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
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Aug 11, 2021	2021_715672_0027	010227-21	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Fenelon Court
44 Wychwood Crescent Fenelon Falls ON K0M 1N0

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

JENNIFER BATTEN (672)

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): July 7, 8, 9, 13, 14 and 15, 2021

Two intakes related to a resident fall with injuries.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Recreation Manager (RM), Nutritional Manager (NM), Physiotherapist, IPAC Lead, MDS/RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), housekeepers, recreation aides, health screeners, maintenance workers, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Nutritional Care, Resident Abuse and Neglect, Fall Preventions, Safe Handling, Resident Transfers and Hot Weather. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control and medication administration practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **2 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 :

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

During observations conducted in the home, Inspector observed the following:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- There were two residents in the home with contact/droplet precautions implemented. Inspector noted the PPE stations outside of the resident room(s) were missing one or more of the required PPE items, such as masks for staff to change following the provision of resident care.

- Staff were observed exiting resident rooms who had contact/droplet precautions implemented but did not change their facial masks following the provision of resident care.

- In multiple resident bathrooms, bathrooms in shared resident rooms, bathrooms in the spa/shower rooms and shared bathrooms for staff/visitors, there were open rolls of toilet paper sitting on the back of toilet tanks, on countertops beside the toilets and/or on the floor beside the toilet.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff were observed to be walking in the hallways with gloves on.

- Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and served to a resident.

- Administrator indicated the home did not have an internal policy related to the masking of residents, as directed on page six of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, which was issued on April 7, 2021.

- Residents were observed to be seated in television lounges without maintaining physical distancing.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted; Directive #3 for Long-Term Care Homes; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead and Administrator. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

A Complaint and a Critical Incident Report were submitted to the Director related to a fall sustained by resident #001. Resident was being transported in an unsafe manner by a staff member and fell.

PSW #100 was not available for interview during the inspection.

Record review indicated resident #001 had been assessed by the Physiotherapist (PT) prior to the incident occurring and provided direction to staff to ensure specific interventions were in place and implemented prior to transporting the resident.

During separate interviews, the PT and Director of Care (DOC) verified the expectation in the home was for intervention to be in place prior to transporting a resident.

By not ensuring the specific interventions were in place prior to transporting the resident, there was actual harm caused from the fall.

Sources: Complaint and Critical Incident Report submitted to the Director, resident #001's written plan of care, PT assessments, interviews with PSW #101, RPN #103, the Physiotherapist and DOC. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5p.m. and once every evening or night.

Review of the internal “Resident Home Area Daily Temperature Log” from an identified period of time indicated the licensee was monitoring air temperatures twice daily, instead of the required three times per day. During separate interviews, the Environmental Service Manager (ESM) and the Administrator verified temperatures in the home were only being measured and documented twice per day.

By not ensuring temperatures were measured at a minimum of three times per day, as per the requirement, residents were placed at possible risk of being exposed to rooms with elevated temperatures, which could lead to discomfort and dehydration.

Sources: Internal “Resident Home Area Daily Temperature Log” and interviews with the ESM and Administrator. [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that temperatures required to be measured under subsection (2) are documented at least once every morning, once every afternoon between 12 p.m. and 5p.m. and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that strategies were developed and implemented to respond to resident #004, who was demonstrating responsive behaviours.

A Complaint and Critical Incident Report related to a fall sustained by resident #001 indicated that resident #001 was being targeted by resident #004. As a result, resident #001 was assisted by PSW #100 in a mobility device, away from resident #004 and resident #001 fell to the floor due to being improperly transported.

Record review indicated that resident #004 had multiple incidents of targeting co-residents in the home and exhibiting other identified responsive behaviours. Review of resident #004's written plan of care in place at the time of the incident indicated there were no goals or interventions for staff to implement specific to exhibited responsive behaviours. Following the incident with resident #001, resident #004 did have interventions implemented to assist in managing the responsive behaviours.

During separate interviews, PSW #101, RPN #103 and the BSO RPN verified resident #004 had been exhibiting responsive behaviours leading up to the incident with resident #001, which included targeting co-residents. The BSO RPN and DOC indicated the expectation in the home was that when residents were noted to exhibit responsive behaviours, staff were to identify the behaviours, implement interventions and create a plan of care for the resident, in order to manage their safety and the safety of all other residents in the home.

By not ensuring resident #004 had strategies developed and implemented to respond to their demonstrated responsive behaviours, residents in the home were placed at risk of harm.

Sources: Complaint and Critical Incident Report submitted to the Director, resident #001's written plan of care, resident #004's written plans of care, interviews with PSW #101, RPN #103, RNs #102 and #115, BSO RPN, and the DOC. [s. 53. (4) (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 strategies are developed and implemented to respond to residents demonstrating responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector noted that several bottles of medicated treatment creams were stored in resident #005's bedroom. Inspector observed two more random resident rooms of the same resident home area and observed bottles of medicated treatment creams in residents #006 and #007's bedrooms. During separate interviews, PSW #105, RNs #102 and #115 and the Director of Care (DOC) indicated the expectation in the home was for medicated treatment creams to be stored in the locked medication room when not being used.

By not ensuring that drugs were stored in an area or medication cart that was kept secured and locked when not in use, residents were placed at risk of ingesting and/or incorrectly applying medicated treatment creams without the knowledge or supervision of staff.

Sources: Observations conducted, interviews with PSW #105, RNs #102 and #115 and the DOC. [s. 129. (1) (a)]

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 drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and is kept secured and locked, to be implemented voluntarily.

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

Issued on this 12th day of August, 2021

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) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2021_715672_0027
Log No. / No de registre :	010227-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 11, 2021
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Fenelon Court 44 Wychwood Crescent, Fenelon Falls, ON, K0M-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Keenan

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with with s. 229 (4) of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the process completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

During observations conducted in the home, Inspector observed the following:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- There were two residents in the home with contact/droplet precautions implemented. Inspector noted the PPE stations outside of the resident room(s)

were missing one or more of the required PPE items, such as masks for staff to change following the provision of resident care.

- Staff were observed exiting resident rooms who had contact/droplet precautions implemented but did not change their facial masks following the provision of resident care.

- In multiple resident bathrooms, bathrooms in shared resident rooms, bathrooms in the spa/shower rooms and shared bathrooms for staff/visitors, there were open rolls of toilet paper sitting on the back of toilet tanks, on countertops beside the toilets and/or on the floor beside the toilet.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff were observed to be walking in the hallways with gloves on.

- Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and served to a resident.

- Administrator indicated the home did not have an internal policy related to the masking of residents, as directed on page six of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, which was issued on April 7, 2021.

- Residents were observed to be seated in television lounges without maintaining physical distancing.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted; Directive #3 for Long-Term Care Homes;

interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead and Administrator.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Voluntary Plan of Correction was issued to the home during Critical
Incident System inspection #2020_815623_0011 which was issued to the home on July 31, 2020.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2021

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with section s. 36 of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Ensure residents who require the use of footrests on their wheelchairs are safely transferred and positioned.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

A Complaint and a Critical Incident Report were submitted to the Director related to a fall sustained by resident #001. Resident was being transported in an unsafe manner by a staff member and fell.

PSW #100 was not available for interview during the inspection.

Record review indicated resident #001 had been assessed by the Physiotherapist (PT) prior to the incident occurring and provided direction to staff to ensure specific interventions were in place and implemented prior to transporting the resident.

During separate interviews, the PT and Director of Care (DOC) verified the expectation in the home was for intervention to be in place prior to transporting a resident.

By not ensuring the specific interventions were in place prior to transporting the resident, there was actual harm caused from the fall.

Sources: Complaint and Critical Incident Report submitted to the Director, resident #001's written plan of care, PT assessments, interviews with PSW #101, RPN #103, the Physiotherapist and DOC.

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

Severity: There was actual harm to resident #001 and risk of harm to other residents in the home when staff do not use safe transferring and positioning devices or techniques when assisting residents.

Scope: The scope of this non-compliance was isolated, as only one resident was harmed as a result.

Compliance History: One or more areas of non-compliance were issued to the home related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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