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

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5700 Yonge Street 5th Floor
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5700, rue Yonge 5e étage
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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 2, 2021	2021_833763_0008	005733-21	Other

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Westbury Long Term Care Residence
495 The West Mall Etobicoke ON M9C 5S3

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

IANA MOLOGUINA (763)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): April 8, 12, 14, 15, 16, 19, 20, 2021.

The following intakes were completed during this Other Inspection:

- Log #005733-21 was related to COVID-19 testing requirements.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10 s. 73. (1) 10 was identified in this inspection and has been issued in Inspection Report #2021_833763_0009, dated June 2, 2021, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Infection Prevention and Control (IPAC) Lead, Food and Nutrition Manager (FNM), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW). Additionally, the inspector spoke with entrance screening staff, as well as housekeeping, agency and recreation staff.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

infection prevention and control (IPAC) program when they failed to follow room capacity restrictions in a unit dining room and activity room.

The inspector observed lunch meal service as part of general IPAC observations. At the time of observation, the dining room had a sign upon entry that indicated a maximum of 15 people were allowed to occupy the room at any given time to ensure appropriate physical distancing. The activity room on the fifth floor had a five person capacity restriction. The inspector observed the dining room to be occupied by 15 to 17 people at various times during meal service, in addition to one dietary staff who was in the meal servery area.

Capacity limits had exceeded several times as staff entered and exited the dining room to prepare and serve trays for residents eating in their rooms, to assist residents with eating, and to transport additional residents into the dining room. The activity room was also over the capacity limit, being occupied by up to seven people throughout the meal service. The inspector did not observe residents entering or exiting these rooms independently during the meal service.

Staff interviewed indicated that they were not sure why the capacity restrictions were above the maximal limits, but thought there were more staff assisting residents than usual. Staff were also confused about the capacity restrictions in dining and activity rooms, as they were not sure if what was indicated on the room capacity signs was what staff were supposed to follow.

The home’s managerial staff indicated that the room capacity limit restrictions were implemented based on the home’s corporate direction to assist homes in determining physical distancing capabilities of various shared rooms in the home. Homes were to measure square footage of dining and activity rooms and determine the room capacity restrictions to guide staff in ensuring physical distancing guidelines were followed once in the rooms. It was expected that staff followed the capacity limits as indicated on room signs.

Sources: observations, room capacity restriction signs on dining and activity rooms, staff interviews (PSW #108, RN #106, DOC #116, IPAC Lead #110, Administrator #100). [s. 229. (4)]

2. The licensee has failed to ensure that staff participated in the implementation of the home’s IPAC program when they failed to wear the required Personal Protective

Equipment (PPE).

At the beginning of the inspection, the inspector observed the main floor of the building where around half the staff were wearing face masks and eye protection, while others only wore face masks, including the screening staff. Some residents were observed on the main floor, but the main floor did not house any resident rooms and the home was not experiencing a COVID-19 outbreak. The administrator indicated to the inspector that the home was following universal masking precautions as directed by Ministry of Long-Term Care (MLTC) guidelines, but eye protection was not required. Staff wore eye protection universally throughout the building if they wished to decrease their risk of COVID-19 exposure.

The inspector observed resident home areas around lunch meal service. Staff were observed assisting residents to sit in the dining room for meal service, as well as providing one on one feeding assistance. Most staff observed in hallways and dining areas wore only face masks during observation.

PSW #104 was observed delivering lunch to two newly admitted residents on isolation in their room. The droplet/contact precaution signs upon room entry instructed the staff to wear full PPE (eye protection, mask, gown and gloves) when providing direct resident care, and when within two metres of residents. PSW #104 entered the first resident room, donning a gown, mask, and gloves. They did not use eye protection. They called for staff assistance to help reposition the first resident, and the additional staff entered the room with only a mask on, donning a gown and gloves once they determined direct care was required. They also did not wear eye protection. PSW #104 then entered the second resident's room without doffing their PPE, delivered their food tray, and went back to the first resident's room to finish setting them up for the meal. Once the first resident was eating independently, they doffed their PPE and put on a new set to provide total feeding assistance to the second resident. They still did not have eye protection on. PSW #104 indicated that their face shield broke and they did not have time to get a new one from the fourth floor where additional stock was kept. They knew they were required to wear eye protection when entering isolated resident rooms as indicated on the droplet/contact precaution signs. They also indicated that they did not change their PPE during meal service for the isolated residents until they were required to provide direct care to the residents. When the inspector asked why there was no additional eye protection available for use in the PPE receptacles located by the isolation rooms, PSW #104 indicated that they usually wore a face shield throughout their shift and were allowed to reuse them during their shift, so did not require additional face shields to be

available in the PPE receptacles.

The inspector interviewed the home's IPAC lead later in the inspection, who indicated that staff needed to wear full PPE when entering resident isolation rooms, including eye protection, whether or not they were providing direct care to the resident, and to don a new set of PPE when entering a new isolation room. They also indicated that the home was following universal eye protection in addition to universal mask use in the facility, as directed by a December 2020 memo from the home's corporate office that instructed home staff to use face shields in all resident areas unless they were on a break. Kitchen staff were exempt from using face shields when working over a heat source or in the freezer. When the inspector shared their observations of staff not using face shields throughout the building, the IPAC lead did not know why that was the case; they confirmed that staff should have been using face shields throughout the building, especially when providing direct resident care, such as when feeding residents in the dining room.

The inspector conducted additional observations of staff and residents around lunch meal service after speaking with the home's IPAC lead. Several staff were wearing both face shields and masks. Some of the staff wore only masks in the dining rooms, in resident rooms and in the hallways, providing direct care to a variety of residents. This included a PSW staff, a housekeeping staff and the unit RN. When interviewed, staff provided conflicting information as to what was expected of them regarding PPE use in the home. Some believed universal eye protection was in place, and others believed eye protection was only required when providing direct care to residents. Staff indicated that they should have worn eye protection during the above observations but either found it uncomfortable or lost it. The inspector spoke with the home's administrator after the above observations and confirmed that the December 2020 corporate memo was supposed to be followed in the home, indicating that universal face shield use was a requirement of all staff in the home during inspection.

Sources: home observations; contact/droplet precaution signs; "Universal Face Shields" corporate memo dated December 2, 2020; staff interviews (PSW #104, RN #114, IPAC Lead #110, and other staff). [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 when they did not follow public health recommendations for setting up their active screening area during the COVID-19 pandemic.

The inspector observed the home's active screening area as part of general IPAC observations. The home was not experiencing a COVID-19 outbreak at the time of the observation. Two screening staff were conducting active screening of home visitors, including essential caregivers and staff, assisting visitors with filling out visitor logs and taking their body temperatures while standing less than one metre away from them. The screening staff only wore face masks during screening. The screening station had a small plexiglass partition set up near the seating area of the screening staff but did not provide protection to screening staff when they left the plexiglass area to assist visitors.

The "COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes" created by Public Health Ontario (PHO) indicated that homes were to ensure that screening staff wore, at a minimum, a mask, eye protection and gloves or were behind a plexiglass partition, to limit risk of COVID-19 exposure from home visitors while they were being screened for entry.

The home's administrator indicated that the plexiglass partition of the seating area was only one layer of protection used by screening staff when coming in contact with home visitors; screening staff were expected to wear eye protection in addition to wearing a face mask if they had to step away from the screening area to assist visitors, as they would be unable to maintain appropriate physical distancing in that instance. They agreed that if appropriate physical distancing could not be maintained, screening staff needed to follow the guidelines indicated in the PHO IPAC checklist as indicated above. During the inspection, the screening area setup was revised and tables were placed strategically around the plexiglass partition to limit screening staff mobility so they could maintain physical distancing guidelines, and remain behind the plexiglass partition at all times during the screening process.

Sources: observations; the "COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes" by Public Health Ontario, current as of April 23, 2020; staff interviews (staff #102, Administrator #100). [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 in ensuring 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 LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to carry out an operational directive when they permitted a support worker into the facility without getting a COVID-19 test.

The Minister of Long-Term Care issued the “COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes” (Minister’s Directive), effective January 8, 2021, pursuant to s. 174.1 of the Long-Term Care Homes Act, 2007, which authorized the Minister to issue operational or policy directives respecting long-term care homes where they considered it in the public interest to do so. The directive stated that every licensee had to ensure that, in a home not experiencing an outbreak of COVID-19, all support workers demonstrated that they have received a negative COVID-19 test result before granting them entry as a visitor.

The home advised the MLTC that an agency nurse was permitted entry into the home without getting a COVID-19 test. The home’s screening staff stepped away from their post, and a newly hired security staff who was left to monitor the screening area mistakenly let the support worker in without ensuring they had completed a COVID-19 test prior to entry.

Record reviews and interviews indicated that the agency nurse visited the facility on several dates to provide treatment to a resident for a wound infection. They required scheduled visits from an external provider. The agency nurse stated that they did not complete a COVID-19 test prior to home entry on any of their visits, as their hiring agency told them they did not require one. They communicated the same to the screening staff on their visits and were permitted entry. They wore full PPE during their visit and left the facility immediately after treatment completion. The home’s administrator confirmed that these treatments were not emergency visits and thus required the support worker to follow the Minister’s Directive as indicated.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan); COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes (Minister’s Directive), effective January 8, 2021; home email records and visitor logs; staff interviews (staff #107 and #101, Administrator #100). [s. 174.1 (3)]

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 in ensuring that all operational directives issued by the Minister are carried out, to be implemented voluntarily.

Issued on this 4th day of June, 2021

[redacted]

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) :	IANA MOLOGUINA (763)
Inspection No. / No de l’inspection :	2021_833763_0008
Log No. / No de registre :	005733-21
Type of Inspection / Genre d’inspection:	Other
Report Date(s) / Date(s) du Rapport :	Jun 2, 2021
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Westbury Long Term Care Residence 495 The West Mall, Etobicoke, ON, M9C-5S3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sara Rickards

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 Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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 s. 229. (4) of the O. Reg. 79/10, s. 229 (4).

Specifically, the licensee must do the following:

1. Provide clear direction to all staff and visitors of the home for appropriate use of Personal Protective Equipment (PPE) when working with residents on isolation, while working in resident care areas and when in common areas of the home, based on the most up-to-date practice guidelines. Maintain a record of any education or communication material shared with staff, including any updates provided if changes were required.

2. Ensure that PPE is easily accessible to staff in the home on all units, at all times.

3. Train IPAC Champions on each unit to support the appropriate use of PPE. Maintain a record of any training completed, including any additional training provided if changes to PPE protocol are required.

4. Implement an auditing system to ensure that staff from all departments, and any visitors of the home, participate in the implementation of the Infection Prevention and Control (IPAC) program, including the appropriate use of PPE. Complete a minimum of ten audits per week on various home areas and shifts. Maintain a record of audits completed, including documenting any corrective action taken as a result of the audits. Continue auditing until no further concerns arise with the use of PPE by staff, or for a period of one month - whichever comes first.

Grounds / Motifs :

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

1. The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program when they failed to wear the required Personal Protective Equipment (PPE).

At the beginning of the inspection, the inspector observed the main floor of the building where around half the staff were wearing face masks and eye protection, while others only wore face masks, including the screening staff. Some residents were observed on the main floor, but the main floor did not house any resident rooms and the home was not experiencing a COVID-19 outbreak. The administrator indicated to the inspector that the home was following universal masking precautions as directed by Ministry of Long-Term Care (MLTC) guidelines, but eye protection was not required. Staff wore eye protection universally throughout the building if they wished to decrease their risk of COVID-19 exposure.

The inspector observed resident home areas around lunch meal service. Staff were observed assisting residents to sit in the dining room for meal service, as well as providing one on one feeding assistance. Most staff observed in hallways and dining areas wore only face masks during observation.

PSW #104 was observed delivering lunch to two newly admitted residents on isolation in their room. The droplet/contact precaution signs upon room entry instructed the staff to wear full PPE (eye protection, mask, gown and gloves) when providing direct resident care, and when within two metres of residents. PSW #104 entered the first resident room, donning a gown, mask, and gloves. They did not use eye protection. They called for staff assistance to help reposition the first resident, and the additional staff entered the room with only a mask on, donning a gown and gloves once they determined direct care was required. They also did not wear eye protection. PSW #104 then entered the second resident's room without doffing their PPE, delivered their food tray, and went back to the first resident's room to finish setting them up for the meal. Once the first resident was eating independently, they doffed their PPE and put on a new set to provide total feeding assistance to the second resident. They still did not have eye protection on. PSW #104 indicated that their face shield broke and they did not have time to get a new one from the fourth floor where additional stock was kept. They knew they were required to wear eye protection when entering isolated resident rooms as indicated on the droplet/contact precaution

signs. They also indicated that they did not change their PPE during meal service for the isolated residents until they were required to provide direct care to the residents. When the inspector asked why there was no additional eye protection available for use in the PPE receptacles located by the isolation rooms, PSW #104 indicated that they usually wore a face shield throughout their shift and were allowed to reuse them during their shift, so did not require additional face shields to be available in the PPE receptacles.

The inspector interviewed the home's IPAC lead later in the inspection, who indicated that staff needed to wear full PPE when entering resident isolation rooms, including eye protection, whether or not they were providing direct care to the resident, and to don a new set of PPE when entering a new isolation room. They also indicated that the home was following universal eye protection in addition to universal mask use in the facility, as directed by a December 2020 memo from the home's corporate office that instructed home staff to use face shields in all resident areas unless they were on a break. Kitchen staff were exempt from using face shields when working over a heat source or in the freezer. When the inspector shared their observations of staff not using face shields throughout the building, the IPAC lead did not know why that was the case; they confirmed that staff should have been using face shields throughout the building, especially when providing direct resident care, such as when feeding residents in the dining room.

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Sources: home observations; contact/droplet precaution signs; "Universal Face Shields" corporate memo dated December 2, 2020; staff interviews (PSW #104, RN #114, IPAC Lead #110, and other staff).

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

Severity: There was minimal risk of harm because there were no COVID-19 positive residents in the home at the time of inspection.

Scope: This non-compliance was widespread as more than three staff observed did not follow appropriate PPE protocol.

Compliance History: Two written notifications (WN) and one voluntary plan of correction (VPC) were issued to the home related to different sub-sections of the legislation in the past 36 months. (763)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 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 2nd day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Iana Mologuina

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