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
Feb 16, 2021	2021_784762_0001	003510-20, 017454-20, 020226-20	Complaint

Licensee/Titulaire de permis

Shepherd Village Inc.
3758/3760 Sheppard Avenue East Toronto ON M1T 3K9

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

Shepherd Lodge
3760 Sheppard Avenue East Toronto ON M1T 3K9

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

MOSES NEELAM (762)

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): January 14, 18-22 and 25, 2021

The following intakes were inspected during this Complaint and Follow up Inspection:
- Log #017454-20 related to a complaint regarding multiple areas of the residents activities of daily living (ADLs), infection control and hydration.
- Log #003510-20/ Inspection #2020_626501_0003, related to Compliance Order (CO) #1, specifically around the Long-Term Care Homes (LTCH) falls prevention program and policies
- Log #020226-20/Inspection #2020_829757_0023, related to the abuse of a resident

During the course of the inspection, the inspector(s) spoke with Manager for Quality and Compliance(QCM),Registered Dietician (RD), Recreation Manager, Recreation Assistant, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family members and residents.

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_829757_0023	762
O.Reg 79/10 s. 8. (1)	CO #001	2020_626501_0003	762

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on the hydration status and any risks relating to hydration.

The resident care plan indicated resident #006 was to have a certain amount of fluid per day. Based on a review of records the resident was not receiving their recommended amount of fluid and was consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The plan of care did not contain an assessment of the resident’s hydration status or identify any risks related to the resident consumption of 25-50% less than what we required; this was confirmed by the RD.

The resident was sent out to the hospital multiple times, during which the resident was diagnosed with a specific condition that could be related to dehydration. A review of the records seven days prior to the resident being sent out to the hospital indicated that the resident was having between an average of 65-85% fluid prior to being sent to the hospital. As a result, the resident was at actual risk of harm, as the resident experienced the symptoms of dehydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104;

2. The licensee has failed to ensure that the plan of care was based on the hydration status and any risks relating to hydration.

The resident care plan indicated resident #002 was to have a certain amount of fluid per day. Based on the assessment of the dietician on two different dates, the resident was not receiving their recommended amount of fluid and was consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The plan of care did not contain an assessment of the resident’s hydration status or identify any risks related to the resident consumption of 25-50% less than what was required; this was confirmed by the RD. As a result, the resident was at potential risk of experiencing negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interview with RD #104;

3. The licensee has failed to ensure that the plan of care was based on the hydration status and any risks relating to hydration.

The registered dietician assessment indicated that resident #004 was to have a certain amount of fluid. A review of the records showed that the resident's documented fluid intake showed that the resident was consuming less than their average requirement. The resident was drinking below 75% of the fluid for 23% of the review period. The plan of care did not contain the resident's hydration status or identify any risks related to the resident consumption of 25% less than what was required; this was confirmed by the RD. As a result, the resident was at potential risk of experiencing negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104 and RPN #105;

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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition program has a system to monitor and evaluate the fluid intake of residents with identified risks related to hydration.

The resident care plan indicated resident #006 was to have a certain amount of fluid per day. Based on a review of records the resident was not receiving their recommended amount of fluid and were consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The plan of care did not contain an assessment of the resident's hydration status or identify any risks related to the resident consumption of 25-50% less than what we required; this was confirmed by the RD.

The resident was sent out to the hospital multiple times, during which the resident was diagnosed with a specific condition that could be related to dehydration. A review of the records seven days prior to the resident being sent out to the hospital indicated that the resident was having between an average of 65-85% fluid prior to being sent to the hospital. As a result, the resident was at actual risk of harm, as the resident experienced the symptoms of dehydration. In separate interviews, RPNs and the RD indicated that the residents hydration would not be evaluated in between the RD's quarterly or significant change assessments, if the PSW did not provide a report or the Registered Staff did not notice signs of dehydration from a resident. As a result, the resident was at actual risk of harm, as the resident experienced the symptoms of dehydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104, RPN #109 and QCM #113;

2. The licensee has failed to ensure that the nutrition program has a system to monitor and evaluate the fluid intake of residents with identified risks related to hydration.

The resident care plan indicated resident #002 was to have a certain amount of fluid per day. Based on the assessment of the dietician on two different dates, the resident was not receiving their recommended amount of fluid and was consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. In separate interviews, the RPN and

RD indicated that the residents hydration would not be evaluated in between the RD’s quarterly or significant change assessments, if the PSW did not provide a report or the Registered Staff did not notice signs of dehydration from a resident. As a result, the resident was at potential risk of experiencing negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104 and RPN #109

3. The licensee has failed to ensure that the nutrition program has a system to monitor and evaluate the fluid intake of residents with identified risks related to hydration.

The registered dietician assessment indicated that resident #004 was to have a certain amount of fluid. A review of the records showed that the resident’s documented fluid intake showed that the resident was consuming less than their average requirement. In separate interviews, RPNs and the RD indicated that the residents hydration would not be evaluated in between the RD’s quarterly or significant change assessments, if the PSW did not provide a report or the Registered Staff did not notice signs of dehydration from a resident. As a result, the resident was at potential risk of experiencing the negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104, RPN #105 and RPN #108

Additional Required Actions:

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

Issued on this 25th day of February, 2021

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MOSES NEELAM (762)
Inspection No. / No de l'inspection :	2021_784762_0001
Log No. / No de registre :	003510-20, 017454-20, 020226-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 16, 2021
Licensee / Titulaire de permis :	Shepherd Village Inc. 3758/3760 Sheppard Avenue East, Toronto, ON, M1T-3K9
LTC Home / Foyer de SLD :	Shepherd Lodge 3760 Sheppard Avenue East, Toronto, ON, M1T-3K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Fiore

To Shepherd Village Inc., 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. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee must be compliant with r. 26. (3) 14 of the Regulations 79/10:

Specifically, the licensee must:
1. Ensure the plan of care is based on an interdisciplinary assessment of residents #002, #004 and #006's hydration status and any risks in relation to hydration.
2.Ensure in the RD's assessment residents #002, #004 and #006 hydration status and any risks related to hydration are noted.
3. Ensure all direct care staff are educated on the residents hydration status, any risks related to hydration and where this information can be found in the plan of care. A record of this education must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was based on the hydration status and any risks relating to hydration.

The resident care plan indicated resident #006 was to have a certain amount of fluid per day. Based on a review of records the resident was not receiving their recommended amount of fluid and was consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The plan of care did not contain an assessment of the resident's hydration status or identify any risks related to the resident consumption of 25-50% less than what we required; this was confirmed by the RD.

The resident was sent out to the hospital multiple times, during which the resident was diagnosed with a specific condition that could be related to dehydration. A review of the records seven days prior to the resident being sent out to the hospital indicated that the resident was having between an average of 65-85% fluid prior to being sent to the hospital. As a result, the resident was at actual risk of harm, as the resident experienced the symptoms of dehydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104; (762)

2. The resident care plan indicated resident #002 was to have a certain amount of fluid per day. Based on the assessment of the dietician on two different dates, the resident was not receiving their recommended amount of fluid and were consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The plan of care did not contain an assessment of the resident's hydration status or identify any risks related to the resident consumption of 25-50% less than what was required; this was confirmed by the RD. As a result, the resident was at potential risk of experiencing the negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interview with RD #104; (762)

3. The registered dietician assessment indicated that the resident #004 was to have a certain amount of fluid. A review of the records showed that the resident's documented fluid intake showed that the resident was consuming less than their average requirement. The resident was drinking below 75% of the fluid for 23% of the review period. The plan of care did not contain the resident's hydration status or identify any risks related to the resident consumption of 25% less than what was required; this was confirmed by the RD. As a result, the resident was at potential risk of experiencing the negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104 and RPN #105;

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

Severity: There was actual risk of harm because residents #006 was drinking less than recommended fluid prior to being sent out to the hospital multiple times with an diagnosis that could be related to dehydration. Resident #002 and #004 were at minimal risk of harm as there was no indication of the plan of care being based on the resident's hydration status and risks related to hydration.

Scope: The Scope of this non-compliance was widespread because there was no indication of the plan of care being based on the residents hydration status and risks related to hydration for three out of three residents

Compliance History: One written notifications (WN) and Voluntary Plan of Correction (VPC) was issued to the home related to different sub-sections of the legislation in the past 36 months. (762)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 14, 2021

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. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with s. 68. (2) (d) of the Regulations 79/10:

Specifically, the licensee must:
1. Establish a process by which resident #002, #004 and #006's fluids are evaluated more frequently than every quarter or significant change by the RD.
2. Establish a process for making a referral to the RD when the resident is not meeting their hydration goals.
3. Ensure all direct care staff are educated on the residents hydration goals and where this information can be found in the plan of care. A record of this education must be kept

Grounds / Motifs :

1. The licensee has failed to ensure that the nutrition program has a system to monitor and evaluate the fluid intake of residents with identified risks related to hydration.

The resident care plan indicated resident #006 was to have a certain amount of fluid per day. Based on a review of records the resident was not receiving their recommended amount of fluid and was consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The plan of care did not contain an assessment of the resident's hydration status or identify any risks related to the resident consumption of 25-50% less than what we required; this was confirmed by the RD.

The resident was sent out to the hospital multiple times, during which the resident was diagnosed with a specific condition that could be related to dehydration. A review of the records seven days prior to the resident being sent out to the hospital indicated that the resident was having between an average of 65-85% fluid prior to being sent to the hospital. As a result, the resident was at actual risk of harm, as the resident experienced the symptoms of dehydration. In separate interviews, RPNs and the RD indicated that the residents hydration would not be evaluated in between the RD's quarterly or significant change assessments, if the PSW did not provide a report or the Registered Staff did not notice signs of dehydration from a resident. As a result, the resident was at actual risk of harm, as the resident experienced the symptoms of dehydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104, RPN #109 and QCM #113;
(762)

2. The resident care plan indicated resident #002 was to have a certain amount of fluid per day. Based on the assessment of the dietician on two different dates, the resident was not receiving their recommended amount of fluid and was consuming less than their average requirement. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. The average daily fluid intake indicated the resident was drinking between 50-75% of their fluid intake. In separate interviews, the RPN and RD indicated that the residents hydration would not be evaluated in between the RD's quarterly or significant change assessments, if the PSW did not provide a report or the Registered Staff did not notice signs of dehydration from a resident. As a result,

the resident was at potential risk of experiencing the negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104 and RPN #109 (762)

3. The registered dietician assessment indicated that the resident #004 was to have a certain amount of fluid. A review of the records showed that the resident's documented fluid intake showed that the resident was consuming less than their average requirement. The resident was drinking below 75% of the fluid for 23% of the review period. The plan of care did not contain the resident's hydration status or identify any risks related to the resident consumption of 25% less than what was required; this was confirmed by the RD. As a result, the resident was at potential risk of experiencing the negative symptoms of risks related to hydration.

Sources: Progress notes; Fluid Look back reports; Policies on hydration and nutrition; Quarterly Nutrition assessments; Care plans; Interviews with RD #104 and RPN #105;

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

Severity: There was actual risk of harm because residents #006 was drinking less than recommended fluid prior to being sent out to the hospital multiple times with an diagnosis that could be related to dehydration. Resident #002 and #004 were at minimal risk of harm as there was no indication of the plan of care being based on the residents hydration status and risks related to hydration.

Scope: The Scope of this non-compliance was widespread because there was no indication of the plan of care being based on the residents hydration status and risks related to hydration for three out of three residents

Compliance History: One written notifications (WN) and Voluntary Plan of Correction (VPC) was issued to the home related to different sub-sections of the legislation in the past 36 months. (762)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 14, 2021

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 16th day of February, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Moses Neelam

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