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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 22, 2022	2022_877632_0003	015551-21, 015913-21, 018975-21, 018977-21, 000313-22	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 Hamilton ON L8N 4A6

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

St. Joseph's Villa, Dundas
56 Governor's Road Dundas ON L9H 5G7

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

YULIYA FEDOTOVA (632), ADELFA ROBLES (723), KELLY HAYES (583)

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): March 21-25, 28-31, 2022.

During the course of the inspection, the inspectors toured the home and completed the Infection Prevention and Control (IPAC) checklist, observed and interviewed residents and staff, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following intakes were completed during this Complaint inspection:
Log #015913-21 and #000313-22 were related to resident abuse.
Log #018975-21 and #018977-21 were related to staffing.
Log #015551-21 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Manager (RCM) #1, RCM #2, Director of Operations (DOP), Director of Residents Care (DOC), Chief Operating Officer/Acting DOC North Tower, Nurse Practitioner, Dietary Aid (DA), Occupational Therapist (OT), Physiotherapist (PT), Physiotherapist Assistance (PTA), Registered Dietitian, Infection Prevention and Control (IPAC) Lead, personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), Wound Care Nurse, Therapeutic Recreationist, Environmental Aide, residents and their families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
4 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. 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 :

1. The licensee failed to ensure that staff members used safe transferring techniques when residents #001, #003 and #004 were transferred with specified assistive devices.

The home's Policy provided directions to staff on how to assist residents when using specified assistive devices.

A) In March 2022, Inspector #583 and RPN #135 identified resident #003's safety was at the risk.

The manufacturer's instructions provided staff with directions on how to assist residents when using specified assistive devices.

Resident #003’s care plan indicated specified interventions and identified the resident's self-performance status.

The resident's safety was at risk when PSW #141 assisted the resident with their identified activity had not followed the manufacturer's instructions.

B) In an interview with resident #001 during the inspection, they shared that a number of staff provided specified assistance to the resident, including on an identified day in March, 2022, which was confirmed by PSW #134.

The resident's care plan specified interventions for the resident.

The resident's safety was put at increased risk, when the care plan and policy were not followed on a number of occasions when the resident was provided assistance with their identified activity.

C) In March 2022, PSW #133 shared staff provided specified assistance to resident #004.

The resident's care plan specified interventions when providing care to the resident.

The resident's safety was at increased risk when the care plan and policy were not followed when the resident was provided assistance with their identified activity.

D) During interviews conducted with both direct care and management staff, it was shared that it was common practice to provide a specified assistance in the home for residents using specified assistive devices.

It was confirmed that this practice did not align with the home’s Policy that was in place at the time of the inspection.

Sources: The home's Policy (revised on August 27, 2020) and specified assistive device manufacturer's instructions; resident #001, #003 and #004's care plans; observations; interviews with resident #001, Administrator and other staff.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a particular weekly assessment was completed for resident #001 as specified in their plan of care.

In January 2022, a complaint was received from resident #001 with specific care concerns. In an interview with the resident in March 2022, they shared information about their specified health status.

The resident's care plan related to a health condition provided specific directions to staff. Resident #001's records were reviewed for a period of time in 2022 and indicated that assessments were not conducted consistently. The Administrator shared the expectation on completing and documenting the assessments for the resident.

Staff not completing specified assessments may have contributed to the risk of the resident's health condition not being managed. Strategies to effectively manage the resident's health condition may not have been offered to the resident.

Sources: The specified Consult Letter and specific assessment tools; the home's Policy (revised on April 29, 2021), resident #001's progress notes and care plan; interviews with resident #001, Administrator, DOC #128, RCM #129 and other staff. [s. 6. (7)]

2. The licensee failed to ensure that care was completed for resident #001 as specified in their plan of care.

In an interview with resident #001 during the inspection they shared that an identified number of staff provided assistance to the resident. In October 2021, a specified intervention was put in place when providing care to the resident. At the time of this inspection, this intervention was still in place and the resident required a specified assistance from an identified number of staff during this care activity.

In March 2021, resident #001 shared their care was provided not according to their plan of care. During an interview, PSW and the RPN confirmed that all specified activities, involving assistance to the resident, were completed not according to their plan of care.

Sources: Resident #001's plan of care, interviews with resident #001, PSW #134 and other staff. [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 and ensuring that weekly specified assessments and care are completed for residents as specified in their plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 was provided with fluids that were safe.

In March 2022, it was observed that a resident was provided a drink not specified in their care plan.

Based on the nutrition assessment, the resident’s written care plan directed staff to provide a specified drink to the resident, which was confirmed by the RD.

The resident's safety may have been at increased risk when they consumed specified fluids.

Sources: Resident #002's care plan, Nutrition and Hydration Assessment; observations; interview with the RD. [s. 11. (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 and ensuring that residents are provided with fluids that are safe, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of a between-meal beverage in the identified period of time.

In March 2022, Inspector #723 observed that the in-between meal beverage was not offered or served to the residents in an identified home area. PSW #112 confirmed that they were not able to offer or serve in-between meal beverage.

DOP #115 stated that staff were expected to serve in-between meal beverages.

Failure to provide in-between meal beverages to residents may have increased nutritional and hydration risks to the residents.

Sources: Observations; interviews with PSW #112, RN #113 and DOP #115. [s. 71. (3) (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 and ensuring that each resident is offered a minimum of a between-meal beverage in an identified period of time, to be implemented voluntarily.

WN #5: 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 staff participated in the implementation of the IPAC Program.

The home's Policy under Routine Practices identified expectations for staff on wearing full Personal Protective Equipment (PPE) for all persons entering the room of a resident who required specified additional precaution measures.

A) RPN #110 entered a resident's room who required additional precaution measures as per the sign on their bedroom door. RPN #110 completed a medication pass and was not wearing full PPE. RPN #110 confirmed that all residents in the specified home area were on precautions and that they did not use all the required PPE, when they completed a medication pass with the resident.

Interview with ICP #107 stated that staff were expected to don full PPE as per protocol when going into the resident's room who required specified additional precautions and when coming into the resident's personal space.

The resident and staff member may have been at increased risk of exposure to infectious organisms when staff did not wear appropriate PPE when providing care to the resident.

Sources: The home's Policy#: POL-01 (last reviewed on March 22, 2022); observations; interviews with RPN #110 and ICP #107.

B) The home’s Policy under Routine Practices identified expectations for staff to encourage and support residents to perform hand hygiene before and after meals.

In March 2022, during the meal observation a number of residents were not encouraged or supported to perform hand hygiene prior to meals, which was confirmed by PSW #117. Interview with RN #113 confirmed that some residents in the unit would require assistance in performing hand hygiene. RN #113 and ICP #107 confirmed that staff were expected to provide hand hygiene to residents before and after meals.

In March 2022, during snack observation in a specified home area, PSW #116 served in between meal beverage to an identified number of residents, and none of them were supported or encouraged with their hand hygiene. PSW #116 stated they offered hand hygiene to residents prior to meals but not when they were serving snacks/drinks.

In March 2022, during snack observation a number of residents were served in between meal beverage by PSW #120 and none of them were encouraged or supported with their hand hygiene. PSW #120 stated they were supposed to offer hand hygiene to residents during snacks but were not able to because they were busy.

Residents may have been at increased risk of exposure to infectious organisms when they were not encouraged or supported with hand hygiene prior to meals and or snacks/drinks.

Sources: The home's Policy#: POL-01 (last reviewed on March 22, 2022); observations; interviews with PSWs' #116, #117, #120, RN #113, and ICP #107.

C) The home’s Policy under Routine Practices identified requirements about hand hygiene: before and after contact with any patient/resident, to their body substance or their environment, before and after preparing, handling, serving or eating food or feeding a patient/resident.

In March 2022, during snack observation in an identified home area, PSW #116 was observed not performing hand hygiene when preparing and serving drinks in between residents. PSW #116 guided a resident’s hand, while drinking their beverage, but did not

perform hand hygiene before and after assisting the resident. During an interview, PSW#116 stated they performed hand hygiene before they started serving drinks but was not aware that they were supposed to perform hand hygiene when serving snacks/beverages in between each resident. Interview with RN#102 stated there were a number of residents in the home area on additional precautions. RN #102 also stated that staff were expected to perform hand hygiene when serving snacks/beverages in between each resident.

In March 2022, during snack observation in a specified home area, PSW #120 was observed not consistently performing hand hygiene in between residents when preparing and serving drinks. PSW #120 was observed to perform hand hygiene less number of times than a number of residents served drinks inside their rooms. While assisting an identified number of residents by guiding their hands for their drinks, PSW #120 did not perform hand hygiene before and after these activities.

The risk of infection transmission increased when staff failed to perform hand hygiene when preparing and serving drinks in between each resident.

Sources: The home's Policy#: POL-01 (last reviewed on March 22, 2022); observations; interviews with PSW #116 and RN#102. [s. 229. (4)]

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 and ensuring that staff participates in the implementation of the IPAC Program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's right to participate in decision making was fully respected and promoted.

A complaint was received from resident #001. They shared wishes to have identified interventions in place when staff provided assistance with their identified Activities of Daily Living (ADLs).

The Physiotherapy assessment and care plan provided specified interventions for the resident.

During the inspection resident #001's ADLs were supported by staff with a specified assistance. During interviews with staff, it was identified that the resident did not have an opportunity to have identified interventions in place when staff provided assistance with their identified ADLs. The resident did not feel their decision-making was respected.

Sources: the home's Policy (revised on August 27, 2020), resident #001’s Physiotherapy Assessment and care plan; interviews with the Administrator, DOC #128, RCM #129 and PSW staff. [s. 3. (1) 9.]

Issued on this 3rd day of May, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	YULIYA FEDOTOVA (632), ADELFA ROBLES (723), KELLY HAYES (583)
Inspection No. / No de l’inspection :	2022_877632_0003
Log No. / No de registre :	015551-21, 015913-21, 018975-21, 018977-21, 000313-22
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 22, 2022
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, Hamilton, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Dundas 56 Governor's Road, Dundas, ON, L9H-5G7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jaimie Williams

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To St. Joseph's Health System, 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. 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 comply with s. 36 of O. Reg. 79/10.

A) i. Ensure staff working in a specified home area use specified assistive techniques, when assisting residents' #001, #003 and #004.
ii. Provide education to PSW #134 on how to identify a resident's requirements, the manufacturer's instructions for specified assistive devices and the home's policies.
iii. Provide education to PSW #141 on how to identify a resident's transfer requirements and the home's specified policies.
iv. Maintain a record of the date and content of the training provided to PSWs' #134 and #141.
v. Audit staff when using a specified assistive device in an identified home area to ensure compliance:
- Complete audits weekly for a minimum of one month, or until all staff are compliant with the process.
- Keep records of the audit, including when the audit was completed, what the findings were, the corrective actions taken and who completed the audit.

B) i. Provide clear direction to all direct care staff on the procedures when using a specific transfer device.
ii. Ensure the direction aligns with the home's policies.
iii. Maintain documentation of the content and format the direction was provided.

Grounds / Motifs :

1. 1. The licensee failed to ensure that staff members used safe transferring techniques when residents #001, #003 and #004 were transferred with specified assistive devices.

The home's Policy provided directions to staff on how to assist residents when using specified assistive devices.

A) In March 2022, Inspector #583 and RPN #135 identified resident #003's safety was at the risk.

The manufacturer's instructions provided staff with directions on how to assist residents when using specified assistive devices.

Resident #003's care plan indicated specified interventions and identified the resident's self-performance status.

The resident's safety was at risk when PSW #141 assisted the resident with their identified activity had not followed the manufacturer's instructions.

B) In an interview with resident #001 during the inspection, they shared that a number of staff provided specified assistance to the resident, including on an identified day in March, 2022, which was confirmed by PSW #134.

The resident's care plan specified interventions for the resident.

The resident's safety was put at increased risk, when the care plan and policy were not followed on a number of occasions when the resident was provided assistance with their identified activity.

C) In March 2022, PSW #133 shared staff provided specified assistance to resident #004.

The resident's care plan specified interventions when providing care to the resident.

The resident's safety was at increased risk when the care plan and policy were not followed when the resident was provided assistance with their identified activity.

D) During interviews conducted with both direct care and management staff, it

was shared that it was common practice to provide a specified assistance in the home for residents using specified assistive devices.

It was confirmed that this practice did not align with the home's Policy that was in place at the time of the inspection.

Sources: The home's Policy (revised on August 27, 2020) and specified assistive device manufacturer's instructions; resident #001, #003 and #004's care plans; observations; interviews with resident #001, Administrator and other staff.

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

Severity: The residents experienced minimal harm during transfers assisted by the home's staff.

Scope: This non-compliance was widespread as three out of three residents were placed at risk for unsafe transfers.

Compliance History: One Director Referral (DR), two Compliance Orders (COs) and one Voluntary Plan of Correction (VPC) were issued to the home in the past 36 months related to s. 36. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 11, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 22nd day of April, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Yuliya Fedotova

Service Area Office /
Bureau régional de services : Hamilton Service Area Office