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 West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Sep 1, 2021	2021_792659_0017	007734-21, 009940-21, 009941-21, 010907-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Cambridge Country Manor
3680 Speedsville Road, R.R. #1 Cambridge ON N3H 4R6

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

JANETM EVANS (659)

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): July 28, 29, 30, Aug 4, 5, 6 and 9, 2021.

The following intakes were included in this inspection:
Log #010907-21\ Critical Incident System report (CIS) related to drinking water supply system
Log #007734-21\ CIS report related to a resident fall with injury
Log #009941-21\ Follow-up regarding Infection Prevention and Control (IPAC)
Log #009940-21\ Follow up regarding Abuse policy

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Dietitian Consultant, Food Service and Support Manager (FSSM), Region of Waterloo Public Health Inspector (PH), a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers, Maintenance and Housekeeping staff, screener and residents.

Observations were completed of resident dining and snack services, Infection Prevention and Control (IPAC) procedures, the home's air temperature, staff to resident interactions and general care and cleanliness of the home. The following records were reviewed including but not limited to: progress notes, care plans, reports, surveillance testing records, an emergency plan, compliance plans and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20.	CO #001	2021_610633_0012	659

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 all staff participated in the implementation of the home's Infection Prevention and Control (IPAC) measures and Public Health Ontario

(PHO) best practices related to precautions for a resident on COVID-19 isolation and for resident hand hygiene.

A) The home's IPAC Routine Practices procedure, advised staff that a mask and eye protection should be worn during procedures and care activities likely to generate splash or sprays or when they were within two meters of a coughing resident. Their donning and doffing procedures advised staff to always don PPE before contact with residents. Following use, PPE must be removed and discarded carefully. The outside of the eyepiece and front of the mask were considered contaminated. Eyewear was to be removed and placed in a designated receptacle for reprocessing. Masks were to be removed and discarded.

On July 28, 2021, Inspector #659 was advised that protective eyewear was to be worn at all times, as per public health recommendation for their region, due to the variant of concern.

At the time of the inspection two residents were isolated under droplet and contact precautions for symptoms of COVID-19. The residents had been tested for COVID-19 and the home was awaiting the results.

During the inspection the following was observed: a PSW entered the room of a resident on droplet/contact precautions without donning protective eyewear. Their protective eyewear was instead observed on top of their head. When they exited the resident's room, they did not dispose of their mask or clean their personal protective eyewear prior to entering another resident's room.

Two staff were observed within two meters of residents when providing care and they did not dispose of their facemask with attached visor after exiting the residents' room.

Not ensuring staff donned and doffed their mask and eye protection as required, placed staff and residents at increased risk for disease transmission.

Sources: observations, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, home’s policy - Routine Practices reviewed April 2018, home's policy - Donning and Doffing of Personal Protective Equipment, dated April 2018, interviews with DOC, staff and Waterloo Region PH inspector

B) Public Health Ontario (PHO), Just Clean Your Hands Long-Term Care Home

Implementation Guide, directed staff to encourage and assist residents to perform hand hygiene before and after meals and snacks. The home's policy for hand hygiene stated that some residents may require assistance with hand hygiene and that the hands of residents, staff, volunteers, and family members were to be cleaned before assisting with meals or snacks.

Observations completed on July 28 and 29, 2021, during morning snack and lunch showed three staff had not encouraged or assisted residents with hand hygiene prior to or following meals and snacks.

Not ensuring hand hygiene was completed prior to and following meals and snacks, may have placed residents and staff at increased risk for disease transmission.

Sources: observations, Policy : Hand hygiene, revised Sept 2020, Public Health Ontario, Just Clean Your Hands Long-Term Care Home Implementation Guide, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, interviews with DOC, staff, PH inspector. [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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 was revised when the resident's care needs changed and care set out in the plan was no longer necessary.

A resident who had a history of falls, fell and sustained an injury and was sent to hospital for assessment.

Their plan of care included a number of fall prevention interventions and directed staff to ensuring the resident was receiving 15 minute safety checks until a chair alarm was available and ensuring the call bell was within the resident's reach.

The resident was observed in their wheelchair with their call bell lying on the bed and not within the resident's reach. When asked, the resident did not know what the call bell was for or how to use it.

The ADOC said there were several care interventions in the resident's plan of care that were no longer necessary for this resident as their health status had changed and staff had not revised the resident's plan of care.

Sources: Observations, review of care plan, interviews with ADOC and staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident's plan of care is reviewed and revised at least every six months and any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature measurements of the designated cooling areas, were documented at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night.

Cambridge Country Manor Air temperature logs showed there were 37/77 days (48%) days where the temperature in these designated cooling areas had not been measured and documented. On the days when the air temperature was measured in the designated cooling areas, it was documented once a day.

Failure to measure and document temperatures of the designated cooling areas as per the legislation, may have inhibited the home's ability to address air temperature concerns in a timely manner, and may have placed residents at risk for heat related illnesses.

Sources: Cambridge Country Manor Air temp log, interviews with FSSM and maintenance staff [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperature is measure and documented in writing in every cooling area of the home once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 174.1. Directives by the Minister. Specifically, the licensee failed to comply with s. 174.1(3). Every licensee of a long-term care home shall carry out every operational policy directive that applies to the long-term care home.

The Minister's Directive: Minister's directive, COVID-19: Long-term care home surveillance testing and access to homes, effective July 16, 2021, requires that all staff, caregivers, student placements and volunteers working in or visiting a long-term care home, unless exempted as per section 3, 4.1, 5 and 6, take: one polymerase chain reaction (PCR) test and one antigen test on separate days within a seven-day period. The time period between PCR testing should be as close to seven days as can practically be achieved or an antigen test at a frequency set out in the Ministry of Health COVID-19 guidance: Considerations for antigen point-of-care testing effective June 3, 2021 or as amended, at a minimum

The COVID-19 Guidance: Considerations for Antigen Point-of-Care Testing (POCT), version 6, dated June 3, 2021 said the frequency of the Antigen POCT may be performed one to two times per week during step three of Ontario's reopening plan, for individuals not fully vaccinated.

The licensee had implemented antigen point of care testing. Review of two weeks of the home's surveillance testing for staff who were not fully immunized showed two staff who were not fully vaccinated, were permitted access to the home to work without testing during that time period.

The DOC said the staff members should have had surveillance testing completed one to two times per week during that time period and acknowledged the staff members worked without being tested for COVID-19.

Failure to complete surveillance testing for staff as per the Minister's Directive, placed all staff and residents of the home at risk for possible disease transmission.

Sources: Surveillance testing records, staff schedules July 16 to August 1, 2021, interview with ADOC and DOC. [s. 174.1 (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee will follow the Minister's Directive, COVID-19: Long-term care home surveillance testing and access to homes, and conduct all staff surveillance testing in accordance with the directive, to be implemented voluntarily.

Issued on this 27th day of September, 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) :	JANETM EVANS (659)
Inspection No. / No de l'inspection :	2021_792659_0017
Log No. / No de registre :	007734-21, 009940-21, 009941-21, 010907-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 1, 2021
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Cambridge Country Manor 3680 Speedsville Road, R.R. #1, Cambridge, ON, N3H-4R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Richardson

To Caressant-Care Nursing and Retirement Homes Limited, 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)

Linked to Existing Order / Lien vers ordre existant: 2021_610633_0011, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 229 (4)

Specifically, the licensee will ensure
1. Two identified staff are retrained to ensure compliance with donning/doffing of personal protective equipment (PPE).

2. That all direct care staff are re-educated to ensure compliance with hand hygiene as per Public Health Ontario (PHO) best practices. The training should be documented and maintained in the home. It should include the date, time, name of the person providing the training, name of staff and sign off and training material.

3. A designated individual conducts a daily audit of resident hand hygiene on all shifts. The audit should be completed for three residents during one meal or snack service on each home area. The audits should include the date of the audit, the time, the home area, the name of the person completing the audit, the name of the staff observed, the name of the resident and action taken, if any. The audits should be documented and maintained onsite. The audits should continue for a minimum of one month, or until the home has determined they have met compliance with resident hand hygiene practices.

Grounds / Motifs :

1. Compliance order #001 related to O. Reg. 79/10, s. 229. 4 from inspection 2021_610633_0011 issued on June 8, 2021, with a compliance due date of June 15, 2021, is being re-issued as follows:
The licensee has failed to ensure that all staff participated in the implementation

of the home's Infection Prevention and Control (IPAC) measures and Public Health Ontario (PHO) best practices related to precautions for a resident on COVID-19 isolation and for resident hand hygiene.

1. The licensee has failed to ensure that all staff participated in the implementation of the home's Infection Prevention and Control (IPAC) measures and Public Health Ontario (PHO) best practices related to precautions for a resident on COVID-19 isolation and for resident hand hygiene.

A) The home's IPAC Routine Practices procedure, advised staff that a mask and eye protection should be worn during procedures and care activities likely to generate splash or sprays or when they were within two meters of a coughing resident. Their donning and doffing procedures advised staff to always don PPE before contact with residents. Following use, PPE must be removed and discarded carefully. The outside of the eyepiece and front of the mask were considered contaminated. Eyewear was to be removed and placed in a designated receptacle for reprocessing. Masks were to be removed and discarded.

On July 28, 2021, Inspector #659 was advised that protective eyewear was to be worn at all times, as per public health recommendation for their region, due to the variant of concern.

At the time of the inspection two residents were isolated under droplet and contact precautions for symptoms of COVID-19. The residents had been tested for COVID-19 and the home was awaiting the results.

During the inspection the following was observed: a PSW entered the room of a resident on droplet/contact precautions without donning protective eyewear. Their protective eyewear was instead observed on top of their head. When they exited the resident's room, they did not dispose of their mask or clean their personal protective eyewear prior to entering another resident's room.

Two staff were observed within two meters of residents when providing care and they did not dispose of their facemask with attached visor after exiting the residents' room.

Not ensuring staff donned and doffed their mask and eye protection as required, placed staff and residents at increased risk for disease transmission.

Sources: observations, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, home's policy - Routine Practices reviewed April 2018, home's policy - Donning and Doffing of Personal Protective Equipment, dated April 2018, interviews with DOC, staff and Waterloo Region PH inspector

B) Public Health Ontario (PHO), Just Clean Your Hands Long-Term Care Home Implementation Guide, directed staff to encourage and assist residents to perform hand hygiene before and after meals and snacks. The home's policy for hand hygiene stated that some residents may require assistance with hand hygiene and that the hands of residents, staff, volunteers, and family members were to be cleaned before assisting with meals or snacks.

Observations completed on July 28 and 29, 2021, during morning snack and lunch showed three staff had not encouraged or assisted residents with hand hygiene prior to or following meals and snacks.

Not ensuring hand hygiene was completed prior to and following meals and snacks, may have placed residents and staff at increased risk for disease transmission.

Sources: observations, Policy : Hand hygiene, revised Sept 2020, Public Health Ontario, Just Clean Your Hands Long-Term Care Home Implementation Guide, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, interviews with DOC, staff, PH inspector. [s. 229. (4)]

Sources: observations, Policy : Hand hygiene, revised Sept 2020, Public Health Ontario, Just Clean Your Hands Long-Term Care Home Implementation Guide, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, interviews with DOC, staff, PH inspector.

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

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

Severity: The licensee not ensuring that staff followed IPAC precautions in accordance with Directive #3 and PHO best practices for PPE use and disposal and hand hygiene for residents, placed staff and residents at minimal risk for infectious disease transmission.

Scope:This non compliance was a pattern as two out of three home areas were observed to be in non-compliance.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 229.4 of O. Reg 79/10. This subsection was issued as a CO on June 8, 2021, during inspection #2021_610633_0011 with a compliance due date of June 15, 2021. In the past 36 months three other COs were issued to the home for unrelated areas of the legislation, all of which have been complied. (659)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 31, 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
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 1st day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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