Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2019	2019_780699_0020	008845-19, 008910-19, 013520-19, 014784-19, 015363-19, 015477-19, 015868-19, 015884-19, 016855-19	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

PRAVEENA SITTAMPALAM (699), ORALDEEN BROWN (698), REBECCA LEUNG (726)

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): September 16, 17, 19, 20, 23, 24, 25, 26, 27, 30 and October 1, 2, and 3, 2019.

Off site interviews were conducted from October 4, 7, and 8th, 2019.

The following complaint intakes were inspected during this inspection:

Log 013520-19 - follow up to compliance order;
Log 008910-19 and 008845-19 related to plan of care, short staffing, pest control, infection prevention and abuse;
Log 014784-19 related to abuse and responsive behaviour;
Log 015477-19 related to medication administration, skin and wound and plan of care; and
Log 015884-19 related to abuse.

The following Critical Incident System intake(s) related to the same issue (e.g., alleged abuse) were completed during this Complaint inspection:
Log #015363-19, CIS 2969-000035-19 related to abuse;
Log #015868-19, CIS 2969-000037-19 related to fracture of unknown cause; and
Log #016855-19, CIS 2969-000041-19 related to staff to resident neglect.

A Written Notification (WN) under LTCHA, 2007, c.8, s. 6 (7), identified in this inspection (Log #015868-19 and 015884-19) will be issued under Critical Incident inspection 2019_780699_0021 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Environmental Supervisor (ES), Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, staff training
records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_530726_0005	726

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified medication was administered to

resident #021 in accordance with the directions for use specified by the prescriber.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding resident #021 not receiving their medication on two specified dates.

Interview with resident #021's family member indicated they visited resident #022 on a specified date. They had a discussion with the nurse regarding the resident's identified medication and was told by the nurse that they could not find the vial with the medication. The family member indicated that the resident had not received the medication for two days because the staff could not find the medication.

Review of resident #021's electronic medication administration record (MAR) revealed that they did not receive their medication on two specified dates as per doctor's orders.

Review of the home's Medication policy #RC 04-02-01, Revised November 2015, under procedures, indicated that residents should receive medication and treatment as ordered by the Physician or RN/EC, unless the resident refuses.

During an interview with RPN #100, they acknowledged that when there is a medication incident, the resident must be assessed to make sure they are ok. The family, the doctor, the manager must be notified, and an incident report must be filled out. They acknowledged that sometimes medications were placed in the wrong resident's bin in error and that resident #021's medication was re-ordered from the pharmacy and the original medication eventually was found in another resident's bin.

In conclusion, the identified medication was not administered on two specified dates to resident #021 in accordance with the directions for use specified by the prescriber.

2. The licensee has failed to ensure that an identified medication was administered to resident #022 in accordance with the directions for use specified by the prescriber.

The scope was expanded to include resident #022 as non compliance was identified related to medication administration for resident #021.

Record review of resident #022's MAR revealed that they did not receive their medication on a specified date. Documentation in the progress notes revealed that the medication was not given at an identified time by RPN #124.

In an interview with RPN #124, they revealed that resident #022 did not get their medication on a specified date because it could not be found. They also stated that they reported it to the oncoming shift who later found the medication. They continued to say that the medication strips got stuck behind the drawers in the medication cart when it falls out, is difficult to retrieve and that medication was sometimes taken from another day's supply, but in that instance, the entire pack was missing. They acknowledged that they informed the pharmacy but did not complete an incident report.

In conclusion, the identified medication was not administered on a specified date in accordance with the directions specified by the prescriber. [s. 131. (2)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #011, the plan of care related to medication administration was reassessed when the care set out was not effective.

The MLTC received a complaint related to the management of resident #011's responsive behaviours.

Record review of resident #011's minimum data set (MDS) indicated that for cognitive daily decision making, the resident was moderately impaired.

Record review of resident #011's medication administration record (MAR) between two specified months indicated the following:
-an identified medication twice daily at lunch and dinner; and
-an identified medication, three times a day.

Further review of the MAR between two specified months indicated resident #011 was successfully administered an identified medication 8 out of 80 doses. Additionally, resident #011 was successfully administered an identified medication 10 out of 43 doses.

Review of resident #011's progress notes indicated that the resident would be triggered by medication administration and have an identified responsive behaviour. Further review of the progress notes did not indicate what strategy should be utilized for the identified trigger.

Review of resident #011's plan of care, did not identify any strategies or interventions related to administration of medications.

In an interview with RPN #143, they indicated if a resident was refusing medications, they would report to the physician and alternate methods of administering the medications would be considered. RPN #143 further indicated that resident #011's plan of care was ineffective in managing their behaviours.

In an interview with DOC #103, they indicated that for residents that are refusing medications, they would try to re-approach. They further indicated for resident #011, that other strategies should be tried, such as crush the medications, have the physician reassess the medication. DOC #103 stated that if a resident was continuously refusing medication, it would probably be discontinued.

The licensee failed to ensure that resident #011's plan of care was reassessed when interventions were ineffective. Through record review and staff interviews, it was identified that resident #011 consistently refused identified medications between a two month period. Review of the progress notes and care plan did not indicate that staff tried different strategies or interventions to administer an identified medication for the resident. The resident continued to have responsive behaviours that were not managed. [s. 6. (10) (c)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #011, weekly skin assessments were completed.

The MLTC received a CIS related to alleged rough care causing an identified altered skin integrity found on resident #011. The MLTC also received a complaint related to unknown altered skin integrity on resident #011.

Record review of resident #011's progress notes indicated that on the four identified dates, the resident was observed to have altered skin integrity.

Further review of resident #011's progress notes and assessments, did not reveal when the above mentioned altered skin integrity was assessed, monitored or when it was healed.

In an interview with RPN #141, they indicated that bruises, rashes, and skin tears are considered altered skin integrity and weekly assessments should be conducted. They further indicated that when altered skin integrity is healed, they would document in the progress notes. RPN #141 indicated that if the documentation of skin assessments were not in the progress notes, then it was not done.

In an interview with DOC #103, they stated that if a resident was exhibiting altered skin integrity, they would be assessed weekly and there would be documentation indicating the altered skin integrity was healed. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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 there was a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices.

In an interview, Administrator #117 stated that they were unsure if the home had a lead for their Infection Prevention and Control (IPAC) program.

In an interview, DOC #103 confirmed that the home did not have a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

2. The licensee has failed to ensure that PSW #131 participated in the implementation of the infection prevention and control program.

Two Critical Incident System (CIS) reports were submitted to the MLTC related to identified injuries with unknown causes observed for resident #007.

The inspector conducted an observation of a transfer with an identified transfer device and the provision of specified care for resident #007 by PSW #130 and PSW #131 inside resident #007's room.

During the observation for the provision of a specified care, the inspector observed both PSWs put on gloves before starting the procedure. Towards the end of the specified care, the inspector observed PSW #131 use an identified wipe to a specified area on resident #007's body and disposed of the wipe in the garbage. The inspector observed PSW #131 did not change their gloves afterwards and continued working with the same pair of gloves on their hands. PSW #131 then pulled the clean blanket and bed sheet over with their gloved hands to cover resident #007 and grabbed a pillow to place it underneath a specified area for the resident.

In an interview, PSW #131 acknowledged the identified wipe that they removed from resident #007's specified body area was not clean.

In an interview, RPN #129 acknowledged that the identified wipe that PSW #131 removed from resident #007's specified body area was dirty and PSW #131 should have changed their gloves after discarding the dirty wipe, before touching the resident's bed linen and pillow.

In an interview, DOC #103 acknowledged that PSW #131 should have changed their gloves after discarding the dirty wipe before continuing to provide care for resident #007. The home has failed to ensure that PSW #131 participated in the implementation of the home's infection prevention and control program. [s. 229. (4)]

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 licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices and that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 24th day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PRAVEENA SITTAMPALAM (699), ORALDEEN BROWN (698), REBECCA LEUNG (726)
Inspection No. / No de l'inspection :	2019_780699_0020
Log No. / No de registre :	008845-19, 008910-19, 013520-19, 014784-19, 015363-19, 015477-19, 015868-19, 015884-19, 016855-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 17, 2019
Licensee / Titulaire de permis :	Villa Colombo Seniors Centre (Vaughan) Inc. 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	Villa Colombo Seniors Centre (Vaughan) 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Murad

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Villa Colombo Seniors Centre (Vaughan) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 131. (2). Specifically, the licensee must upon receipt of this compliance order:

1) Ensure that resident #021 and #022, and all other residents medications are administered in accordance with the directions for use specified by the prescriber, stored in their designated medication bin inside the medication cart for ease of access and be readily available for administration.

2) Develop an internal auditing system that is conducted monthly for the next three months as of the receipt of this order to ensure that individual resident medications are stored correctly in their designated bins inside the medication cart.

3) Maintain a written record of the above-mentioned audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit, the outcome of the audit and any action taken as a result of the audit.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that an identified medication was administered to resident #021 in accordance with the directions for use specified by the prescriber.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding resident #021 not receiving their medication on two specified dates.

Interview with resident #021's family member indicated they visited resident

#022 on a specified date. They had a discussion with the nurse regarding the resident's identified medication and was told by the nurse that they could not find the vial with the medication. The family member indicated that the resident had not received the medication for two days because the staff could not find the medication.

Review of resident #021's electronic medication administration record (MAR) revealed that they did not receive their medication on two specified dates as per doctor's orders.

Review of the home's Medication policy #RC 04-02-01, Revised November 2015, under procedures, indicated that residents should receive medication and treatment as ordered by the Physician or RN/EC, unless the resident refuses.

During an interview with RPN #100, they acknowledged that when there is a medication incident, the resident must be assessed to make sure they are ok. The family, the doctor, the manager must be notified, and an incident report must be filled out. They acknowledged that sometimes medications were placed in the wrong resident's bin in error and that resident #021's medication was re-ordered from the pharmacy and the original medication eventually was found in another resident's bin.

In conclusion, the identified medication was not administered on two specified dates to resident #021 in accordance with the directions for use specified by the prescriber.

2. The licensee has failed to ensure that an identified medication was administered to resident #022 in accordance with the directions for use specified by the prescriber.

The scope was expanded to include resident #022 as non compliance was identified related to medication administration for resident #021.

Record review of resident #022's MAR revealed that they did not receive their medication on a specified date. Documentation in the progress notes revealed that the medication was not given at an identified time by RPN #124.

In an interview with RPN #124, they revealed that resident #022 did not get their medication on a specified date because it could not be found. They also stated that they reported it to the oncoming shift who later found the medication. They continued to say that the medication strips got stuck behind the drawers in the medication cart when it falls out, is difficult to retrieve and that medication was sometimes taken from another day's supply, but in that instance, the entire pack was missing. They acknowledged that they informed the pharmacy but did not complete an incident report.

In conclusion, the identified medication was not administered on a specified date in accordance with the directions specified by the prescriber. [s. 131. (2)]

The severity of this issue was determined to be a level 2 as there was potential risk to resident #021 and #022. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:
-Voluntary Plan of Correction (VPC) issued June 16, 2017;
-Compliance Order (CO) issued August 28, 2018; and
-VPC issued December 19, 2018. (698)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 17, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 17th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Praveena Sittampalam

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