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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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Téléphone: (416) 325-9660
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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
Mar 29, 2022	2022_780699_0004 (A1)	013830-21, 013831-21, 015738-21, 020146-21, 021045-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Erin Meadows
2930 Erin Centre Boulevard Mississauga ON L5M 7M4

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

Amended by NITAL SHETH (500) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The LTC home has requested an extension to the Compliance Due Date (CDD) for CO #001 related to recent recruitment of staff and training requirements- extension granted, new CDD April 14, 2022.

Issued on this 29th day of March, 2022 (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

Inspection Report under *the Long-Term Care Homes Act, 2007*

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2930 Erin Centre Boulevard Mississauga ON L5M 7M4

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

Amended by NITAL SHETH (500) - (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): January 24-28, 31, 2022.

The following Critical Incident System (CIS) intakes were completed:

-Log #015738-21 [CIS 2881-000018-21], #020146-21 [CIS 2881-000022-21] related to falls with injury.

The following Follow up intakes were completed:

-Log #013830-21 related to Compliance Order (CO) #001 from inspection #2021_766500_0022;

-log #013831-21 related to CO #002 from inspection #2021_766500_0022.

A mandatory Infection Prevention and Control (IPAC) checklist was completed.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Neighbourhood Coordinator (NC), Kinesiologist (KIN), Peel Public Health Case Manager (PPHCM), IPAC lead, Registered practical nurses (RPN), personal support workers (PSW), and housekeeping aide (HA).

During the course of the inspection the inspector observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control

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

- **4 WN(s)**
- **2 VPC(s)**
- **1 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
O.Reg 79/10 s. 36.	CO #002	2021_766500_0022	699
O.Reg 79/10 s. 8. (1)	CO #001	2021_766500_0022	699

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

The home submitted a CIS report indicating that the home was declared in a respiratory outbreak.

a) During observations conducted by the inspector, the DNC and the NC told the

inspector that the only residents that were on droplet/contact isolation in the home were residents who had tested positive for a respiratory infection, and those with pending test results. All other residents were not isolated, however staff could wear personal protective equipment (PPE) based on a point of care risk assessment. Only five residents were on isolation precautions at the time the inspector conducted observations.

Both the IPAC lead and the PPHCM, stated that droplet/contact precautions should have been in place for the whole home, and that all residents should have been on contact/droplet precautions at the time of the inspector's observations. The IPAC lead stated that the residents were placed on droplet/contact isolation as they were identified as high-risk exposures due to the number of staff that were testing positive on the neighbourhoods. Staff were expected to wear the required PPE for contact/droplet precautions, which included a gown, face shield, mask, and gloves, and/or a N95 respirator [for suspected, probable, or confirmed respiratory infection cases], for resident interactions. The inspector observed staff entering resident rooms, interacting with residents, while wearing some but not all of the required personal protective equipment. There was no consistent use of additional precautions by staff.

Staff stated that they discontinued isolation of residents when the required ten days of isolation had passed, and once they received direction from the IPAC lead. However, when the IPAC lead was off for a period of time, they were not aware of who to contact for direction. The IPAC Lead said that they would communicate to the leaders of the units about the ongoing IPAC measures throughout the home and that the information should be communicated to the staff on the neighbourhoods. The DNC indicated that when the IPAC lead was off, the IPAC tasks were delegated to the leadership team to communicate to the staff. The IPAC lead and the DNC acknowledged that there was a gap in the communication with the staff and the implementation of additional precautions and expectations during the outbreak.

b) As per the home’s policy, Managing a Respiratory Outbreak, outbreak signs were to be placed on the entrance of the neighbourhood, main entrances and elevators. There were no outbreak signs noted by the inspector upon entry to the home. The home had posted droplet/contact precaution signs on the entrance doors to the neighbourhoods and all the resident doors. Staff indicated that the droplet/contact precaution signs on the resident doors meant that the home was in outbreak, but did not necessarily mean they were required to wear full PPE.

This was up to the comfort of the staff. The home did not have signage to indicate the entire home was in outbreak as per the IPAC lead.

Residents who were on droplet/contact isolation and unable to stay in their room due wandering behaviours and/or at risk for falls in their room, could be brought to an area where staff could supervise them. However, the expectation was that staff should wear the appropriate PPE while interacting with the residents, such as wearing a N95 respirator.

A resident was on droplet/contact isolation, as they had signs and symptoms of a respiratory infection and were subsequently tested. The inspector observed a staff member, only wearing a face shield and surgical mask, in front of the resident who was in the TV lounge, less than 6 feet away from another resident. Staff indicated it was difficult to keep the resident on isolation as they had behaviours of wandering, however, they re-directed them as best they could.

c) Staff were expected to take their breaks in the dining room or country kitchen, six feet apart from each other. Staff were not to take breaks in resident rooms or in areas that were not identified as break areas. Three staff were observed in the activity room on the Trafalgar neighbourhood, less than six feet apart, not wearing a surgical mask and with their face shield off. Another staff member was observed in a resident room, taking their break, while the resident was not in the room. In front of the DNC's office, near the double doors leading to the retirement home, two staff were observed having lunch, less than 6 feet apart, with their mask and face shield off.

d) Inconsistent hand hygiene practices were observed. Staff were observed assisting different residents with putting on their clothing protectors for meals, and interacting with residents in preparation for the meal, but, with no hand hygiene completed between resident interactions.

The risk of transmission of a respiratory infection to residents was increased due to the lack of implementation of the IPAC program, and communication to staff about required additional precautions.

Sources: Observations conducted by the inspector; record review of a resident’s progress notes; home’s policy, “Managing a Respiratory Outbreak” Tab 04-05; Directive #5, issued December 17, 2021; and interviews with relevant staff. [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

As per Directive #3, issued December 24, 2021, home's were required to develop and implement a COVID-19 Outbreak Plan, which included weekly IPAC self-audits at a minimum of every two weeks when the home was not in an outbreak, and at a minimum of once a week when the home was in an outbreak. The home did not complete audits for two weeks. The home had an increased likelihood of missing gaps in the implementation of their IPAC program, when audits were not completed, placing residents at an increased risk of transmission.

Sources: Observations conducted by inspector, IPAC Self-audit dated January 5, 2022, Directive #3, and interviews with staff. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home submitted a CIS report related to a resident who sustained a fall with injury.

The resident was observed to self-transfer out of their mobility device and onto the floor due to responsive behaviour. Two staff assisted the resident back to their mobility device. Review of the progress notes, and assessment tab in PointClickCare (PCC) did not indicate that a post fall assessment was completed. Staff stated that a resident that self-transferred out of their mobility device would be considered a fall and that a post fall assessment should be completed. They acknowledged that a post fall assessment was not completed for the resident's fall. The resident did not sustain an injury.

Sources: The resident's progress notes, assessments, and interview with staff. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: 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 :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident required a specified fall intervention when seated in their mobility device as part of their plan of care. During observations conducted by the inspector, the resident was noted to be in their mobility device without the specified fall intervention in place. The fall intervention had not been transferred to the loaner mobility device which put them at increased risk of falls.

Sources: Resident's care plan, observations conducted, interviews with staff. [s. 6. (7)]

Issued on this 29th day of March, 2022 (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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NITAL SHETH (500) - (A1)
Inspection No. / No de l'inspection :	2022_780699_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013830-21, 013831-21, 015738-21, 020146-21, 021045-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 29, 2022(A1)
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Erin Meadows 2930 Erin Centre Boulevard, Mississauga, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sutha Vinayaga

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

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 s. 229. (4) of the O. Regs 79/10.

Specifically, the licensee shall :

1. Develop and implement a written audit tool to be completed on every shift, for a period of one month upon receipt of this order, to monitor that all staff wear the required PPE, while working in resident care areas; and follow the home's IPAC policy. The audit must include, date and time, who conducted the audit and any corrective actions taken as a result of the audit. The records must be made available upon request.
2. Re-educate all registered staff, including the leadership team, on the home's 'Managing a Respiratory Outbreak' policy.
3. Develop a protocol for residents who are unable maintain isolation or contact droplet precautions due to responsive behaviours or increased risk of falls, to mitigate risk of transmission of infection to other residents and staff. All direct care staff should be educated on the protocol.
4. Post outbreak and droplet/contact precaution signage as specified in the home's 'Managing Respiratory Outbreaks' policy.
5. Designate break areas for staff, that are clearly identifiable by staff and includes signage regarding IPAC measures to be followed.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

The home submitted a CIS report indicating that the home was declared in a

respiratory outbreak.

a) During observations conducted by the inspector, the DNC and the NC told the inspector that the only residents that were on droplet/contact isolation in the home were residents who had tested positive for a respiratory infection, and those with pending test results. All other residents were not isolated, however staff could wear personal protective equipment (PPE) based on a point of care risk assessment. Only five residents were on isolation precautions at the time the inspector conducted observations.

Both the IPAC lead and the PPHCM, stated that droplet/contact precautions should have been in place for the whole home, and that all residents should have been on contact/droplet precautions at the time of the inspector's observations. The IPAC lead stated that the residents were placed on droplet/contact isolation as they were identified as high-risk exposures due to the number of staff that were testing positive on the neighbourhoods. Staff were expected to wear the required PPE for contact/droplet precautions, which included a gown, face shield, mask, and gloves, and/or a N95 respirator [for suspected, probable, or confirmed respiratory infection cases], for resident interactions. The inspector observed staff entering resident rooms, interacting with residents, while wearing some but not all of the required personal protective equipment. There was no consistent use of additional precautions by staff.

Staff stated that they discontinued isolation of residents when the required ten days of isolation had passed, and once they received direction from the IPAC lead. However, when the IPAC lead was off for a period of time, they were not aware of who to contact for direction. The IPAC Lead said that they would communicate to the leaders of the units about the ongoing IPAC measures throughout the home and that the information should be communicated to the staff on the neighbourhoods. The DNC indicated that when the IPAC lead was off, the IPAC tasks were delegated to the leadership team to communicate to the staff. The IPAC lead and the DNC acknowledged that there was a gap in the communication with the staff and the implementation of additional precautions and expectations during the outbreak.

b) As per the home's policy, Managing a Respiratory Outbreak, outbreak signs were to be placed on the entrance of the neighbourhood, main entrances and elevators. There were no outbreak signs noted by the inspector upon entry to the home. The

home had posted droplet/contact precaution signs on the entrance doors to the neighbourhoods and all the resident doors. Staff indicated that the droplet/contact precaution signs on the resident doors meant that the home was in outbreak, but did not necessarily mean they were required to wear full PPE. This was up to the comfort of the staff. The home did not have signage to indicate the entire home was in outbreak as per the IPAC lead.

Residents who were on droplet/contact isolation and unable to stay in their room due wandering behaviours and/or at risk for falls in their room, could be brought to an area where staff could supervise them. However, the expectation was that staff should wear the appropriate PPE while interacting with the residents, such as wearing a N95 respirator.

A resident was on droplet/contact isolation, as they had signs and symptoms of a respiratory infection and were subsequently tested. The inspector observed a staff member, only wearing a face shield and surgical mask, in front of the resident who was in the TV lounge, less than 6 feet away from another resident. Staff indicated it was difficult to keep the resident on isolation as they had behaviours of wandering, however, they re-directed them as best they could.

c) Staff were expected to take their breaks in the dining room or country kitchen, six feet apart from each other. Staff were not to take breaks in resident rooms or in areas that were not identified as break areas. Three staff were observed in the activity room on the Trafalgar neighbourhood, less than six feet apart, not wearing a surgical mask and with their face shield off. Another staff member was observed in a resident room, taking their break, while the resident was not in the room. In front of the DNC's office, near the double doors leading to the retirement home, two staff were observed having lunch, less than 6 feet apart, with their mask and face shield off.

d) Inconsistent hand hygiene practices were observed. Staff were observed assisting different residents with putting on their clothing protectors for meals, and interacting with residents in preparation for the meal, but, with no hand hygiene completed between resident interactions.

The risk of transmission of a respiratory infection to residents was increased due to the lack of implementation of the IPAC program, and communication to staff about

required additional precautions.

Sources: Observations conducted by the inspector; record review of a resident's progress notes; home's policy, "Managing a Respiratory Outbreak" Tab 04-05; Directive #5, issued December 17, 2021; and interviews with relevant staff.

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

Severity: There was actual risk to residents contracting COVID-19 as staff failed to implement appropriate IPAC measures.

Scope: This issue was widespread as all neighbourhoods were affected in the home.

Compliance history: In the last 36 months, the licensee was found to be non-compliant in the same subsection, with 1 Voluntary Plan of Correction (VPC) issued. (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 14, 2022(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

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

Issued on this 29th day of March, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by NITAL SHETH (500) - (A1)

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

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