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 West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Nov 02, 2020	2020_610633_0016 (A1)	002751-20, 007290-20, 008346-20, 010684-20, 013492-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Dufferin
151 Centre Street SHELBURNE ON L9V 3R7

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

Dufferin Oaks
151 Centre Street SHELBURNE ON L9V 3R7

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

Amended by SHERRI COOK (633) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension to November 13, 2020, to complete staff training requested by the home.

Issued on this 2 nd day of November, 2020 (A1)

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

Original report signed by the inspector.

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

Division des opérations relatives aux soins de longue durée
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151 Centre Street SHELBURNE ON L9V 3R7

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

Dufferin Oaks
151 Centre Street SHELBURNE ON L9V 3R7

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

Amended by SHERRI COOK (633) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10-14, 17-20, 2020.

The following intakes were completed in this Critical Incident System inspection: Log #'s 007290-20, 008346-20, 013492-20 and 010684-20 related to falls prevention; Log #002751 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Facility Manager (FM), Registered Nurses (RNs), the Wound Care Lead (WCL)/Registered Practical Nurse (RPN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Nurses Aide (NA) and residents.

In addition, the inspectors(s) observed resident care and staff to resident interactions. The plan of care for the identified residents was reviewed as well the home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 :

The licensee failed to ensure that two resident's received an initial skin wound assessment by the registered staff using a clinically appropriate assessment tool when clinically indicated.

A) A residents wrists were reddened and a bruise was noted. Staff were unable to determine the extent of the resident's injury in the absence of skin assessments not being completed by the registered staff for bruising as required. There were no prior or further assessments regarding the resident's bruising completed.

Sources- The resident's progress notes, skin and wound assessments and eTAR; the LTCHs investigation notes; interviews with a RPN, the WCL and others.

B) A resident sustained a skin injury during a fall. There was no initial or further skin and wound assessments of the resident's wounds completed.

Sources: The resident's skin and wound assessments, eTAR, progress notes; interview with a RPN and the WCL.

2. The licensee has failed to ensure that a resident, who had multiple areas of altered skin integrity, received immediate treatment to promote, prevent and treat infection.

A resident had multiple areas of altered skin integrity. The resident was at risk for further skin breakdown due to their diagnoses and decreased bed mobility. Registered staff documented initial signs of infection involving the resident's wound. A registered staff member had applied the incorrect treatment dressing which resulted in increased moisture to the area. Assessments and treatment for the wound infection were delayed and the wound worsened. The resident required increased pain management during this time period.

Sources: The resident's skin assessments, WCL referrals, progress notes, eTAR, lab result, prescriber orders and interviews with the WCL and others.

3. The licensee has failed to ensure that two resident's, who had multiple areas of altered skin integrity, were reassessed at a minimum of at least weekly by a member of the registered nursing staff when clinically indicated.

A) A resident had two areas of bruising. An initial skin assessment was completed however, there was no further monitoring or weekly skin assessments.

Sources: The resident's skin assessments, eTAR, progress notes, interviews with the WCL and others.

B) A resident had multiple areas of altered skin integrity. A staff member said the one area had healed however, another staff member said that two areas were sore, reddened and required off-loading to relieve pressure. A pressure injury was not assessed until 12 days later. There was no further monitoring and no assessments completed for four areas of skin breakdown. A pressure injury was not monitored or assessed weekly and the wound worsened during this time period.

Despite receiving training on skin and wound, multiple staff had varying answers regarding the expectation for skin and wound assessment and monitoring. The home's training did not include the home's policy. There were instances where the home's policy was not followed by staff regarding assessing/monitoring skin and wound daily on the eTAR and completing the minimum of weekly assessments when clinically indicated on a clinically appropriate tool. The home's policy also did not provide clear directions for staff for assessing all areas of altered skin integrity.

Sources: The resident skin and wound assessments, progress notes, eTAR; the LTCHs Skin and Wound Program policy (September 2019) and staff training records (August 2019), interview with the WCL and others.

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 O.Reg 79/10, s. 81. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 81.

Findings/Faits saillants :

The licensee has failed to ensure that a medical directive and treatment orders for a resident's wounds were individualized to the resident's condition and needs.

A resident had multiple areas of alter skin integrity. The routine standing admission orders for the resident did not identify the resident's individualized skin conditions and specify each skin and wound treatment. The resident's written prescriber orders were transcribed by the registered staff to the resident's treatment record however, these did not specify the number of wounds, type or location and did not specify the treatment required for each area. A registered staff member applied the incorrect skin and wound treatment and the resident's wounds worsened.

Sources: The resident routine admission orders, prescriber order forms, progress notes, skin and wound assessments, eTAR, interviews with the WCL, ADOC and others.

Additional Required Actions:

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

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that responsive behavior interventions that were set out in the plan of care were provided to a resident as specified in their plan.

A resident was known to be aggressive. When the resident was demonstrating responsive behaviours towards another resident, staff were directed to use specific techniques to manage the resident's behaviours. An incident occurred with another resident and a staff member did not follow the responsive behaviour interventions in the resident's care plan. The residents behaviours increased and altered skin integrity was noted after the staff member intervened.

Sources: The resident care plan; the LTCHs investigation records, and interview with the DOC.

2. The licensee has failed ensure that a resident’s plan of care regarding their skin and wound and safety care needs was provided to the resident as set out in their plan of care.

A) PSW staff were directed to reposition a resident hourly on their side to offload pressure however, on two dates, the resident was observed lying supine directly on their back in bed. The resident stated they were in pain.

B) PSW staff were directed to complete a safety check and document. An incident occurred and the resident's safety check was not completed as required. The resident was found in an unsafe situation and they stated they were in pain.

C) PSW staff were directed to ensure the resident’s call bell was placed in a specific position so that the resident could use it to call for assistance. On two dates, the resident’s call bell was observed not within reach. The resident was unable to call staff for help while they were in pain.

Sources: Resident observations/interview; skin and wound assessments, care plan, POC, and interview with a PSW and others.

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 responsive behavior interventions are provided to a resident and the skin and wound/safety needs for another resident are provided to the residents as specified in their plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (1) Subject to subsections (2) to (4), every licensee of a long-term care home shall ensure that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage,
(a) the heating system; O. Reg. 79/10, s. 19 (1).
(b) emergency lighting in hallways, corridors, stairways and exits; and O. Reg. 79/10, s. 19 (1).
(c) essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment. O. Reg. 79/10, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home’s generator had the capacity to maintain a resident's essential equipment during a power outage.

There was a power outage at the home and a resident's essential equipment was not serviced by the home's generator. The resident experienced increased pain and was unsafe when the power was interrupted at the home.

Sources: Resident observation/interview; care plan, POC, the home’s related policy (January 2019), interviews with a RPN, the FM and others.

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 home's generator services all essential equipment at the home when there is a power outage, to be implemented voluntarily.

Issued on this 2 nd day of November, 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

Ordre(s) de l'inspecteur

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

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHERRI COOK (633) - (A1)
Inspection No. / No de l'inspection :	2020_610633_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002751-20, 007290-20, 008346-20, 010684-20, 013492-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 02, 2020(A1)
Licensee / Titulaire de permis :	Corporation of the County of Dufferin 151 Centre Street, SHELBURNE, ON, L9V-3R7
LTC Home / Foyer de SLD :	Dufferin Oaks 151 Centre Street, SHELBURNE, ON, L9V-3R7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Wagner

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

To Corporation of the County of Dufferin, 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 :

The licensee must be compliant with O. Reg. 79/10 s. 50(2)(b)(i)(ii)(iv).

Specifically, the licensee must ensure that:

A) Two resident's receive an initial and weekly skin assessment for altered skin integrity using a clinically appropriate tool when clinically indicated.

B) The home's skin and wound policy is reviewed and revised to ensure compliance with the legislation and clear direction for staff regarding the assessment of skin and wound concerns.

C) All registered staff receive re-training on the home's revised skin and wound policy. The date of training and staff sign off must be documented and a record kept in the home.

D) The home develops and implements a plan as needed for the WCL coverage to ensure that when they are not able to perform their duties or are absent there is a trained registered staff member available to assess and treat skin and wound concerns.

E) An auditing process is developed and implemented to ensure compliance with the legislation and the home's process for the assessment and providing treatment of skin and wound concerns. The date, who is responsible, the resident's audited, the results and actions taken in response must be documented and a record kept in the home. Audits are to be completed until such time as staff are compliant with the legislation and the home's skin and wound policy.

Grounds / Motifs :

1. The licensee failed to ensure that two resident's received an initial skin wound assessment by the registered staff using a clinically appropriate assessment tool when clinically indicated.

A) A residents wrists were reddened and a bruise was noted. Staff were unable to determine the extent of the resident's injury in the absence of skin assessments not being completed by the registered staff for bruising as required. There were no prior or further assessments regarding the resident's bruising completed.

Sources- The resident's progress notes, skin and wound assessments and eTAR; the LTCHs investigation notes; interviews with a RPN, the WCL and others.

B) A resident sustained a skin injury during a fall. There was no initial or further skin and wound assessments of the resident's wounds completed.

Sources: The resident's skin and wound assessments, eTAR, progress notes; interview with a RPN and the WCL.

2. The licensee has failed to ensure that a resident, who had multiple areas of altered skin integrity, received immediate treatment to promote, prevent and treat infection.

A resident had multiple areas of altered skin integrity. The resident was at risk for further skin breakdown due to their diagnoses and decreased bed mobility. Registered staff documented initial signs of infection involving the resident's wound. A registered staff member had applied the incorrect treatment dressing which resulted in increased moisture to the area. Assessments and treatment for the wound infection were delayed and the wound worsened. The resident required increased pain management during this time period.

Sources: The resident's skin assessments, WCL referrals, progress notes, eTAR, lab result, prescriber orders and interviews with the WCL and others.

3. The licensee has failed to ensure that two resident's, who had multiple areas of altered skin integrity, were reassessed at a minimum of at least weekly by a member of the registered nursing staff when clinically indicated.

A) A resident had two areas of bruising. An initial skin assessment was completed however, there was no further monitoring or weekly skin assessments.

Sources: The resident's skin assessments, eTAR, progress notes, interviews with the WCL and others.

B) A resident had multiple areas of altered skin integrity. A staff member said the one area had healed however, another staff member said that two areas were sore, reddened and required off-loading to relieve pressure. A pressure injury was not

assessed until 12 days later. There was no further monitoring and no assessments completed for four areas of skin breakdown. A pressure injury was not monitored or assessed weekly and the wound worsened during this time period.

Despite receiving training on skin and wound, multiple staff had varying answers regarding the expectation for skin and wound assessment and monitoring. The home's training did not include the home's policy. There were instances where the home's policy was not followed by staff regarding assessing/monitoring skin and wound daily on the eTAR and completing the minimum of weekly assessments when clinically indicated on a clinically appropriate tool. The home's policy also did not provide clear directions for staff for assessing all areas of altered skin integrity.

Sources: The resident skin and wound assessments, progress notes, eTAR; the LTCHs Skin and Wound Program policy (September 2019) and staff training records (August 2019), interview with the WCL and others.

An order was made by taking the following factors into account:
Severity: Lack of assessment and treatment contributed to worsening wounds.
Scope: This non-compliance was widespread as 3/3 residents reviewed were not assessed.
Compliance History: the home has a history of unrelated non-compliance in the past 36 months.

(767)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 13, 2020(A1)

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 81. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 81.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 81.

Specifically, the licensee must ensure that orders for the treatment of skin and wound concerns for a resident are individualized for each skin/wound concern and the treatment required.

Grounds / Motifs :

1. The licensee has failed to ensure that a medical directive and treatment orders for a resident's wounds were individualized to the resident's condition and needs.

A resident had multiple areas of alter skin integrity. The routine standing admission orders for the resident did not identify the resident's individualized skin conditions and specify each skin and wound treatment. The resident's written prescriber orders were transcribed by the registered staff to the resident's treatment record however, these did not specify the number of wounds, type or location and did not specify the treatment required for each area. A registered staff member applied the incorrect skin and wound treatment and the resident's wounds worsened.

Sources: The resident routine admission orders, prescriber order forms, progress notes, skin and wound assessments, eTAR, interviews with the WCL, ADOC and others.

An order was made by taking the following factors into account:
Severity: Lack of individualized wound treatment orders resulted in the incorrect treatment being applied and worsening wound infection.
Scope: This non-compliance was a pattern as 2/3 treatment orders were not individualized.
Compliance History: the home has a history of unrelated non-compliance in the past 36 months.

(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 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 2 nd day of November, 2020 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by SHERRI COOK (633) - (A1)

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