Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
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33, rue King Ouest, étage 4
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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
Feb 25, 2022	2022_947752_0002	016477-21, 019564-21, 019860-21, 001847-22	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

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

Altamont Care Community
92 Island Road Scarborough ON M1C 2P5

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

LUCIA KWOK (752), ELLA LEVINSKAYA (734225)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 31, February 1, 2, 3, and 4, 2022.

The following intakes were completed in this Critical Incident System (CIS) inspection:
A follow-up log to Compliance Order (CO) #001, O. Reg. 79/10, s. 229 (4) related to Infection Prevention and Control (IPAC), issued under inspection #2021_882760_0036 on October 13, 2021, with a compliance due date of November 1, 2021;
Log #019564-21 related to a fall resulting in significant change in status;
Log #019860-21 related to loss of accommodation service; and
Log #001847-22 related to an environmental hazard.

During the course of the inspection, the inspector(s) spoke with residents, the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Environmental Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), laundry aide, housekeepers, and the maintenance worker.
The inspectors conducted a tour of the home, observed the provision of care, and resident and staff interactions. The inspectors reviewed pertinent clinical records, and relevant policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home

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)

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 the staff participated in the implementation of the home's infection prevention and control (IPAC) program, specifically, staff hand hygiene (HH) practice, availability of personal protective equipment (PPE), the appropriate use of PPE, and the disposal of soiled laundry and personal items.

The home's IPAC lead, Assistant Director of Care (ADOC) #102, indicated that the whole facility was in a COVID-19 outbreak at the time of the inspection. The Director of Care (DOC) and ADOC #102 stated that according to the direction from Toronto Public Health Unit, staff were required to don and doff the appropriate PPE for droplet/contact precautions when providing direct care to residents or when unable to maintain six feet distance from the residents.

Observations were conducted and the following were noted:
a) Staff HH practices
-On separate occasions, two staff doffed and disposed their soiled gown and did not conduct HH.
-A staff was observed to have doffed and disposed their soiled gown, no HH was conducted and then made direct contact with another resident.
-Personal Support Worker (PSW) #105 shared that HH was not needed after disposing a soiled gown and prior to donning a cleaned gown.

b) Availability of PPE
-The PPE caddie outside of five resident rooms did not have sanitizing wipes available.
-The PPE caddie outside of one resident room did not have surgical masks and sanitizing wipes available.
-The PPE caddie outside of one resident room did not have gloves and sanitizing wipes available.
-The DOC stated that the home's IPAC lead had assigned staff responsible to ensure

PPE caddies outside of resident rooms were stocked with the appropriate PPE.

c) Appropriate use of PPE
-Registered Practical Nurse (RPN) #104 was observed to provide direct care to three different residents in their rooms without donning gowns and gloves. Each time, when RPN #114 exited the residents' rooms, they did not doff nor sanitize their soiled face shield and replace their soiled surgical mask.
-On several occasions, multiple staff members provided direct care to residents in their rooms without wearing the required PPE, did not doff and disinfect their soiled eye protection, doff and replace their soiled surgical mask/respirator upon exit.
-RPN #104 stated that the home advised them to only wear gowns in COVID-19 positive residents rooms and there was no need to change their face shields as there was no COVID-19 positive resident case.
-RPN #115 acknowledged that they should have donned gown and gloves prior to entering a resident's room to provide direct care, however, they did not need face shield as the facility was not in outbreak.

d) Disposal of soiled PPE and personal items
-On one occasion, an unlabelled face shield in a clear bag was left on top of a white garbage can in the hallway outside of a resident room.
-On multiple occasions in different resident home areas, multiple staff and visitor disposed their soiled gown in laundry hamper in the unit hallway.
-On one occasion, two staff were observed to dispose soiled personal care products into the garbage in the hallway.
-RPN #114 stated that it was the practice to dispose soiled gowns into laundry hampers in the hallways as there was none available inside residents' rooms.
-The Environmental Services Manager (ESM) stated that extra laundry hampers were purchased and placed inside residents' rooms or as close by the room door as possible for the disposal of soiled gowns. The ESM and DOC stated the expectation was for staff to doff and dispose the soiled gown in the resident's room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff.

By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observation conducted throughout the inspection; Interviews with direct care

staff, registered staff, DOC, ADOC #102, ESM; LTCH's IPAC policies and procedures. [s. 229. (4)] (752)

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' falls prevention interventions were provided as per their plan of care.

a) A resident's care plan indicated that they were at high risk for falls. Their care plan documented several fall preventions interventions. Inspectors #752 observed that the resident was in their bed without the use of the specified interventions. RPN #111 acknowledged that resident's fall preventions interventions were not in place.

b) A resident's care plan indicated that they were at high risk for falls and one of their fall preventions interventions was to always use a safety device. During observation, PSW #113 acknowledged that the resident did not have their safety device in place.

There was minimal risk to the residents as their falls preventions interventions were not in place to mitigate their risk for falls.

Sources: Observation (Feb 2, 3, 2022); Interviews with PSW #113, RPN #111; residents' care plan. [s. 6. (7)] (752)

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 care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

The licensee has failed to ensure that use of restraints were included in residents' plan of care.

Two residents' care plan documented they were at high risk for falls. On one occasion, Inspectors #752 and #734225 observed the two residents were in mobility device in a position which prevented them from free movement. PSW #112 stated that this was done by staff to prevent the resident from getting up due to their fall risk. PSWs #112 and #113 confirmed that position was considered a restraint for both residents and should have been documented in their plans of care.

Inspector #752 reviewed both residents' plans of care and there was no record of any restraint assessments conducted.
In both residents' plans of care, there was:
-no indication that a risk of serious body harm was determined;
-no alternatives were considered and tried;
-no order from the physician, or registered nurse in the extended class;
-no indication of consent from the resident or their substitute decision maker (SDM);
-no detailed plan of care relating to the use of restraint.

The DOC stated that it would be considered a restraint.

ADOC #103, the home's restraint program lead, confirmed there was no use of restraints in the home.

As a result of staff applying the positioning which prevented free movement constituted a restraint without meeting the requirements, there was actual risk of falls and injuries for the residents.

Sources: Observations (February 3, 2022); Interviews with PSWs #112, #113, DOC, ADOC #103; Residents' care plan, electronic Medication Administration Record (eMAR), Point Click Care (PCC) assessments, LTCH's personal assistance service devices (PASDs) and restraints policies and procedures, last revised April 2019. [s. 31. (1)] (752)

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 a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

The licensee has failed to ensure that the emergency plans for the home were evaluated and updated at least annually.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to environmental hazard in the home resulting in the evacuation of 10 residents to other resident home areas.

Inspector #734225 reviewed the emergency plans for the home and noted that seven of the eight plans have not been evaluated and updated since 2016.

The Executive Director (ED) confirmed there was no documentation found for the evaluations or updates since 2016.

There was potential risk to the residents given that staff would follow outdated information during emergency situations.

Sources: Facility Emergency Manual - last revised November 2021, Interview with ED. [s. 230. (6)] (734225)

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 emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information, to be implemented voluntarily.

Issued on this 8th day of March, 2022

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) :	LUCIA KWOK (752), ELLA LEVINSKAYA (734225)
Inspection No. / No de l'inspection :	2022_947752_0002
Log No. / No de registre :	016477-21, 019564-21, 019860-21, 001847-22
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 25, 2022
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, Scarborough, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Zahra Mawjii

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 Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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

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 # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_882760_0036, CO #001;

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 O. Reg. 79/10.

Specifically, the licensee must:

1. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

2. Ensure caddies with personal protective equipment (PPE) are fully stocked at all times.

3. Conduct audits to ensure staff's compliance to proper techniques for donning and doffing PPE and hand hygiene (HH). Keep a documented record of the audits conducted, including the date and location of the audit, the person who conducted the audit, and the person who was audited. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH.

4. Conduct audits to ensure staff's compliance to proper soiled linen and garbage disposal process. Keep a documented record of audits conducted, including the date and location of the audit, the person who conducted the audit, and the staff audited.

Grounds / Motifs :

1. Compliance order #001 related to O. Reg. 79/10, s. 229. (4) from inspection #2021_882760_0036 issued on October, 13, 2021, with a compliance due date of November 1, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff participated in the implementation of the home's infection prevention and control (IPAC) program, specifically, staff hand hygiene (HH) practice, availability of personal protective equipment (PPE), the appropriate use of PPE, and the disposal of soiled laundry and personal items.

The home's IPAC lead, Assistant Director of Care (ADOC) #102, indicated that the whole facility was in a COVID-19 outbreak at the time of the inspection. The Director of Care (DOC) and ADOC #102 stated that according to the direction from Toronto Public Health Unit, staff were required to don and doff the appropriate PPE for droplet/contact precautions when providing direct care to residents or when unable to maintain six feet distance from the residents.

Observations were conducted and the following were noted:
a) Staff HH practices
-On separate occasions, two staff doffed and disposed their soiled gown and did not conduct HH.
-A staff was observed to have doffed and disposed their soiled gown, no HH was conducted and then made direct contact with another resident.
-Personal Support Worker (PSW) #105 shared that HH was not needed after disposing a soiled gown and prior to donning a cleaned gown.

b) Availability of PPE
-The PPE caddie outside of five resident rooms did not have sanitizing wipes available.
-The PPE caddie outside of one resident room did not have surgical masks and sanitizing wipes available.
-The PPE caddie outside of one resident room did not have gloves and sanitizing wipes available.
-The DOC stated that the home's IPAC lead had assigned staff responsible to ensure PPE caddies outside of resident rooms were stocked with the appropriate PPE.

c) Appropriate use of PPE
-Registered Practical Nurse (RPN) #104 was observed to provide direct care to three different residents in their rooms without donning gowns and gloves. Each

time, when RPN #114 exited the residents' rooms, they did not doff nor sanitize their soiled face shield and replace their soiled surgical mask.
-On several occasions, multiple staff members provided direct care to residents in their rooms without wearing the required PPE, did not doff and disinfect their soiled eye protection, doff and replace their soiled surgical mask/respirator upon exit.
-RPN #104 stated that the home advised them to only wear gowns in COVID-19 positive residents rooms and there was no need to change their face shields as there was no COVID-19 positive resident case.
-RPN #115 acknowledged that they should have donned gown and gloves prior to entering a resident's room to provide direct care, however, they did not need face shield as the facility was not in outbreak.

d) Disposal of soiled PPE and personal items
-On one occasion, an unlabelled face shield in a clear bag was left on top of a white garbage can in the hallway outside of a resident room.
-On multiple occasions in different resident home areas, multiple staff and visitor disposed their soiled gown in laundry hamper in the unit hallway.
-On one occasion, two staff were observed to dispose soiled personal care products into the garbage in the hallway.
-RPN #114 stated that it was the practice to dispose soiled gowns into laundry hampers in the hallways as there was none available inside residents' rooms.
-The Environmental Services Manager (ESM) stated that extra laundry hampers were purchased and placed inside residents' rooms or as close by the room door as possible for the disposal of soiled gowns. The ESM and DOC stated the expectation was for staff to doff and dispose the soiled gown in the resident's room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff.

By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observation conducted throughout the inspection; Interviews with direct care staff, registered staff, DOC, ADOC #102, ESM; LTCH's IPAC policies

and procedures. [s. 229. (4)] (752)

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

Severity: There was actual risk of harm to the residents because there was actual risk of transmission of infectious agents due to the staff not participating in the implementation of the IPAC program and PPE not being fully stocked outside of resident rooms.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during the inspection and from observations throughout the home.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 229. (4) of O. Reg 79/10. This subsection was issued as a CO on October 13, 2021, during inspection #2021_882760_0036, with a compliance due date of November 1, 2021. In the past 36 months, two voluntary plans of correction (VPC) and one CO were issued to the same subsection of the legislation, all of which have been complied. (752)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Ontario

Ministry of Long-Term Care

Ministère 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

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

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

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

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

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

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

Issued on this 25th day of February, 2022

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Lucia Kwok

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