Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
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Bureau régional de services de Centre-Est
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 2021	2021_823653_0012	018423-20, 003074-21, 007579-21	Critical Incident System

Licensee/Titulaire de permis

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

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

Yee Hong Centre - Scarborough Finch
60 Scottfield Drive Scarborough ON M1S 5T7

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

ROMELA VILLASPIR (653)

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): May 26, 27, 28, 31, June 1, and 2, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

-Log #018423-20 related to falls prevention and management;
-Log #003074-21 related to an unexpected death;
-Log #007579-21 related to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Student PSW, Registered Practical Nurses (RPNs), Registered Nurses (RNs), External Contractor, Physiotherapy Assistant (PTA), Occupational Therapist (OT), Infection Prevention and Control (IPAC) Manager, On-call Physician, Assistant Directors of Resident Care (ADRCs), and the Director of Resident Care (DRC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, provision of resident care, staff to resident interactions, reviewed clinical health records, staffing schedule, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was protected from abuse.

The home submitted a Critical Incident Report (CIR) to the Director related to staff to resident abuse. A review of progress notes and staff interviews indicated resident #003 reported an incident that involved Personal Support Worker (PSW) #122 during care provision. Registered Practical Nurse (RPN) #111 stated as per their assessment, there was no pain nor injuries that resulted from the incident.

The Director of Resident Care (DRC) indicated based on the home's internal investigation, they learned that earlier in the shift, PSW #122 performed care activities without obtaining resident #003's consent. After a meal service, the resident rang their call bell and PSW #114 responded and told the resident they will be right back, and then left the room. However, PSW #122 came and told the resident they will assist with care. The resident insisted to wait for another PSW, and without the resident's consent, PSW #122 attempted to provide care. Resident #003 resisted, and it was at that time that another incident happened, involving PSW #122. The DRC confirmed that the resident felt threatened by PSW #122, based on their reaction and response regarding the incident. The DRC further stated that PSW #122 was not immediately sent home after the nurse and the Assistant Director of Resident Care (ADRC) were made aware of the allegation of abuse.

Sources: CIR and progress notes; Interviews with PSW #114, RPN #111, ADRC #113, and the DRC. [s. 19. (1)]

2. The licensee has failed to ensure that resident #002 was free from neglect by the staff in the home.

The home submitted a CIR related to the unexpected death of resident #002.

A review of resident #002's clinical health records revealed the resident's Substitute

Decision-Maker (SDM) consented to a specified care intervention.

A review of progress notes and an interview with RPN #110 indicated on a specified day and time, PSW #115 called them to resident #002's room. Upon arrival, the resident was in bed, unresponsive, and the RPN did not perform the specified care intervention after finding the resident. After about half an hour, the RPN called Registered Nurse (RN) #112, and the RN instructed them to contact ADRC #116, who was the on-call manager. The RN did not immediately come to the unit to further assess resident #002 nor provided assistance to RPN #110.

An interview with PSW #118 indicated they had last seen the resident around half an hour prior to the incident, and did not notice anything unusual with them during care.

An interview with RN #112 indicated that RPN #110 called them 40 minutes after the RPN had found the resident unresponsive. The RN questioned why the RPN did not immediately initiate the specified care intervention, and why the RPN called them late.

An interview with the DRC indicated that as per the home's expectation, if a resident was found unresponsive and they had advance directives for a specified care intervention, which had been previously confirmed by the resident or SDM, then it should be initiated, emergency code would be announced in the building, and 911 would be called. The DRC further indicated that RPN #110 and RN #112 did not meet the home's expectation in regards to responding to an unresponsive resident.

Sources: CIR, progress notes, record of consent to treatment; Interviews with PSW #118, RPN #110, RN #112, the DRC, and other staff. [s. 19. (1)]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, regarding wearing the required eye protection.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive, issued on May 21, 2021, all staff and essential visitors are required to wear appropriate eye protection when they are within 2 Metres (M) of a resident as part of provision of direct care and/or when they interact with a resident in an indoor area.

The following observations were conducted by Inspector #653:

-Three staff members in the TV room were not wearing eye protection, and were within 2M of residents.
-Two PSWs, and Student PSW #101 performed care activities inside the room without wearing eye protection.
-A staff member was in the hallway dancing with a resident within 2M in distance, and was not wearing eye protection.
-An Essential Care Giver (ECG) was providing continence care to a resident in the room, and was not wearing eye protection.
-A resident was on droplet/ contact precautions. ECG was inside the room not wearing eye protection, and was within 2M from the resident.
-A Physiotherapy Assistant (PTA) was assisting a resident with standing exercises, and the PTA was not wearing eye protection.
-During a meal service in the dining room, three staff members who were not wearing eye protection, were feeding the residents.
-During a meal service in the dining room, four staff members who were not wearing eye protection, were feeding the residents.
-An ECG was inside a resident's room, not wearing eye protection, and was feeding the resident.

An interview with the home’s Infection Prevention and Control (IPAC) manager indicated that the staff and ECGs were required to wear eye protection when providing care services to the residents. There was potential risk for transmission of infectious agents

including the COVID-19 virus, with the staff and ECGs not wearing eye protection.

Sources: Inspector #653's observations; Interviews with the IPAC manager and other staff. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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 resident #003's plan of care was reviewed and revised when their care needs changed.

A review of the Occupational Therapist (OT)'s progress note and an interview with the OT, indicated they assessed the resident's transfer status in November 2020, and recommended a specified type of assistance with transfers. The OT confirmed they had not received any other referral ever since, and was not aware of any changes with the resident's transfer status. A review of resident #003's care plan in May 2021, revealed that the transfer status was not updated based on the OT's recommendations. During an interview, the DRC acknowledged that the resident's plan of care was not reviewed and revised when their transfer needs changed, and the associated risks were safety concerns, and the resident not receiving current individualized care they required.

Sources: Progress notes, care plan; Interviews with the OT, the DRC, and other 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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

The home submitted a CIR to the Director related to staff to resident abuse. ADRC #113 indicated the allegation of abuse involving resident #003 was reported to them by RPN #111. The ADRC did not call the Ministry of Long-Term Care (MLTC)'s after hours emergency contact to report the allegation of abuse, and decided to wait until they could confirm the incident with the DRC. The ADRC and the DRC acknowledged that the allegation of abuse was not immediately reported to the Director.

Sources: CIR and progress notes; Interviews with PSW #114, RPN #111, ADRC #113, and the DRC. [s. 24. (1)]

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 has failed to ensure that the staff participated in the implementation of the home's IPAC Program.

The following observations were conducted by Inspector #653:

-PSW #100 and Student PSW #101 entered a resident's room without performing hand hygiene, and donned gloves. Both of them performed care activities inside the room. PSW #101 did not perform hand hygiene before leaving the room, and Student PSW #101 was noted to rub Alcohol-Based Hand Rub (ABHR) on both hands while holding onto a garbage bag on one hand.
-A resident's room had contact precautions signage posted on the door. RN #102 indicated to inspector that the additional precautions signage was supposed to be droplet/ contact as the resident exhibited symptoms of COVID-19 and was tested pending swab results.
-An external contractor exited the tub room wearing full Personal Protective Equipment (PPE), walked in the hallway, and exited the unit. The contractor indicated to the inspector they were only in the tub room and were not in contact with any resident, so they did not remove nor change their PPE.
-A resident's room was on droplet/ contact precautions and the PPE caddy was not stocked with gowns.
-A resident's room was on contact precautions, however, as per progress notes, the resident had exhibited symptoms of COVID-19 and was tested pending swab results. The IPAC manager indicated that the additional precautions signage was supposed to be droplet/ contact precautions.

An interview with the home's IPAC manager indicated that the risks associated to the staff not participating in the implementation of the home's IPAC program would be in case of any COVID-19 positive, it would become difficult to contain spread of infection.

Sources: Inspector #653's observations; Interviews with the IPAC manager and other staff. [s. 229. (4)]

Issued on this 17th day of June, 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) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2021_823653_0012
Log No. / No de registre :	018423-20, 003074-21, 007579-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 15, 2021
Licensee / Titulaire de permis :	Yee Hong Centre for Geriatric Care 2311 McNicoll Avenue, Scarborough, ON, M1V-5L3
LTC Home / Foyer de SLD :	Yee Hong Centre - Scarborough Finch 60 Scottfield Drive, Scarborough, ON, M1S-5T7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Chee

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

1. Review the following with Personal Support Worker (PSW) #114, Registered Practical Nurse (RPN) #111, and Assistant Director of Resident Care (ADRC) #113:
-Grounds of Compliance Order (CO) #001 related to resident #003;
-The home's expectation and relevant policies and procedures regarding their roles and responsibilities for identifying and responding to potential and actual abuse.

2. Review the following with RPNs #110, #120, Registered Nurse (RN) #112, and ADRC #116:
-Grounds of CO #001 related to resident #002;
-The home's expectation and relevant policies and procedures regarding a medical emergency.

3. Document the review, including the date, attendees, and the staff member who facilitated the review.

4. A record is required to be kept by the licensee for all actions undertaken in items #1 to #3.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003 was protected from

abuse.

The home submitted a Critical Incident Report (CIR) to the Director related to staff to resident abuse. A review of progress notes and staff interviews indicated resident #003 reported an incident that involved Personal Support Worker (PSW) #122 during care provision. Registered Practical Nurse (RPN) #111 stated as per their assessment, there was no pain nor injuries that resulted from the incident.

The Director of Resident Care (DRC) indicated based on the home's internal investigation, they learned that earlier in the shift, PSW #122 performed care activities without obtaining resident #003's consent. After a meal service, the resident rang their call bell and PSW #114 responded and told the resident they will be right back, and then left the room. However, PSW #122 came and told the resident they will assist with care. The resident insisted to wait for another PSW, and without the resident's consent, PSW #122 attempted to provide care. Resident #003 resisted, and it was at that time that another incident happened, involving PSW #122. The DRC confirmed that the resident felt threatened by PSW #122, based on their reaction and response regarding the incident. The DRC further stated that PSW #122 was not immediately sent home after the nurse and the Assistant Director of Resident Care (ADRC) were made aware of the allegation of abuse.

Sources: CIR and progress notes; Interviews with PSW #114, RPN #111, ADRC #113, and the DRC. (653)

2. The licensee has failed to ensure that resident #002 was free from neglect by the staff in the home.

The home submitted a CIR related to the unexpected death of resident #002.

A review of resident #002's clinical health records revealed the resident's Substitute Decision-Maker (SDM) consented to a specified care intervention.

A review of progress notes and an interview with RPN #110 indicated on a specified day and time, PSW #115 called them to resident #002's room. Upon arrival, the resident was in bed, unresponsive, and the RPN did not perform the

specified care intervention after finding the resident. After about half an hour, the RPN called Registered Nurse (RN) #112, and the RN instructed them to contact ADRC #116, who was the on-call manager. The RN did not immediately come to the unit to further assess resident #002 nor provided assistance to RPN #110.

An interview with PSW #118 indicated they had last seen the resident around half an hour prior to the incident, and did not notice anything unusual with them during care.

An interview with RN #112 indicated that RPN #110 called them 40 minutes after the RPN had found the resident unresponsive. The RN questioned why the RPN did not immediately initiate the specified care intervention, and why the RPN called them late.

An interview with the DRC indicated that as per the home's expectation, if a resident was found unresponsive and they had advance directives for a specified care intervention, which had been previously confirmed by the resident or SDM, then it should be initiated, emergency code would be announced in the building, and 911 would be called. The DRC further indicated that RPN #110 and RN #112 did not meet the home's expectation in regards to responding to an unresponsive resident.

Sources: CIR, progress notes, record of consent to treatment; Interviews with PSW #118, RPN #110, RN #112, the DRC, and other staff.

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

Severity: There was actual risk of harm to resident #003 as the resident felt threatened and fearful of PSW #122 as a result of the incident. There was actual risk of harm to resident #002 when the registered staff member did not perform the care intervention as per their advance directive, when they were found unresponsive.

Scope: The scope of this non-compliance was a pattern, because two residents that were reviewed during the inspection were affected.

Compliance History: In the last 36 months, the licensee was found to be non-

compliant with LTCHA s. 19 (1) and a Written Notification (WN) and Compliance Order (CO) which had been complied, were issued to the home. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 15th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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