Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
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Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 14, 2020	2020_800532_0009	020543-19, 020545-19, 020547-19, 020548-19, 020550-19, 020551-19, 020553-19, 021924-19, 003576-20, 005525-20, 007992-20	Follow up

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

NUZHAT UDDIN (532), JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 5-23, 2020.

The following intakes were completed in this Follow-up (FU) inspection:
Log # 003576-20 CI # 2603-000007-20 related to fall prevention.
Log # 007992-20 IL-77221-CW and Log # 020550-19, FU related to medication administration.
Log # 005525-20 CI # 005525-20 related to alleged abuse.
Log # 020543-19, FU related to plan of care.
Log # 020545-19, FU related to 24/7 RN.
Log # 020547-19, FU related to continence.
Log # 020548-19, FU related to staffing plan.
Log # 020551-19, FU related to skin and wound.
Log # 020553-19, FU related to training.
Log # 021924-19, FU related to abuse policy.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer-Primacare, Executive Director (ED), acting Director of Care (DOC), Associate Director of Care (ADOC), Primacare Consultant, Quality Coordinator, Activity Aide, Physiotherapist (PT), Operations Manager-Pinkerton, Security Guard-Pinkerton, Behavioural Support Ontario (BSO), Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Service Assistant (RSA), Housekeeper, family members and residents.

The inspectors also toured resident home areas, observed resident care provision and resident staff interaction, reviewed relevant residents' clinical records, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this 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. 131. (2)	CO #011	2019_727695_0025	606
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2019_727695_0029	532
O.Reg 79/10 s. 31. (3)	CO #009	2019_727695_0025	532
O.Reg 79/10 s. 50. (2)	CO #001	2019_727695_0025	532
O.Reg 79/10 s. 51. (2)	CO #003	2019_727695_0025	532
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2019_727695_0025	606
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #008	2019_727695_0025	606
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #005	2019_727695_0025	532

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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

a) A complaint submitted to the Ministry of Long -Term Care (MLTC) alleged that the Home did not manage an identified resident’s pain.

A pain assessment in Point Click Care (PCC) was completed as a result of their change in condition and identified the resident’s pain level.

Clinical records for the resident including the progress notes stated that a Registered Practical Nurse (RPN) reported to the ADOC that the resident's Substitute decision Maker (SDM) said the resident’s pain had increased and was not relieved by their pain medications. The SDM told the RPN that they had concerns about the resident’s pain management.

The resident’s record did not show evidence that a pain assessment was initiated to assess the resident’s change in condition as reported by the SDM.

The Registered Nurse (RN) and the Director of Care (DOC) stated that when a resident's pain was not managed, it was the Home's expectation that a pain assessment in PCC be completed. The DOC acknowledged that a pain assessment was not completed to assess the resident's pain.

b) A Critical Incident (CI) reported that an identified resident fell and sustained a serious injury.

The RN said that the resident was assessed, and they verbalized their pain level.

The resident's progress notes reviewed for the identified period stated that the resident verbalized increased pain. The progress notes stated that the resident verbalized being uncomfortable during transfers and complained that their pain was "severe".

The Home’s PAIN SYMPTOM MANAGEMENT policy last reviewed February 2020, directed registered staff to screen for the presence of pain and complete a pain assessment electronically when a resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) following implementation of pharmacological and/or non-pharmacological interventions.

The resident's pain levels, found under the Weights and Vitals Summary, were assessed consistently above four out of ten for an identified period.

The resident's assessments were reviewed and there was no evidence that a pain assessment was initiated to re-assess the resident's unresolved pain.

The resident's progress notes stated that the resident had sustained a significant injury. Registered Nurses (RNs) acknowledged that when a resident has increased pain or new pain, a pain assessment located in PCC would be completed. In the case of the identified residents, this was not done.

The licensee failed to ensure that when the identified residents' pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place policy or protocol, the licensee was required to ensure that the policy or protocol was complied

with.

In accordance with O. Reg. 79/10 114 (1) and in reference to 114 (2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home.

The Home's policy and procedure entitled, "Subcutaneous Medication Infusion", #10-6 Medical Pharmacies -Special Policies -Pharmacy Policy and Procedure Manual for LTC Homes-last revised February 2017 directed the registered staff to administer medication through the infusion set and to dedicate one infusion set to one medication only; and since there is only ONE medication going into the site, flushing the tubing with saline after each medication administration is not necessary and not advised.

a) A complaint submitted the MLTC alleged that the Home did not manage an identified resident’s pain.

The resident's progress notes stated that a subcutaneous medication infusion set was initiated for the administration of medication. Progress notes also stated that concerns were raised by the resident’s SDM that the resident was in pain. The ADOC responded and obtained an order for a different medication to manage the resident’s pain.

Record review stated that the medication was administered in the same infusion set dedicated for the administration of the initial pain medication. The ADOC acknowledged that they did not follow the Home's policy directing staff to use one infusion set to administer one medication.

The licensee has failed to ensure that the Home's "Subcutaneous Medication Infusion" policy was complied with.

b) The Home’s policy entitled, “Medical Pharmacies, Pharmacy Policy and Procedure Manual, for Long Term Care Homes stated: The Medication Administration Record (MAR) was a legal document listing all medications prescribed for an individual resident. The MAR was used to document all medications administered, not administered, or refused by a resident. MARS may be maintained in electronic (e-MAR) or paper versions. Failure to chart a medication that has been given or not given is considered a medication incident.

The resident's progress notes stated that some of their scheduled medications were given late because the Registered Practical Nurse (RPN) assigned to complete the medication pass was an agency nurse. The resident's eMAR showed documentation that a specified medication was not administered because the medication was not available.

The RPN said when they arrived for their shift, they were able to locate the medication, in another area of the medication cart. They called the on-call doctor and obtained permission from them to administer it.

The resident's eMAR did not show evidence that the medication was administered.

The RPN said they administered the medication to the resident that evening but did not sign the eMAR indicating that it was administered. They shared that they were not aware it was their policy to do so.

The Home's policy in relation to documenting medication administration was not complied with. [s. 8. (1) (b)]

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On November 19, 2019, compliance order (CO) #011 from inspection number 2019_727695_0025 (A1) made under O.Reg 79/10, s. 131. (2) was issued with a compliance due date of February 25, 2020. The licensee complied with the legislative requirement however, failed to complete part d) of the compliance order related to medication incidents.

A resident 's progress notes stated that medication was found in the resident's room. The medication was scheduled to be administered at specified hour. The Director of Care (DOC) followed up with the registered staff who administered the medications to the resident to ensure they were swallowed before they left the room.

Documentation provided by the DOC contained information that the registered staff involved in the incident was informed of the incident and provided with corrective actions. The document did not include any information on the follow up with the resident, the resident's physician, and Substitute Decision Maker (SDM) as required by legislation. The DOC acknowledged this.

The licensee has failed to ensure that a medication incident involving the resident was reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident was protected from abuse by co-resident.

O. Reg 79/10 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report was submitted to MLTC in relation to an incident where a resident approached another resident and proceeded to touch them inappropriately.

Risk management stated that the resident said they thought the other resident was going to shake their hand instead they touched them.

Record review indicated that there was a similar incident on a specified date where the same resident was witnessed touching another co-resident inappropriately. Since that incident an intervention to address the resident's responsive behaviours was implemented.

An Activity Aid and a PSW stated that they both witnessed the incident between the two residents, however, the new intervention was not in place at the time of the incident.

The licensee has failed to ensure that the resident was protected from abuse by another resident. [s. 19. (1)]

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), JANET GROUX (606)
Inspection No. / No de l'inspection :	2020_800532_0009
Log No. / No de registre :	020543-19, 020545-19, 020547-19, 020548-19, 020550-19, 020551-19, 020553-19, 021924-19, 003576-20, 005525-20, 007992-20
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 14, 2020
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

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 Caressant-Care Nursing and Retirement Homes Limited, 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. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with s. 52 (2) of O. Reg. 79/10.

Specifically, the licensee must:
Ensure that when the identified resident's and all other resident 's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

a) A complaint submitted to the Ministry of Long -Term Care (MLTC) alleged that the Home did not manage an identified resident's pain.

A pain assessment in Point Click Care (PCC) was completed as a result of their change in condition and identified the resident's pain level.

Clinical records for the resident including the progress notes stated that a Registered Practical Nurse (RPN) reported to the ADOC that the resident's Substitute decision Maker (SDM) said the resident's pain had increased and was not relieved by their pain medications. The SDM told the RPN that they had

concerns about the resident's pain management.

The resident's record did not show evidence that a pain assessment was initiated to assess the resident's change in condition as reported by the SDM.

The Registered Nurse (RN) and the Director of Care (DOC) stated that when a resident's pain was not managed, it was the Home's expectation that a pain assessment in PCC be completed. The DOC acknowledged that a pain assessment was not completed to assess the resident's pain. (606)

2. b) A Critical Incident (CI) reported that an identified resident fell and sustained a serious injury.

The RN said that the resident was assessed, and they verbalized their pain level.

The resident's progress notes reviewed for the identified period stated that the resident verbalized increased pain. The progress notes stated that the resident verbalized being uncomfortable during transfers and complained that their pain was "severe".

The Home's PAIN SYMPTOM MANAGEMENT policy last reviewed February 2020, directed registered staff to screen for the presence of pain and complete a pain assessment electronically when a resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) following implementation of pharmacological and/or non-pharmacological interventions.

The resident's pain levels, found under the Weights and Vitals Summary, were assessed consistently above four out of ten for an identified period.

The resident's assessments were reviewed and there was no evidence that a pain assessment was initiated to re-assess the resident's unresolved pain.

The resident's progress notes stated that the resident had sustained a significant injury. Registered Nurses (RNs) acknowledged that when a resident has increased pain or new pain, a pain assessment located in PCC would be completed. In the case of the identified residents, this was not done.

The licensee failed to ensure that when the identified residents' pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

The severity of this issue was determined to be a level 3, actual risk. The scope of the
issue was level 2, pattern. The home had a level 2 compliance history, with previous non compliance to a different subsection. (606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 14th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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