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

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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
Mar 8, 2021	2021_838760_0008	015579-20	Critical Incident System

Licensee/Titulaire de permis

Yee Hong Centre for Geriatric Care
2311 McNicoll Avenue Scarborough ON M1V 5L3

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

Yee Hong Centre - Markham
2780 Bur Oak Avenue Markham ON L6B 1C9

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

JACK SHI (760)

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): March 1, 2, 3, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to a fall.

During the course of the inspection, the inspector(s) spoke with Activation Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Associate Director of Resident Care (ADRC) and the Director of Resident Care (DRC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

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

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 and a person in the facility followed the home's infection prevention and control (IPAC) practices. According to two ADRCs, the

home was following contact/droplet precautions during a number of days while the inspector was present at the home.

An ADRC told the inspector that the home's IPAC practices related to contact and droplet precautions are the following:
- Full personal protective equipment (PPE) is to be worn when staff enter resident rooms and they are to be doffed off after coming out.
- Staff are also supposed to be changing their mask and cleaning their face shield when they exit a resident's room.

Observations and interviews with staff were carried out throughout the home and noted the following:

- A PPE caddie outside a resident’s room did not have any gowns in them. The ADRC stated the staff are supposed to be stocking resident gowns right after they finish using the last one.
- A PSW was observed walking out of a resident's room and performing hand hygiene on their soiled gloves. The PSW acknowledged they should not have done this and stated that the home's practice is to remove their soiled gloves and perform hand hygiene afterwards.
- An RPN was seen doffing off their PPE after coming out of a resident's room. The RPN was not seen doffing off their used surgical mask and when the inspector had asked if they did, the RPN shortly replied that they did not and stated they should and changed their surgical mask.
- Another PSW was seen coming out of a resident’s room and removed their soiled gloves and placed them in the pocket of their scrubs. The PSW said they could not find a garbage can and indicated that the gloves were clean because they had rolled them up. The inspector pointed at a garbage can located a few steps away and the PSW stated they could have thrown their soiled gloves inside that garbage can. The ADRC further commented that the PSW should not have had their soiled gloves in their scrubs and that it should have been discarded right away.
- A person in the facility was seen wearing their gloves while they exited a unit of the home. The inspector had asked them about their practice and they stated they were not sure about this practice. The person discarded the gloves shortly after the inspector had brought it to their attention. The ADRC commented that gloves are not to be worn outside resident rooms.
- An activation aide was seen with a gown on while in the hallways on a unit. The activation aide discarded their gown after walking towards the nursing station from a

resident’s room. The activation aide said they donned on their PPE in front of the resident's room. The activation aide acknowledged they should have doffed off their PPE if they were not going to enter the resident’s room.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and visitors of the home and a lack of PPE equipment inside a PPE caddie. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with two ADRCs, two PSWs, an RPN, an activation aide; Observations made throughout the home. [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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 resident #001's care plan provided clear directions to the staff related to their use of a fall prevention intervention.

A Critical Incident System (CIS) report was submitted by the home related to a fall that the resident sustained and subsequently, they had a significant change in their condition and diagnosis of an injury. The resident's care plan at the time of the inspection indicated interventions that are used for fall prevention but did not indicate the use of a certain fall prevention intervention. The resident was observed to have a specified intervention in place that was not identified on the care plan. An RN was asked initially if the resident had that fall prevention intervention and they stated that they did not know. The RN reviewed the resident's care plan and replied that they did not have it. However, the RN subsequently made an observation and confirmed the resident did use this fall prevention intervention. The ADRC stated that a resident's care plan should be updated based on their fall prevention interventions. There was potential risk to the resident, as unclear directions on a resident's care plan may lead to the staff not following the interventions developed and if the resident was falling, the interventions would not be in place to support them.

Sources: Review of resident #001's care plan; Observations with the resident; Interview with an RN, an ADRC and other staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #001's care plan was followed related to an aspect of their care.

A CIS report was submitted related to the resident's fall that was sustained and subsequently, they had a significant change in their condition and diagnosis of an injury. A review of the resident's care plan the resident at that time indicated a type of assistance required to prevent falls. A review of the resident's progress notes indicated that a PSW had found the resident on the floor, after they had turned away from the resident. The resident stated they had lost their balance when they were by themselves. Another PSW who responded to incident, stated that the resident should not have left alone. There was actual harm to the resident, as the PSW did not follow this resident's care plan and turned away from the resident, resulting in them sustaining a fall and a significant change in their condition.

Sources: Interview with a PSW, an ADRC; Review of resident #001's progress notes and care plan. [s. 6. (7)]

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 resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for resident #001.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home's policy and procedure "Fall Prevention and Management", dated September, 2020. The policy states that if a resident's fall is unwitnessed or if there is a suspected head injury, staff will complete a head injury routine and monitor the resident's neurological status.

A CIS report was submitted related to the resident's fall that was sustained and subsequently, they had a significant change in their condition and diagnosis of an injury. The resident had another unwitnessed fall after this one. A head injury routine (HIR) was

initiated. A review of the HIR indicated that during a certain period, an RPN documented that the resident was "sleeping" and did not document any vital signs on the resident. A review of the RPN's documentation did not indicate any reason why the HIR monitoring was not completed during the noted period. The RPN stated that if the resident's condition is okay and they are in deep sleep, they would not complete HIR monitoring on the resident. An ADRC stated this was incorrect and that the home's policy indicates that the registered staff are to complete the HIR monitoring tool even if the resident is sleeping, unless there is a documented refusal. The ADRC further added that if they are not monitoring residents in deep sleep, this may lead to further injuries. There was potential risk to the resident, as their unwitnessed fall was not being monitored by the RPN for a period of time. The risk associated to the resident would be that if they had a serious injury from their fall, the staff would not have been able to render immediate interventions to the resident, as they were not being monitored.

Sources: Fall Prevention and Management policy, dated September, 2020; Resident #001's progress notes and head injury routines; Interview with an RPN, an ADRC and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

2. A CIS report was submitted by the home related to a fall that resident #003 sustained and resulted in an injury. The resident sustained falls after this one. The HIRs showed that in a number of those falls, which were all unwitnessed, the registered staff had documented "sleeping" for one of their scheduled HIR checks between a scheduled period of time. A review of the progress notes related to those scheduled checks did not indicate that the resident had refused their HIR check during that period. An ADRC stated that the registered staff should be doing the HIR on the resident even if they are sleeping. The ADRC said if the staff are documenting "sleeping" in the HIR, there should also be a reason documented on why these checks were not done. There was potential risk to the resident as a number of their unwitnessed falls were not checked in accordance to the home's policy as it relates to HIR monitoring, resulting in possible delay in providing interventions to the resident, if they had a change in their status.

Sources: Fall Prevention and Management policy, dated September, 2020; Resident #003's progress notes, head injury routine; Interview with an ADRC and other staff. [s. 8. (1) (a),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 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, is complied with;, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were

involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the names of all staff members involved in resident #001's fall was included in the CIS report.

A CIS report was submitted by the home related to a fall that resident #003 sustained and resulted in them being diagnosed with an injury. A review of the CIS report indicated that there was one staff member, an RPN, who had responded to the resident's fall. The RPN indicated that there was a PSW who had informed the RPN that the resident sustained their fall on that date. The ADRC confirmed that there were no PSWs named in the CIS report and that the names of all staff members should be in a CIS report.

Sources: Review of CIS report; Interview with an RPN, an ADRC and other staff. [s. 107. (4)]

2. A CIS report was submitted related to a resident's fall and subsequently, they had a significant change in their condition and the diagnosis of an injury. The CIS report had indicated that a PSW and RPN were involved in the incident. Interviews with those staff indicated that there were an RN and another PSW who was also involved in the incident. The ADRC indicated that a CIS report is supposed to include all the staff members involved in the incident and that the report did not indicate an RN and another PSW.

Sources: Review of CIS report; Interviews with a PSW, an RPN, an ADRC and other staff. [s. 107. (4) 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 a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident, to be implemented voluntarily.

Issued on this 9th day of March, 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

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

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) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2021_838760_0008
Log No. / No de registre :	015579-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 8, 2021
Licensee / Titulaire de permis :	Yee Hong Centre for Geriatric Care 2311 McNicoll Avenue, Scarborough, ON, M1V-5L3
LTC Home / Foyer de SLD :	Yee Hong Centre - Markham 2780 Bur Oak Avenue, Markham, ON, L6B-1C9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Cheung

To Yee Hong Centre for Geriatric Care, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

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

3. Ensure care caddies with PPE are fully stocked at all times.

Grounds / Motifs :

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

According to two ADRCs, the home was following contact/droplet precautions during a number of days while the inspector was present at the home.

An ADRC told the inspector that the home's IPAC practices related to contact and droplet precautions are the following:
- Full personal protective equipment (PPE) is to be worn when staff enter resident rooms and they are to be doffed off after coming out.
- Staff are also supposed to be changing their mask and cleaning their face shield when they exit a resident's room.

Observations and interviews with staff were carried out throughout the home and noted the following:

- A PPE caddie outside a resident's room did not have any gowns in them. The ADRC stated the staff are supposed to be stocking resident gowns right after they finish using the last one.
- A PSW was observed walking out of a resident's room and performing hand hygiene on their soiled gloves. The PSW acknowledged they should not have done this and stated that the home's practice is to remove their soiled gloves and perform hand hygiene afterwards.
- An RPN was seen doffing off their PPE after coming out of a resident's room. The RPN was not seen doffing off their used surgical mask and when the inspector had asked if they did, the RPN shortly replied that they did not and stated they should and changed their surgical mask.
- Another PSW was seen coming out of a resident's room and removed their soiled gloves and placed them in the pocket of their scrubs. The PSW said they could not find a garbage can and indicated that the gloves were clean because they had rolled them up. The inspector pointed at a garbage can located a few steps away and the PSW stated they could have thrown their soiled gloves inside that garbage can. The ADRC further commented that the PSW should not have had their soiled gloves in their scrubs and that it should have been discarded right away.
- A person in the facility was seen wearing their gloves while they exited a unit of the home. The inspector had asked them about their practice and they stated they were not sure about this practice. The person discarded the gloves shortly after the inspector had brought it to their attention. The ADRC commented that gloves are not to be worn outside resident rooms.
- An activation aide was seen with a gown on while in the hallways on a unit. The activation aide discarded their gown after walking towards the nursing station from a resident's room. The activation aide said they donned on their PPE in front of the resident's room. The activation aide acknowledged they should have doffed off their PPE if they were not going to enter the resident's room.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and visitors of the home and a lack of PPE equipment inside a PPE caddie. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with two ADRCs, two PSWs, an RPN, an activation aide; Observations made throughout the home.

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

Severity: There was actual risk of harm to the residents because public health had put the home in contact/droplet precautions and there was potential for possible transmission of infectious agents due to the staff and visitor 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 observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 22, 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 8th day of March, 2021

**Signature of Inspector /
Signature de l’inspecteur :**

**Name of Inspector /
Nom de l’inspecteur :** Jack Shi

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