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

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

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
Jan 10, 2022	2021_947752_0008	019550-21, 019867-21	Critical Incident System

Licensee/Titulaire de permis

Mon Sheong Foundation
36 D'Arcy Street Toronto ON M5T 1J7

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

Mon Sheong Stouffville Long-Term Care Centre
162 Sandiford Drive Stouffville ON L4A 0V6

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

LUCIA KWOK (752)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 20, 21, 22, and 23, 2021.

A log related to alleged staff to resident abuse;
A log related to a resident's fall resulting in significant change in status.

During the course of the inspection, the inspector(s) spoke with residents, housekeeping staff, dietary staff, Personal Support Workers (PSW), Home Area Assistant (HAA), the Environmental Supervisor, Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Directors of Resident Care (ADORC), the Director of Resident Care (DORC), Assistant Administrator, Administrator.
During the course of the inspection, the inspector(s) toured the home, observed Infection Prevention and Control (IPAC) practices, observed resident and staff interactions, reviewed relevant policies and procedures, and reviewed pertinent resident records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically, hand hygiene (HH)

practices, universal masking, donning and doffing of Personal Protective Equipment (PPE) in additional precautions rooms, cleaning of residents' shared equipment, and PPE availability

a) Observations of staff, visitors, and residents HH practices were conducted and the following was noted:

-After lunch service, two residents were not provided with HH after meal and direct contact with another resident. Personal Support Worker (PSW) #104 acknowledged that HH was not provided to the residents.
-On one instance, a staff did not conduct HH after disposing trash into a garbage can inside a resident room.
-During nourishment service, one staff had multiple direct contact with residents and no HH was conducted in between.

Sources: Observations (HH practices); Interview with Assistant Director of Care (ADORCs)/IPAC Leads; Hand hygiene policy #IC- 4.2.2, last revised July 2021.

b) Observations of universal masking was conducted and the following was noted:
-A staff had their mask covering only their mouth while walking in a resident home area hallway.
-A staff had their mask covering only their mouth while sharing a work station/desk with another staff member.

The home's IPAC co-leads, ADORCs #102 and #103, stated that the home's expectation was for all staff, volunteers, and visitors to comply with universal masking while in the Long-Term Care Home (LTCH).

Sources: Observations (universal masking); Interview with ADORCs and staff; IC-3.2.1-Routine Practices & Point-of-care risk Assessment, last revised July 2021, Directive #3 (July 16, 2021).

c) Observation of staff donning and doffing PPE practices were conducted in residents rooms with additional precautions:

- A staff member doffed their soiled face shield in the adjacent resident lounge and did not change their soiled face mask prior to exiting the room. On two occasions, a visitor did not doff their soiled PPE prior to exiting the room.

- Prior to entering the room, PSW #111 donned gloves designated to clean face shields. The PSW shared that despite receiving IPAC training, they were not comfortable in donning and doffing PPE correctly.
- A visitor exited the room without changing their soiled mask, no HH was conducted. The same visitor then re-entered the room without donning the required PPE and exited shortly, no HH conducted.
- The resident and a visitor were in the room. The visitor had their masking hanging off their chin, no face shield nor gloves were worn.
- A staff exited the room without doffing their soiled face shield and face mask. PSWs #114 and #112 stated the home's process was to remind visitors to follow the IPAC measures and to inform the charge nurse when visitors were non-compliant.

ADORCs #102 and #103 stated that staff were to follow the additional precautions and the PPE signage posted outside of resident room doors. They shared that IPAC and PPE training had been provided to all staff and visitors.

Source: Observations (PPE donning/doffing practices in additional precaution rooms); Interviews with staff; donning/doffing PPE signage from York Region Public Health; Routine Practices & Point of- care risk Assessment Policy #IC-3.2.1, last revised July 2021, Additional Precautions Policy #IC-3.2.2, last revised July 2021.

d) On one instance, two staff provided care to a resident using an assistive device and then transported it to the storage room. The PSW stated they provided direct care to a resident with the assistive device and did not sanitize it prior to transporting it to the storage room.

Sources: Observation on December 20, 2021; Interviews with staff; PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012; General Cleaning and Disinfection Policy #IC-4.2.8, last revised July 2021.

e) Observation of PPE availability were conducted and the following noted:

-On one instance, an unlabeled face shield was hanging on the clean face shield rack at the nursing station.
-On multiple occasions, the PPE caddie and storage bins outside of additional precaution rooms did not have clean face shields and face masks available.
-On one instance, a face shield was hanging on an unlabeled hook by the door frame outside of an additional precautions resident room.

-On two instances, Inspector #752 observed boxes of new gloves were left on hand rails in the resident home area hallway.

Registered Practical Nurse (RPN) #117 shared that certain PPE supplies continued to go missing due to residents' responsive behaviours and PPE supplies should not be left on the handrails. A unit RPN shared that PSWs were responsible to restock PPE supplies and to notify registered staff if more supplies were needed.

ADORC #102 stated the home encouraged staff to label their own face shield and they were responsible to clean and sanitize their face shield after each use. RPN #117 shared that their face shield labels kept rubbing off due to repeated sanitizing.

Sources: Observations (PPE availability on additional precautions rooms); Interviews with staff.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Inspector #752 observed that the door of a shower room was unlocked and left opened without any staff supervision. The storage cabinets in the shower room were all unlocked with disinfectant, shampoo, brief and other personal care supplies inside and accessible. The Director of Resident Care (DORC) stated that there was risk to residents when washrooms and cabinets stocked with personal items were not locked and accessible to residents.

As a result, the residents were at risk for entering the shower room which contain potentially harmful substances and items.

Sources: Observations on December 20, 2021; Interviews with PSW#110 and DORC. [s. 9. (1) 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 following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment tool.

The home's skin and wound care lead, Registered Nurse (RN) #116, stated that altered skin integrity included skin tear, redness, pressure ulcer, deep tissue injury, any opened skin, bruises. The expectation was for registered staff to complete weekly assessments for the altered skin areas until resolved. The RN stated that registered staff were to use the clinically appropriate assessment tool in Point Click Care (PCC) called the Skin and Wound App form for pressures ulcers. The expectation was to document the form in its entirety including the measurements of the wound, pertinent information on the wound bed, exudate, periwound, wound pain, the treatment, orders, and progress. The expectation was for staff to use the PCC's Skin Assessment form for skin tears, bruises, redness.

a) A resident had a fall resulting in significant change in condition and their skin integrity was compromised. The initial skin and wound assessments were completed but subsequent weekly assessments were missing the pertinent information as per the home's policy and procedures. Further, the resident's progress notes documented that they had two other areas of altered skin integrity. For one area, an initial skin assessment

was completed but subsequent assessments were missing. For the other area, there was no skin assessment initiated nor completed.

b) A resident had sustained a fall resulting in an area of altered skin integrity. A skin assessment was initiated but did not document the area of altered skin integrity.

c) A resident's clinical record documented an area of altered skin integrity and a Skin and Wound assessment was completed. However, there was no subsequent weekly Skin and Wound assessment. The area had not been resolved.

RN #116, acknowledged the skin assessments for the residents' areas of altered skin integrity were not completed as per the home's policy and procedures.

As a result, the residents' altered skin areas were at risk of not receiving the appropriate treatments and potentially worsened.

Sources: Interview with RN #116; Residents' clinical records and assessments, Wound care policy #NPS-8.8.2, last revised July 2021, Skin and wound care program policy #RC-4.10, last revised July 2021. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident 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, to be implemented voluntarily.

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

Issued on this 14th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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) :	LUCIA KWOK (752)
Inspection No. / No de l'inspection :	2021_947752_0008
Log No. / No de registre :	019550-21, 019867-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 10, 2022
Licensee / Titulaire de permis :	Mon Sheong Foundation 36 D'Arcy Street, Toronto, ON, M5T-1J7
LTC Home / Foyer de SLD :	Mon Sheong Stouffville Long-Term Care Centre 162 Sandiford Drive, Stouffville, ON, L4A-0V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andre Barros

To Mon Sheong Foundation, 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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

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

3. Ensure care caddies and storage drawers with personal protective equipment (PPE) are fully stocked at all times.

4. Conduct audits to ensure residents' shared equipment are cleaned and sanitized after use. Keep a documented record of the audits conducted, including the date and location of the audit, the person who conducted the audit, and the equipment audited.

Grounds / Motifs :

1. The licensee has failed to ensure staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically, hand hygiene (HH) practices, universal masking, donning and doffing of PPE in additional precautions rooms, cleaning of residents' shared equipment, and PPE availability

a) Observations of staff, visitors, and residents HH practices were conducted and the following was noted:

-After lunch service, two residents were not provided with HH after meal and direct contact with another resident. Personal Support Worker (PSW) #104 acknowledged that HH was not provided to the residents.
-On one instance, a staff did not conduct HH after disposing trash into a garbage can inside a resident room.
-During nourishment service, one staff had multiple direct contact with residents and no HH was conducted in between.

Sources: Observations (HH practices); Interview with Assistant Director of Care (ADORCs)/IPAC Leads; Hand hygiene policy #IC- 4.2.2, last revised July 2021.

b) Observations of universal masking was conducted and the following was noted:
-A staff had their mask covering only their mouth while walking in a resident home area hallway.
-A staff had their mask covering only their mouth while sharing a work station/desk with another staff member.

The home's IPAC co-leads, ADORCs #102 and #103, stated that the home's expectation was for all staff, volunteers, and visitors to comply with universal masking while in the Long-Term Care Home (LTCH).

Sources: Observations (universal masking); Interview with ADORCs and staff; IC-3.2.1- Routine Practices & Point-of-care risk Assessment, last revised July 2021, Directive #3 (July 16, 2021).

c) Observation of staff donning and doffing PPE practices were conducted in residents rooms with additional precautions:

- A staff member doffed their soiled face shield in the adjacent resident lounge and did not change their soiled face mask prior to exiting the. On two occasions, a visitor did not doff their soiled PPE prior to exiting the room.
- Prior to entering the room, PSW #111 donned gloves designated to clean face shields. The PSW shared that despite receiving IPAC training, they were not comfortable in donning and doffing PPE correctly.
- A visitor exited the room without changing their soiled mask, no HH was conducted. The same visitor then re-entered the room without donning the

required PPE and exited shortly, no HH conducted.
- The resident and a visitor were in the room. The visitor had their masking hanging off their chin, no face shield nor gloves were worn.
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PSWs #114 and #112 stated the home's process was to remind visitors to follow the IPAC measures and to inform the charge nurse when visitors were non-compliant.

ADORCs #102 and #103 stated that staff were to follow the additional precautions and the PPE signage posted outside of resident room doors. They shared that IPAC and PPE training had been provided to all staff and visitors.

Source: Observations (PPE donning/doffing practices in additional precaution rooms); Interviews with staff; donning/doffing PPE signage from York Region Public Health; Routine Practices & Point of- care risk Assessment Policy #IC-3.2.1, last revised July 2021, Additional Precautions Policy #IC-3.2.2, last revised July 2021.

d) On one instance, two staff provided care to a resident using an assistive device and the transported it to the storage room. The PSW stated they provided direct care to a resident with the assistive device and did not sanitize it prior to transporting it to the storage room.

Sources: Observation on December 20, 2021; Interviews with staff; PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012; General Cleaning and Disinfection Policy #IC-4.2.8, last revised July 2021.

e) Observation of PPE availability were conducted and the following noted:

-On one instance, an unlabeled face shield was hanging on the clean face shield rack at the nursing station.
-On multiple occasions, the PPE caddie and storage bins outside of several additional precautions resident rooms did not have clean face shields and face masks available.
-On one instance, a face shield was hanging on an unlabeled hook by the door frame outside of an additional precautions resident room.

-On two instances, Inspector #752 observed boxes of new gloves were left on hand rails in the resident home area hallway.

Registered Practical Nurse (RPN) #117 shared that certain PPE supplies continued to go missing due to residents' responsive behaviours and PPE supplies should not be left on the handrails. A unit RPN shared that PSWs were responsible to restock PPE supplies and to notify registered staff if more supplies were needed.

ADORC #102 stated the home encouraged staff to label their own face shield and they were responsible to clean and sanitize their face shield after each use. RPN #117 shared that their face shield labels kept rubbing off due to repeated sanitizing.

Sources: Observations (PPE availability on additional precautions rooms); Interviews with staff.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19. [s. 229. (4)]

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

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

Scope: The scope of this non-compliance was patterned because the IPAC related concerns were identified during the inspection and from observations throughout the home.

Compliance History: In the past 36 months, seven WNs and one VPCs were issued to the home related to different sub-sections of the legislation. (752) (752)

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 : Feb 14, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 10th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

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

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