tears, pressure injuries, and any other interruption of the resident's skin. The DOC further indicated that any impaired skin integrity was to be assessed on a weekly basis by the registered staff, within seven days. Together, the DOC and the Inspector reviewed resident #001's wound assessments and progress notes. The DOC indicated to the Inspector that resident #001 had not had weekly skin assessments completed for various lengths of time during 2019, and had not been completed at all for a period of six months. The DOC indicated to the Inspector that based on resident #001's impaired skin integrity, weekly skin assessments should have been completed and were not.

b) Inspector #736 reviewed the progress notes and wound assessments for resident #002. It was noted that the resident had documented impaired skin integrity.

The Inspector noted that a skin and wound assessment was completed on a specified date; and the resident's area of impaired skin integrity was not assessed again until eight days later.

In separate interviews with RPN #102, as well as RNs #103 and #104, they each indicated to the Inspector that resident #002 displayed impaired skin integrity, which was to be assessed weekly. Together with the Inspector, each nurse reviewed resident #002's skin and wound assessment, and each nurse indicated that the skin and wound weekly assessment was not completed weekly for a period of time, and should have been.

In an interview with the DOC, they indicated that they were aware that resident #002 had impaired skin integrity. The DOC indicated that the resident was to have a weekly skin

and wound assessment completed as there was impaired skin integrity. Together, the DOC and Inspector reviewed resident #002's skin and wound assessments, and the DOC indicated that for a period of time, the resident did not have a weekly skin and wound assessment completed and should have.

c) Inspector #736 reviewed the progress notes and wound assessments for resident #003. It was noted that the resident had impaired skin integrity.

The Inspector noted that a skin and wound assessment was completed on a specific date, and a progress note captured a wound assessment a day later. The Inspector was unable to locate any skin and wound assessments, or progress notes related to the impaired skin integrity assessment until 35 days later. The Inspector conducted further record review after the assessment of the impaired skin integrity, and was not able to locate a wound assessment until eight days later.

In separate interviews with RPN #102, as well as RNs #103 and #104, they each indicated to the Inspector that resident #003 displayed impaired skin integrity, which was to be assessed weekly. Together with the Inspector, each nurse reviewed resident #003's skin and wound assessments and progress notes, and each nurse indicated that the skin and wound weekly assessment were not completed weekly for two periods of time, and should have been.

In an interview with the DOC, they indicated that they were aware that resident #003 had impaired skin integrity. The DOC indicated that the resident was to have a weekly skin and wound assessment completed as there was impaired skin integrity, at least once every seven days. Together, the DOC and the Inspector reviewed resident #003's skin and wound assessments and progress notes, and the DOC indicated that for a period of 35 days, the resident did not have a weekly skin and wound assessment completed and should have. The DOC also indicated that for another period of time, the resident did not have a skin assessment completed within seven days and should have. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

a) A CI report was submitted to the Director related to an allegation of staff to resident neglect towards resident #001, as a result of the lack of skin and wound assessments that had not been completed. Please see Written Notice (WN) #1, part a for further details.

Inspector #736 reviewed resident #001's progress notes and wound assessments, which indicated that as of a specific date, resident #001 had various impaired skin concerns.

The Inspector also reviewed a progress note titled "Physiotherapist Assessment Note", dated four days later, which indicated that resident #001 had no skin breakdown.

In an interview with the DOC, they indicated to the Inspector that the physiotherapist in the home should have been aware of concerns with resident skin conditions. Together, the DOC and Inspector reviewed resident #001's progress notes that included skin and

wound assessments and the “Physiotherapist Assessment Note”; the DOC indicated that the physiotherapist note did not reflect that resident #001 had known skin breakdown at the time of the assessment and should have been consistent with the nursing assessment of the resident’s skin conditions.

b) Inspector #736 reviewed resident #003’s progress notes and wound assessments, which indicated that on two separate dates, the resident was noted to have various areas of impaired skin integrity.

The Inspector also reviewed a progress note titled “Physiotherapist Assessment Note”, which indicated that the resident had no skin integrity concerns.

In an interview with the DOC, they indicated to the Inspector that the physiotherapist in the home should have been aware of concerns with resident skin conditions. Together, the DOC and Inspector reviewed resident #003’s progress notes that included skin and wound assessments and the “Physiotherapist Assessment Note”; the DOC indicated that the physiotherapist note did not reflect that resident #003 had known skin integrity concerns at the time of the assessment and should have been consistent with the nursing assessment of the resident’s skin conditions. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the outcomes of the care set out in the plan of care was documented.

A CI report was submitted to the Director related to an allegation of staff to resident neglect towards resident #001. The CI report indicated that during the licensee’s internal investigation, it was noted that the resident had an as needed specified treatment to be applied to the resident, which had been applied by Personal Support Worker (PSW) staff on a regular basis, however, not documented by the registered staff.

Inspector #736 interviewed PSW #107, who indicated that in the home, if a resident required a specified treatment to be applied, the PSW was responsible for applying the treatment, and the registered staff were responsible to document the treatment. The PSW indicated to the Inspector that they had previously applied specified treatment to resident #001 at different times, however, could not recall exact dates.

Inspector #736 reviewed resident #001’s electronic medication administration record and noted that for five months, the specified treatment had not been documented as applied.

In separate interviews with RN #103 and RN #104, they indicated to the Inspector that it was discovered that PSW staff had been applying a specified treatment to resident #001, however, registered staff had not been documenting the same. RN #104 indicated that in relation to the specified treatment, care had not been documented as provided.

In an interview with the DOC, they indicated that PSW staff were responsible to apply treatment to the resident and registered staff were responsible to document the application. The DOC indicated that it was discovered that PSWs were applying a specified treatment to resident #001, however, registered staff were not documenting the application. The DOC further indicated that care was not documented as provided in relation to resident #001's treatment. [s. 6. (9) 2.]

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 the staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident, so that their assessments are integrated, consistent with and compliment each other, and ensure that outcomes of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA BELANGER (736)
Inspection No. / No de l'inspection :	2020_782736_0017
Log No. / No de registre :	013021-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 26, 2020
Licensee / Titulaire de permis :	The Ontario Mission of the Deaf 2395 Bayview Avenue, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	Bob Rumball Home for The Deaf 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shirley Cassel

To The Ontario Mission of the Deaf, 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. 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 shall be compliant with s. 50, subsection 2, of the Ontario Regulations 79/10.

Specifically, the licensee shall ensure that when resident #001, #002, or #003, or any other resident, is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) A Critical Incident (CI) report was submitted to the Director related to a neglect allegation of resident #001, as the resident had impaired skin integrity that had not been reassessed for approximately six months. The CI report further indicated that the impaired skin integrity to the resident should have been noted, as another area of impaired skin integrity was being assessed, and a specified treatment was signed for twice weekly by the Registered Practical Nurses (RPNs) for a one month time frame.

Inspector #736 reviewed resident #001's charting, and noted documents related to impaired skin integrity. The Inspector noted that during 2019, the resident had the impaired skin integrity assessed, but failed to be completed on a weekly basis. The Inspector also noted that for a period of six months, there was no indication in the resident's chart that the impaired skin integrity had been assessed.

In separate interviews with Registered Nurse (RN) #103 and RN #104, who was also the lead for the Skin and Wound Program, they both indicated to the Inspector that any kind of rashes, skin tears, bruising, pressure ulcers or scratches, qualified as altered skin integrity for a resident, and therefore, should have been assessed at a minimum weekly, by the registered staff. RN #104 further indicated that they were aware that impaired skin integrity assessments were not being completed on a regular basis for resident #001 for a length of time.

The licensee's internal policy, titled "Skin and Wound Care", number NUR-III-02, last reviewed August 2018, indicated that altered skin integrity was "potential or actual disruption of epidermal or dermal tissue". The licensee's policy provided direction to registered staff related to assessment, and reassessment, as well as documentation.

In an interview with the Director of Care (DOC), they indicated to the Inspector that impaired skin integrity included rashes, skin tears, pressure injuries, and any other interruption of the resident's skin. The DOC further indicated that any impaired skin integrity was to be assessed on a weekly basis by the registered staff, within seven days. Together, the DOC and the Inspector reviewed resident #001's wound assessments and progress notes. The DOC indicated to the Inspector that resident #001 had not had weekly skin assessments completed for various lengths of time during 2019, and had not been completed at all for a period of six months. The DOC indicated to the Inspector that based on resident #001's impaired skin integrity, weekly skin assessments should have been completed and were not.

b) Inspector #736 reviewed the progress notes and wound assessments for resident #002. It was noted that the resident had documented impaired skin integrity.

The Inspector noted that a skin and wound assessment was completed on a specified date; and the resident's area of impaired skin integrity was not assessed again until eight days later.

In separate interviews with RPN #102, as well as RNs #103 and #104, they each indicated to the Inspector that resident #002 displayed impaired skin integrity, which was to be assessed weekly. Together with the Inspector, each nurse reviewed resident #002's skin and wound assessment, and each nurse indicated that the skin and wound weekly assessment was not completed weekly for a period of time, and should have been.

In an interview with the DOC, they indicated that they were aware that resident #002 had impaired skin integrity. The DOC indicated that the resident was to have a weekly skin and wound assessment completed as there was impaired

skin integrity. Together, the DOC and the Inspector reviewed resident #002's skin and wound assessments, and the DOC indicated that for a period of time, the resident did not have a weekly skin and wound assessment completed and should have.

c) Inspector #736 reviewed the progress notes and wound assessments for resident #003. It was noted that the resident had impaired skin integrity.

The Inspector noted that a skin and wound assessment was completed on a specific date, and a progress note captured a wound assessment a day later. The Inspector was unable to locate any skin and wound assessments, or progress notes related to the impaired skin integrity assessment until 35 days later. The Inspector conducted further record review after the assessment of the impaired skin integrity, and was not able to locate a wound assessment until eight days later.

In separate interviews with RPN #102, as well as RNs #103 and #104, they each indicated to the Inspector that resident #003 displayed impaired skin integrity, which was to be assessed weekly. Together with the Inspector, each nurse reviewed resident #003's skin and wound assessments and progress notes, and each nurse indicated that the skin and wound weekly assessment were not completed weekly for two periods of time, and should have been.

In an interview with the DOC, they indicated that they were aware that resident #003 had impaired skin integrity. The DOC indicated that the resident was to have a weekly skin and wound assessment completed as there was impaired skin integrity, at least once every seven days. Together, the DOC and the Inspector reviewed resident #003's skin and wound assessments and progress notes, and the DOC indicated that for a period of 35 days, the resident did not have a weekly skin and wound assessment completed and should have. The DOC also indicated that for another period of time, the resident did not have a skin assessment completed within seven days and should have.

The severity of this issue was determined to be a two, as there was minimal harm to the resident(s). The scope of the issue was a level three, identified as widespread, as it related to three out of three residents reviewed. The home had a level three compliance history, with one or more non-compliance in the last 36

months, including:
-a Voluntary Plan of Correction (VPC) issued on January 28, 2019 (2019_745690_0001) (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Belanger

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