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
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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
Jan 19, 2021	2021_715672_0002	025653-20	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street Aurora ON L4G 3G8

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 12, 2021

The following intake was completed during this critical incident system inspection:

One intake related to a disease outbreak.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Service Aides (RSA), Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents and internal policies related to Infection Prevention and Control. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Acting Administrator (AA), Public Health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide. The home had also received an Order from Public Health due to several areas of non-compliance observed in the home related to infection prevention and control practices.

Observations were conducted by the inspector on an identified date and noted the following:

- Upon entry to the home, there was no screener present at the door, and several minutes passed before one could be located to screen Inspector into the home.

- The resident home areas on the first and second floor, along with the common areas of the home appeared to be in disarray, with large boxes and equipment all over and appeared very disorganized. This made mobility in the hallways of the units very difficult at times, with Inspector having to climb over equipment to access a stairwell instead of maneuvering back down a hallway and waiting for extended periods of time in order to access a hallway due to it being blocked. Residents on the first floor were observed by Inspector to be agitated at times, and upon questioning resident #001 indicated they were frustrated with the mess and noise on the home area and was very confused about what was happening in the home.

- The home identified ill residents by having a specified sign posted on the resident’s bedroom door. Upon inquiry, RSA #105 was unaware of how residents identified as being ill were communicated to staff.

- Identified Personal Protective Equipment (PPE) stations had no gowns, masks or garbage cans present for staff to doff used PPE.

- None of the staff in the home were observed to wipe/disinfect their face shields/eye protection upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields/eye protection from inside to outside upon exiting resident's rooms.

- At approximately 1205 hours, Inspector observed PSW #100 donning PPE in an incorrect manner.

- At approximately 1210 hours, Inspector observed PSW #101 serving fluids to multiple residents for their lunch meal, which included assisting a resident with fluid intake, without completing hand hygiene between each resident. During an interview, PSW #101 indicated the expectation in the home was for staff to have a gown and gloves on when entering a resident's bedroom, and then put on a pair of gloves. After exiting another resident's room, PSW #101 was observed using hand sanitizer on top of their gloves. During a second interview, PSW #101 indicated this practice was completed in order to save time.

- At approximately 1215 hours, Inspector observed PSW #102 donning and doffing PPE in an incorrect manner.

- At approximately 1220 hours, Inspector observed RN #111 administering medications to multiple residents in their rooms without donning/doffing PPE nor completing hand hygiene between each resident.

- At approximately 1230 hours, Inspector observed RSA #104 assisting a resident who was identified as being ill. RSA #104 was observed to have no PPE in place at all. After Inspector questioned the staff member, they exited the resident's room to don the required PPE and was observed to don the PPE in an incorrect manner.

- At approximately 1230 hours, Inspector observed housekeeping staff member #103 assisting an ill resident with their lunch meal, while sitting on the resident's bed.

- At approximately 1235 hours, Inspector observed RSA #105 entering a resident's room to assist with their lunch meal and donned the PPE in an incorrect manner. The resident they were assisting was identified as being ill and upon exit from the resident's room, RSA #105 doffed the PPE incorrectly.

- At approximately 1240 hours, Inspector observed housekeeping staff member #107 going from resident room to resident room, which included residents identified as being ill, in order to complete environmental cleaning. Staff member #107 was not observed to change the PPE gown/gloves they were wearing between each resident room.

- At approximately 1245 hours, Inspector observed RPN #109 administering medications to multiple residents in their rooms without donning/doffing PPE nor completing hand hygiene between each resident. After RPN #109 was spoken to by a manager in the home about their practice, they were then observed to don PPE in order to enter a resident's room, and they donned the PPE in an incorrect manner. After completing the medication administration to an ill resident, the RPN was observed doffing the PPE incorrectly. During an interview, RPN #109 indicated they had not received any training or education related to how to properly don/doff PPE.

- At approximately 1255 hours, Inspector observed RN #111 assisting a resident with their lunch meal in the resident's room, without the required PPE on. During an interview, RN #111 acknowledged they did not have the required PPE in place and exited the resident's room to don the required PPE. RN #111 was observed not to complete hand hygiene prior to donning the PPE and then donned the items in an incorrect manner.

- At approximately 1305 hours, Inspector observed PSW #110 exiting an ill resident's room and was observed to be doffing the PPE incorrectly.

During an interview, the Acting Administrator indicated they were aware there were challenges in the home with staff not adhering to the IPAC guidelines. The Acting Administrator further indicated they were in the process of providing education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance was observed related to hand hygiene and PPE donning/doffing.

As there was an identified outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home and inconsistent supply of PPE outside of resident's rooms. These inconsistent practices posed an actual risk of harm to the residents due to the rapid spread of the illness throughout the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs #100, #101, #102 and #110, RSAs #104 and #105, RPN #109, RN #111, housekeeping staff #107, resident #001 and the Acting 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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training in the required areas, according to the legislation, before performing their responsibilities.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Acting Administrator (AA), Public Health declared the entire home in a

confirmed outbreak and staff were directed to follow contact and droplet precautions home wide. The home had also received an Order from Public Health due to several areas of non-compliance observed in the home related to infection prevention and control practices. Due to this, the home had increased staffing needs, which they had hired new staff members to assist with, along with utilizing multiple agencies for the staffing and cleaning needs of the home.

During multiple interviews conducted related to the infection prevention and control practices in the home, Inspector was informed by multiple staff members who indicated they had worked in the home ranging from one day to one and a half months, that they had not received an orientation to the home, or any education/training related to the Residents' Bill of Rights, the home's mission statement or policy to minimize the restraining of residents, fire prevention and safety or the emergency and evacuation procedures, nor the infection prevention and control practices related to the expectations regarding hand hygiene or the proper usage of PPE.

During an interview, the Acting Administrator indicated that due to the increased staffing needs of the home, they had been hiring and bringing in agency staff “a lot” over the previous days and weeks on all three shifts, and had not had an opportunity to ensure the staff members received the required orientation, education and training required according to the legislation prior to working in the home. The AA further indicated they were aware of the legislative requirements and would immediately implement educational sessions to ensure the new staff members received the orientation and education required over the coming week. By failing to ensure that every staff member received training related to the areas required under the legislative reference, residents were placed at risk of staff not knowing how to react in an emergency or outbreak situation or possibly be subjected to an incident of being restrained or abused.

Sources: Interviews with RSAs #104 and #105, RPN #109, housekeeping staff member #107 and the Acting Administrator. [s. 76. (2)]

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 staff receive training in the required areas, according to the legislation, before performing their responsibilities in the home, to be implemented voluntarily.

Issued on this 19th day of January, 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_0002
Log No. / No de registre :	025653-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 19, 2021
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, Peterborough, ON, K9J-6X6
LTC Home / Foyer de SLD :	The Willows Estate Nursing Home 13837 Yonge Street, Aurora, ON, L4G-3G8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Linda Burr

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

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

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.

3. Ensure that all PPE caddies are fully stocked and that all caddies have all appropriate PPE items in them.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Acting Administrator (AA), Public Health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide. The home had also received an Order from Public Health due to several areas of non-compliance observed in the home related to infection prevention and control practices.

Observations were conducted by the inspector on an identified date and noted the following:

- Upon entry to the home, there was no screener present at the door, and several minutes passed before one could be located to screen Inspector into the home.

- The resident home areas on the first and second floor, along with the common areas of the home appeared to be in disarray, with large boxes and equipment all over and appeared very disorganized. This made mobility in the hallways of the units very difficult at times, with Inspector having to climb over equipment to access a stairwell instead of maneuvering back down a hallway and waiting for extended periods of time in order to access a hallway due to it being blocked. Residents on the first floor were observed by Inspector to be agitated at times, and upon questioning resident #001 indicated they were frustrated with the mess and noise on the home area and was very confused about what was happening in the home.

- The home identified ill residents by having a specified sign posted on the resident's bedroom door. Upon inquiry, RSA #105 was unaware of how residents identified as being ill were communicated to staff.

- Identified Personal Protective Equipment (PPE) stations had no gowns, masks or garbage cans present for staff to doff used PPE.

- None of the staff in the home were observed to wipe/disinfect their face shields/eye protection upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields/eye protection from inside to outside upon exiting resident's rooms.

- At approximately 1205 hours, Inspector observed PSW #100 donning PPE in an incorrect manner.

- At approximately 1210 hours, Inspector observed PSW #101 serving fluids to multiple residents for their lunch meal, which included assisting a resident with fluid intake, without completing hand hygiene between each resident. During an

interview, PSW #101 indicated the expectation in the home was for staff to have a gown and gloves on when entering a resident's bedroom, and then put on a pair of gloves. After exiting another resident's room, PSW #101 was observed using hand sanitizer on top of their gloves. During a second interview, PSW #101 indicated this practice was completed in order to save time.

- At approximately 1215 hours, Inspector observed PSW #102 donning and doffing PPE in an incorrect manner.

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- At approximately 1245 hours, Inspector observed RPN #109 administering medications to multiple residents in their rooms without donning/doffing PPE nor completing hand hygiene between each resident. After RPN #109 was spoken

to by a manager in the home about their practice, they were then observed to don PPE in order to enter a resident's room, and they donned the PPE in an incorrect manner. After completing the medication administration to an ill resident, the RPN was observed doffing the PPE incorrectly. During an interview, RPN #109 indicated they had not received any training or education related to how to properly don/doff PPE.

- At approximately 1255 hours, Inspector observed RN #111 assisting a resident with their lunch meal in the resident's room, without the required PPE on. During an interview, RN #111 acknowledged they did not have the required PPE in place and exited the resident's room to don the required PPE. RN #111 was observed not to complete hand hygiene prior to donning the PPE and then donned the items in an incorrect manner.

- At approximately 1305 hours, Inspector observed PSW #110 exiting an ill resident's room and was observed to be doffing the PPE incorrectly.

During an interview, the Acting Administrator indicated they were aware there were challenges in the home with staff not adhering to the IPAC guidelines. The Acting Administrator further indicated they were in the process of providing education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance was observed related to hand hygiene and PPE donning/doffing.

As there was an identified outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home and inconsistent supply of PPE outside of resident's rooms. These inconsistent practices posed an actual risk of harm to the residents due to the rapid spread of the illness throughout the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs #100, #101, #102 and #110, RSAs #104 and #105, RPN #109, RN #111, housekeeping staff #107, resident #001 and the Acting Administrator.

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

Severity: There was actual risk of harm to the residents because the home was in an identified outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program, and an inconsistent supply of PPE outside resident's rooms.

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: Multiple areas of non-compliance were issued to the home within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 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 19th day of January, 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