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

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
Jun 8, 2020	2020_610633_0008	008563-20, 008762-20	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Forest Heights
60 Westheights Drive KITCHENER ON N2N 2A8

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

SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 19-23, 25-29 and June 1, 2, 2020.

The following complaint inspections were completed during this inspection:

Log #008563-20- related to infection prevention and control (IPAC) and skin and wound care;
Log #008762-20- related to IPAC and pain management.

During the course of the inspection, the inspector(s) spoke with the COVID-19 Response Team Lead Non-hospital, the President of St. Mary's General Hospital, the Acting Medical Officer of Health (AMOH) Waterloo Wellington, Waterloo Public Health team members, the Chief Medical Officer (CMO), a Medical Doctor (MD), the National Director of Operations, the Regional Manager of Operations, Revera Corporate team members, the Executive Director (ED), the Director of Care (DOC), Registered Nurses (RNs), the Wound Care Lead RN (WCL), a Registered Practical Nurse (RPN), a Behavioural Supports Ontario (BSO)\ Personal Support Worker (PSW), PSWs, and family members.

In addition, multiple observations were completed regarding IPAC practices and staff and resident interactions. Extensive records were reviewed that included the plan of care for identified residents, the homes related documentation, policies and procedures, and external records, directives and best practices related to IPAC.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Pain
Skin and Wound Care

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

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

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

The licensee has failed to ensure that the home's infection prevention and control (IPAC) program was implemented.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22 and 30, 2020, Directive #3 was issued and revised to all Long-Term Care Homes (LTC-Homes) under the Long-Term Care Homes Act (LTCHA),2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC-Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC-Homes to implement measures to protect all residents and staff.

The licensee must comply with any order or directive issued under the HPPA which included the implementation of:

1. COVID-19 Directive #1 for Health Care Providers and Health Care Entities regarding the appropriate use of personal protective equipment (PPE).
2. Staff and resident cohorting, which included isolation procedures.
3. Environmental cleaning.

The licensee's outbreak management policy and procedure stated in part that the homes would be proactive and follow the provincial/regional management protocols as applicable. In addition, the policy referenced a specific Public Health Agency of Canada (PHAC) guideline.

A COVID-19 outbreak was declared by Public Health (PH) at Forest Heights LTC-Home on a specific date.

A support team comprised of non-hospital, hospital and Public Health (TRIAD) in conjunction with the Ministry Long-Term Care (MLTC) and the Local Health Integration Network (LHIN) began working with the Licensee and Forest Heights as of a specific date. Decanting multiple residents to three local hospitals was urgently initiated and further resident decanting was required. The purpose of decanting residents to hospital was to ensure appropriate IPAC measures were implemented at the home and was

specifically related to appropriate cohorting of residents and staff.

Two complaints were received by the MLTC which identified concerns related to both resident and staff cohorting, in addition to isolation measures at the home. In response to these concerns, this on-site inspection was initiated on a specific date.

Despite significant TRIAD, MLTC, PH, LHIN team supports, directives, guidance documents and recommendations provided to the home, the information gathered during the course of this inspection showed:

1. There were on-going PPE breaches on several dates.
2. Resident and staff cohorting had not been completed.
3. Resident isolation procedures were not fully implemented.
4. The environmental cleaning of the home's equipment was only implemented on a specific date.

The home and PH reported significant numbers of COVID-19 positive residents, resident deaths and positive staff. Despite supports by a number of agencies and the decanting of residents to hospital, the licensee's failure to implement the home's (IPAC) program and specific IPAC measures as required resulted in continued COVID-19 spread within the home.

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. 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 has failed to ensure that two identified residents, who exhibited altered skin integrity, received the required treatment to promote healing and prevent infection. Weekly skin assessments, using a clinically appropriate assessment instrument specifically designed for skin and wound were not completed as required.

A complaint was received by the Ministry of Long-Term Care (MLTC) by the family member of an identified resident that included a concern regarding the provision of appropriate skin and wound care during the COVID-19 outbreak. The complainant said that residents were at risk for wounds if basic care was not provided and if residents were left bed-bound during the outbreak.

A) The plan of care for this resident showed they had an area of altered skin integrity however, the status of their wound was unclear. Another resident was substituted for this resident.

B) A dated progress note documented that the family member of an identified resident was concerned about a specific wound.

The plan of care for this resident showed that they relied on staff for total care and mobility. During a specific time period, multiple skin and wound assessments were not

completed on specific dates as required. Daily monitoring and dressing checks/changes were not all completed. One wound worsened and another wound developed and worsened.

C) The plan of care for another resident related to skin and wound was reviewed. This resident relied on staff for total care and mobility. The resident was at on-going risk for altered skin integrity related to a specific diagnoses. During a specific time period, multiple skin and wound assessments were not completed on specific dates as required. Daily monitoring and dressing checks/changes were not all completed. The resident's wounds worsened.

D) A dated document showed a number of residents who developed new wounds and their location. An assessment of all residents at the home had not been completed as of a specific date.

Two staff confirmed the expectation for staff related to skin and wound assessments and treatment. They both said that due to insufficient staffing, the wound care lead was pulled to the floor and their role had not been replaced during a specific time period. They both agreed that resident skin and wound assessments and treatments were not completed as required.

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a verbal complaint made to the licensee concerning an allegation of neglect was investigated within 10 days and a response made to the person who made the complaint.

A complaint was received by the MLTC from the family member of an identified resident. The family member alleged neglect related to a specific treatment and IPAC measure at the home. The family member also did not know where the resident currently resided as decanting to hospitals had occurred.

Inspector #633 called the home and spoke with the Regional Manager of Education and Resident Services on a specific date. The nature of the allegation of neglect was discussed in detail and a request was made by the Inspector to investigate this significant concern and update both the family member and the Inspector of the outcome. The ED confirmed they were aware of these concerns. No investigation was completed and a response to the family member and the Inspector did not occur.

Issued on this 10th day of June, 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) :	SHERRI COOK (633)
Inspection No. / No de l'inspection :	2020_610633_0008
Log No. / No de registre :	008563-20, 008762-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 8, 2020
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Forest Heights 60 Westheights Drive, KITCHENER, ON, N2N-2A8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Scott Mumberson

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 O. Reg. 79/10, s. 229 (4).

Specifically, the licensee must ensure that:

1. All staff appropriately use personal protective equipment (PPE) in accordance with the current best practices. Audits of PPE must be conducted and documented and include at a minimum the date, person responsible, location, results and actions taken in response.

2. A staff and resident cohorting plan, which includes isolation procedures and strategies for wandering residents, is developed and implemented in accordance with best practices. The plan must be documented. Audits must be conducted and documented and include at a minimum the date, person responsible, location, results and actions taken in response.

3. Policies, procedures and staff training regarding environmental cleaning must be developed in accordance with best practices, implemented and documented. Audits of environmental cleaning must be conducted and documented and include at a minimum the date, person responsible, location, results and actions taken in response.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's infection prevention and control (IPAC) program was implemented.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22 and 30, 2020, Directive #3 was issued and revised to all Long-Term Care Homes (LTC-Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC-Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC-Homes to implement measures to protect all residents and staff.

The licensee must comply with any order or directive issued under the HPPA which included the implementation of:

1. COVID-19 Directive #1 for Health Care Providers and Health Care Entities regarding the appropriate use of personal protective equipment (PPE).
2. Staff and resident cohorting, which included isolation procedures.
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The licensee's outbreak management policy and procedure stated in part that the homes would be proactive and follow the provincial/regional management protocols as applicable. In addition, the policy referenced a specific Public Health Agency of Canada (PHAC) guideline.

A COVID-19 outbreak was declared by Public Health (PH) at Forest Heights LTC-Home on a specific date.

A support team comprised of non-hospital, hospital and Public Health (TRIAD) in conjunction with the Ministry Long-Term Care (MLTC) and the Local Health Integration Network (LHIN) began working with the Licensee and Forest Heights as of a specific date. Decanting multiple residents to three local hospitals was urgently initiated and further resident decanting was required. The purpose of decanting residents to hospital was to ensure appropriate IPAC measures were implemented at the home and was specifically related to appropriate cohorting of residents and staff.

Two complaints were received by the MLTC which identified concerns related to both resident and staff cohorting, in addition to isolation measures at the home. In response to these concerns, this on-site inspection was initiated on a specific

date.

Despite significant TRIAD, MLTC, PH, LHIN team supports, directives, guidance documents and recommendations provided to the home, the information gathered during the course of this inspection showed:

1. There were on-going PPE breaches on several dates.
2. Resident and staff cohorting had not been completed.
3. Resident isolation procedures were not fully implemented.
4. The environmental cleaning of the home's equipment was only implemented on a specific date.

The home and PH reported significant numbers of COVID-19 positive residents, resident deaths and positive staff. Despite supports by a number of agencies and the decanting of residents to hospital, the licensee's failure to implement the home's (IPAC) program and specific IPAC measures as required resulted in continued COVID-19 spread within the home.

The severity of the issue was actual harm or actual risk for harm. The scope of the issue was widespread as all residents and staff were impacted. The home had a history of unrelated non-compliance. (633)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2020

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. 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 complaint with O. Reg. 79/10, s. 50 (2).

Specifically, the licensee must ensure that:

1. Two identified residents, and all residents with altered skin integrity, receive a weekly skin and wound assessment by the registered staff using a clinically appropriate tool.

2. Two identified residents, and all residents, are provided all clinically indicated skin and wound treatments. Skin and wound treatments are documented per the home's process.

3. All residents at the home are assessed for altered skin integrity and their plan of care is updated. The date of the review, person responsible, resident, result and actions taken in response must be documented.

4. Skin and wound audits that include at a minimum the date, person responsible, resident, results and action taken in response must be implemented regarding weekly assessments, treatment and documentation. Audit documentation must be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that two identified residents, who exhibited altered skin integrity, received the required treatment to promote healing and prevent infection. Weekly skin assessments, using a clinically appropriate assessment instrument specifically designed for skin and wound were not completed as required.

A complaint was received by the Ministry of Long-Term Care (MLTC) by the family member of an identified resident that included a concern regarding the provision of appropriate skin and wound care during the COVID-19 outbreak. The complainant said that residents were at risk for wounds if basic care was not provided and if residents were left bed-bound during the outbreak.

A) The plan of care for this resident showed they had an area of altered skin integrity however, the status of their wound was unclear. Another resident was substituted for this resident.

B) A dated progress note documented that the family member of an identified resident was concerned about a specific wound.

The plan of care for this resident showed that they relied on staff for total care and mobility. During a specific time period, multiple skin and wound assessments were not completed on specific dates as required. Daily monitoring and dressing checks/changes were not all completed. One wound worsened and another wound developed and worsened.

C) The plan of care for another resident related to skin and wound was reviewed. This resident relied on staff for total care and mobility. The resident was at on-going risk for altered skin integrity related to a specific diagnoses. During a specific time period, multiple skin and wound assessments were not completed on specific dates as required. Daily monitoring and dressing checks/changes were not all completed. The resident's wounds worsened.

D) A dated document showed a number of residents who developed new wounds and their location. An assessment of all residents at the home had not been completed as of a specific date.

Two staff confirmed the expectation for staff related to skin and wound assessments and treatment. They both said that due to insufficient staffing, the wound care lead was pulled to the floor and their role had not been replaced during a specific time period. They both agreed that resident skin and wound assessments and treatments were not completed as required.

The severity of the issue was actual harm and/or actual risk for harm. The scope of the issue was a pattern as it was identified for two of three residents that were reviewed. The home had a history of unrelated non-compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 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 8th day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Cook

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