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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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 18, 2021	2021_633577_0005	024884-20, 025097-20, 000262-21, 000302-21, 000586-21, 000915-21, 001588-21, 002547-21, 003923-21	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street Thunder Bay ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street Thunder Bay ON P7C 4Y7

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

DEBBIE WARPULA (577), LAUREN TENHUNEN (196), MELISSA HAMILTON (693)

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 8 to 12, 2021

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-one log regarding alleged staff to resident abuse;
-six logs regarding alleged resident to resident abuse; and
-one log regarding missing medication.

Follow Up inspection #2021_633577_0006 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Infection Prevention and Control Facilitator, Thunder Bay District Health Unit (TBDHU) Public Health Nurse, Clinical Practice and Learning Registered Nurse, Psychogeriatric Resource Consultant, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping aide and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, staff education records, as well as relevant standards and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically to ensure there was specific signage posted on or near the entrance door of affected residents and personal protective equipment was available.

In accordance with Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, homes were required to have signage specific to the type(s) of specific precautions posted. A sign that lists the required precautions was to be posted at the entrance to the resident’s room or bed space; and personal protective equipment (PPE) that was to be worn when re-entering the resident room.

The home’s policy indicated that when specific precautions were initiated, staff were to have placed specific signage at the resident's doorway.

a) Inspector #577 observed a resident room with a door apparatus that contained some PPE, however, no sign was present to indicate the specific precautions or what the required equipment would be.

During an interview with a PSW, they identified that the resident was on specific precautions and that a sign was required to ensure staff were aware.

b) Inspector #577 observed another resident room for specific precautions and noted that no sign was present to indicate the precautions, what the required PPE would be or any available PPE outside the room.

A PSW indicated that they put the sign and apparatus that held the PPE on the inside of

the resident’s door.

The following day, Inspector #577 noted that the sign was not present outside that resident room and the apparatus did not contain PPE.

During an interview with the Infection Prevention and Control Facilitator, they indicated that when a resident was on specific isolation, particular PPE needed to be available to staff and they were required to wear the particular PPE before entering the room. Specific signage was required to be affixed at the entrance of a resident’s doorway, and that practice was different on that unit. They reported that because residents on that unit had a specific tendency, staff would put signage and particular PPE on the inside of the resident’s door. They indicated that it was good practice as they could maintain a two meter distance between the resident’s bed and the equipment.

During an interview with the DOC, they confirmed that the home had the practice of putting particular PPE and specific signage on the inside of the resident’s door on that specific unit. They confirmed that the particular PPE would be contaminated, and staff were not implementing the IPAC program. Further, specific signage was required to be at the resident’s doorway.

In an interview with the Thunder Bay District Health Unit (TBDHU) Public Health Nurse, they advised that in the event where a resident was on specific precautions, particular PPE was to be placed off the floor, outside a resident's room, and not hung on the inside of the resident's room, as then it would be considered contaminated. Further communication from Public Health Ontario Infection Prevention and Control Specialist Registered Nurse, indicated that particular carts or dispensers should be located outside of the residents room; it was principle-based as particular PPE should be under observation to assure its cleanliness. The potential for a resident to tamper with the equipment stored inside their room should be considered.

The failure to have required signage posted on or near the entrance door of affected residents and available PPE outside the resident room, in accordance with Evidence Based Practice (EBP) presented a minimal risk of harm to residents related to the possible contact spread of disease-causing organisms.

Sources: Inspector #577's observations on three different days; interviews with the Director of Care (DOC) and other staff, and Public Health Nurse, Droplet Precautions, Routine Practices and Additional Precautions in All Health Care Settings. [s. 229. (4)]

2. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, 'Just Clean Your Hands' (JCYH) related to staff assisting residents with HH before and after meals.

In accordance with Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings, hand hygiene in Long Term Care homes was to be provided to residents before and after meals and snacks.

Inspector #577 observed a meal service and noticed that residents were not provided with hand hygiene before and after the meal.

A review of the home's Hand Hygiene program did not include a process for staff to assist residents to clean their hands before and after a meal.

The failure to have a hand hygiene program in place in accordance with EBPs presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents; interviews with the Director of Care and other staff; the home's policy Hand Hygiene; and Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings. [s. 229. (9)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 a hand hygiene program is in place in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of the alleged physical abuse of a resident, that the licensee suspected may have constituted a criminal offence.

Inspector #693 reviewed the progress notes for a resident and identified a note that indicated that an RPN and PSW had found a resident in their room with specific injuries. The resident indicated that a PSW had injured them.

The home’s investigation related to the alleged incident, as well as interviews with a CM and the DOC, identified that the alleged incident had not immediately been reported to the police.

Sources: a CIS report; the home's critical incident investigation file; a resident’s progress notes; Zero Tolerance of Resident Abuse and Neglect policy: Investigation and Consequences; Zero Tolerance of Resident Abuse and Neglect policy: Response and Reporting; and interviews with a CM, the DOC, and other relevant staff members. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff complied with the home's zero tolerance of abuse and neglect of residents policy, in regard to investigating the alleged physical abuse of a resident.

Ontario Regulation (O. Reg.) 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident.

Inspector #693 reviewed the progress notes for a resident, and identified a note that indicated that an RPN and PSW had found a resident in their room with specific injuries. The resident indicated that a PSW had injured them.

A review of the home’s policy indicated that the home’s management was to immediately advise the accused employee that they were being removed from the work schedule.

The home’s investigation related to the alleged physical abuse of a resident, as well as interviews with a CM and the DOC, identified that the management on call, when the alleged physical abuse of a resident occurred, should have sent the PSW home, as per the home’s abuse and neglect policy, but did not.

Sources: a CIS report; the home's critical incident investigation file; a resident’s progress notes; Zero Tolerance of Resident Abuse and Neglect policy: Investigation and Consequences; and interviews with the DOC, and other relevant staff members. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that physical abuse of a resident by a PSW, that resulted in harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #693 reviewed the progress notes for a resident, and identified a note that indicated that an RPN and PSW had found a resident in their room with specific injuries. The resident indicated that a PSW had injured them.

A review of the CIS report, the home's investigation related to the alleged physical abuse of a resident, as well as interviews with a CM and the DOC, identified that the incident was not reported to the Director, until the morning after it occurred.

The DOC indicated that the incident should have been reported by the management on call, on the day that it occurred.

Sources: a CIS report; the home's critical incident investigation file; a resident's progress notes; Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences policy; Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; and interviews with the DOC, and other relevant staff members. [s. 24. (1) 2.]

Issued on this 7th day of April, 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) :	DEBBIE WARPULA (577), LAUREN TENHUNEN (196), MELISSA HAMILTON (693)
Inspection No. / No de l’inspection :	2021_633577_0005
Log No. / No de registre :	024884-20, 025097-20, 000262-21, 000302-21, 000586-21, 000915-21, 001588-21, 002547-21, 003923-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 18, 2021
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, Thunder Bay, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, Thunder Bay, ON, P7C-4Y7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jonathon Riabov

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 Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 229 (4) of the LTCHA.

Specifically, the licensee must:
-ensure that specific signage is posted on or near the entrance door of affected residents
-ensure that particular carts or dispensers are located outside of the residents room containing proper personal protective equipment

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically to ensure there was specific signage posted on or near the entrance door of affected residents and personal protective equipment was available.

In accordance with Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, homes were required to have signage specific to the type(s) of specific precautions posted. A sign that lists the required precautions was to be posted at the entrance to the resident's room or bed space; and personal protective equipment (PPE) that was to be worn when re-entering the resident room.

The home's policy indicated that when specific precautions were initiated, staff were to have placed specific signage at the resident's doorway.

a) Inspector #577 observed a resident room with a door apparatus that contained some PPE, however, no sign was present to indicate the specific precautions or what the required equipment would be.

During an interview with a PSW, they identified that the resident was on specific precautions and that a sign was required to ensure staff were aware.

b) Inspector #577 observed another resident room for specific precautions and noted that no sign was present to indicate the precautions, what the required PPE would be or any available PPE outside the room.

A PSW indicated that they put the sign and apparatus that held the PPE on the inside of the resident's door.

The following day, Inspector #577 noted that the sign was not present outside that resident room and the apparatus did not contain PPE.

During an interview with the Infection Prevention and Control Facilitator, they indicated that when a resident was on specific isolation, particular PPE needed to be available to staff and they were required to wear the particular PPE before entering the room. Specific signage was required to be affixed at the entrance of a resident's doorway, and that practice was different on that unit. They reported that because residents on that unit had a specific tendency, staff would put signage and particular PPE on the inside of the resident's door. They indicated that it was good practice as they could maintain a two meter distance between the resident's bed and the equipment.

During an interview with the DOC, they confirmed that the home had the practice of putting particular PPE and specific signage on the inside of the resident's door on that specific unit. They confirmed that the particular PPE would be contaminated, and staff were not implementing the IPAC program. Further, specific signage was required to be at the resident's doorway.

In an interview with the Thunder Bay District Health Unit (TBDHU) Public Health Nurse, they advised that in the event where a resident was on specific precautions, particular PPE was to be placed off the floor, outside a resident's room, and not hung on the inside of the resident's room, as then it would be considered contaminated. Further communication from Public Health Ontario Infection Prevention and Control Specialist Registered Nurse, indicated that particular carts or dispensers should be located outside of the residents room; it was principle-based as particular PPE should be under observation to assure its

cleanliness. The potential for a resident to tamper with the equipment stored inside their room should be considered.

The failure to have required signage posted on or near the entrance door of affected residents and available PPE outside the resident room, in accordance with Evidence Based Practice (EBP) presented a minimal risk of harm to residents related to the possible contact spread of disease-causing organisms.

Sources: Inspector #577's observations on three different days; interviews with the Director of Care (DOC) and other staff, and Public Health Nurse, Droplet Precautions, Routine Practices and Additional Precautions in All Health Care Settings. [s. 229. (4)]

2. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, 'Just Clean Your Hands' (JCYH) related to staff assisting residents with HH before and after meals.

In accordance with Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings, hand hygiene in Long Term Care homes was to be provided to residents before and after meals and snacks.

Inspector #577 observed a meal service and noticed that residents were not provided with hand hygiene before and after the meal.

A review of the home's Hand Hygiene program did not include a process for staff to assist residents to clean their hands before and after a meal.

The failure to have a hand hygiene program in place in accordance with EBPs presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents; interviews with the Director of Care and other staff; the home's policy Hand Hygiene; and Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings. [s. 229. (9)]

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

Severity: There was actual risk of harm to two residents.

Scope: The scope of this non-compliance was a pattern as it affected two out of three residents.

Compliance history: Two voluntary plans of correction (VPCs) were issued to the home related to s. 229 in the past 36 months.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 08, 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 18th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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