Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
Jan 10, 2022	2021_593573_0023	017184-21, 017938-21	Critical Incident System

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road Ottawa ON K1N 5M2

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

Garry J. Armstrong Home
200 Island Lodge Road Ottawa ON K1N 5M2

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

ANANDRAJ NATARAJAN (573)

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): October 28, 2021, November 29, 30, 2021, December 01, 02, 03, 06, 07, 08, 09, and 10, 2021.

The following intake(s) was completed in this Critical Incident System (CIS) inspection: Log #017184-21 and Log #017938-21 were related to staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Long -Term Care (LTC) helper, Personal Support Workers (PSW), Housekeeping staff, Activities Coordinator, Registered Practical Nurses (RPN), Registered Nurses (RN), the Infection Prevention and Control (IPAC) Nurse, the Manager of Hospitality Services, the Manager of Recreation, Leisure and Volunteers, the Program Manager of Resident Care (PMRC), the Program Manager of Personal Care (PMPC), the Administrator and the Director, Long -Term Care Services.

During the course of the inspection, the inspector(s) reviewed the resident health care records, the licensee's investigation notes, relevant home policies and procedures, and other pertinent documents. The Inspector(s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **1 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 #001 was protected from the sexual abuse by a staff member.

Section 2 (1) of the Ontario Regulation 79/10 defines Sexual abuse as subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to alleged staff to resident sexual abuse incident. The CIR indicated that a video footage was obtained that showed an incident of sexual abuse by a staff member to resident #001.

On the previous day to the above critical incident, an Activities Coordinator reported to the Program Manager of Personal Care (PMPC) that a Long -Term Care (LTC) helper witnessed inappropriate behaviour of a staff member to resident #003 in the resident lounge. The staff member seemed to be startled and quickly jumped when they noticed the LTC helper walk into the resident lounge. On the same day after few hours, the Activities Coordinator went again to report to the PMPC that they witnessed the staff member inappropriate behaviour towards resident #003. When the staff member noticed the Activities Coordinator, they quickly jumped and grabbed a clothing protector off the table and continued clearing the table. The Activities Coordinator reported to the PMPC that they and the LTC helper were concerned about the staff member’s behaviour on the unit.

During the interview, the Activities Coordinator stated that the LTC helper discussed with them that they witnessed inappropriate behaviour of the staff member to resident #003. The Activities Coordinator indicated that the LTC helper was concerned about the staff member’s behaviour and the incident on the unit. The Activities Coordinator stated that they reported this incident to the PMPC. The Activities Coordinator indicated that on the same day after few hours, they went again to report to the PMPC that they witnessed the staff member inappropriate behaviour to resident #003. The Activities Coordinator indicated to the inspector that they suspected the staff member’s behaviour towards the resident was sexually inappropriate in nature. The Activities Coordinator indicated that the PMPC communicated to them, that with the information what was provided it was determined that the allegations did not meet the home's definition of sexual abuse. The

Activities Coordinator indicated to the inspector that the staff member's suspicious behaviour and reactions made them to suspect that something was wrong. Furthermore, they indicated that next day they decided to set up a video camera in the resident lounge to capture the staff member's strange behaviour on the unit.

During the interview, the Program Manager of Personal Care stated to the inspector that, the Activities Coordinator reported the LTC helper's and their concerns about the staff member's behaviour and the incident on the unit. The PMPC indicated that they discussed with the Program Manager of Resident Care (PMRC), reviewed the licensee's resident abuse policy and the decision trees. The PMPC indicated to the inspector, that at that time with the information what was provided to them it was determined that the reported incidents did not fall under allegation of sexual abuse. The PMPC stated that an investigation was not initiated, nor did they speak with the LTC helper. The PMPC stated that since it was determined that it was not an allegation of sexual abuse, they did not report to the Ministry of Long- Term Care. Furthermore, the PMPC indicated that the Manager of Hospitality Services had planned to talk with the staff member on the next day, to not take their breaks on the residents' unit.

The failure to identify the allegations of the staff member's inappropriate behaviour with resident #003, lead to no actions being taken by the licensee to protect resident #001 from the sexual abuse by the staff member.

Sources: the licensee's investigation notes, interviews with the Activities Coordinator, the Program Manager of Personal Care, 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 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 Infection Prevention and Control (IPAC) program.

During the lunch meal service, inspector observed a PSW staff removing residents' dirty dishes, clearing the remaining food in the garbage, and placing the dirty dishes in a clearing tray. The inspector observed that the PSW returned to feed a resident, at no time hand washing nor hand hygiene was observed. Further, the inspector observed another PSW staff assist with a resident’s feeding, went to assist another resident in a different table. At no time hand washing nor hand hygiene was observed between the care. The inspector observed a hand washing sink and alcohol-based hand hygiene dispensers in the dining room.

During the same lunch service, the inspector observed that the residents’ hands were not cleaned before and after the lunch meal service. The licensee’s hand hygiene program was based on the Ontario's Just Clean Your Hands (JCYH) program which requires that the staff assist residents to clean their hands before and after meals. The failure to follow the Infection Prevention and Control (IPAC) practices posed an infection control risk to the staff and the residents.

Sources: Direct observations, interview with the Registered Nursing staff for Infection prevention & control and other staff interviews. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the plan of care indicated that the resident was to be transferred with two-person assistance for their transfers.

During the interview, the PSW stated that on a day and month in 2021, they transferred the resident by themselves without the second person assistance. Failing to follow the resident's plan of care for transfers may result in potential risk of harm to the resident.

Sources: the resident's health records and interview with the PSW. [s. 6. (7)]

WN #4: 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 the Long -Term Care (LTC) helper complied with the licensee's policy to promote zero tolerance of abuse and neglect of residents by not reporting immediately.

The licensee's policy related to Resident Abuse and Neglect P&P No :750.65 indicated that "Any staff member, volunteer, resident, family member or visitor can report suspected or witnessed abuse or neglect.

Staff or volunteers who witness or suspect abuse or neglect of any kind, or who receive a report of alleged or suspected abuse or neglect from a resident, family member or visitor, are required to immediately report it to their supervisor, program manager or administrator, who will escalate the allegation to the Ministry of Heath and Long-Term Care"

During the interview, the LTC helper stated that on a day and month in 2021, they witnessed inappropriate behaviour of a staff member to resident #003 in the resident lounge. Furthermore, they indicated that the staff member seemed to be startled and quickly jumped when they noticed them walk into the resident lounge. The LTC helper stated to the inspector that they suspected the staff member's actions were sexually inappropriate towards the resident. The LTC helper stated that they did not immediately report the suspected abuse of the resident to their supervisor.

Failure to immediately report the witness or suspected abuse of the resident as per the licensee's Resident Abuse and Neglect policy, places potential risk of harm to the residents.

Sources: Licensee's Resident Abuse and Neglect P&P No :750.65 policy, interview with the Long -Term Care helper and other staff. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident is immediately investigated.

As cited in the evidence WN #1, on a day and month in 2021, the licensee's failed to immediately investigate the alleged incident of abuse of resident #003.

Failure to immediately investigate every alleged incident of abuse of a resident, places potential risk of harm to the residents.

Sources: the licensee's investigation notes, interviews with the Program Manager of Personal Care and other staff. [s. 23. (1) (a)]

WN #6: 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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

As cited in the evidence WN #1, the allegation of staff to resident #003 abuse on a day and month in 2021, was not immediately reported to the Director.

The failure to immediately report suspected allegation of the resident abuse, places potential risk of harm to the resident. Reporting allegations of suspected abuse to the MLTC would have served to protect the residents.

Sources: the licensee's investigation notes, interviews with the Program Manager of Personal Care and other staff. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004's Substitute Decision Maker (SDM) was immediately notified of the results of the alleged abuse investigation, upon the completion of the investigation.

The inspector spoke with the Program Manager of Personal Care (PMPC), who indicated that an investigation was initiated immediately related to alleged staff to resident abuse incident. The PMPC stated that the formal investigations was completed with no staff to the resident abuse substantiated. Furthermore, the PMPC indicated that they did not immediately notify resident's SDM(s) with the results of the abuse investigation.

Sources: the licensee's investigation notes, interview with the Program Manager of Personal Care. [s. 97. (2)]

Issued on this 27th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANANDRAJ NATARAJAN (573)
Inspection No. / No de l'inspection :	2021_593573_0023
Log No. / No de registre :	017184-21, 017938-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 10, 2022
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, Ottawa, ON, K1N-5M2
LTC Home / Foyer de SLD :	Garry J. Armstrong Home 200 Island Lodge Road, Ottawa, ON, K1N-5M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sheila Bauer

To City of Ottawa, 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, 2007.

Specifically, the licensee must:

1. Ensure that resident #001 is protected from abuse by anyone.

2. Refresher training is provided to the Long -Term Care (LTC) helper, on resident sexual abuse, including the licensee's policy for reporting of abuse.

3. Refresher training is provided to the Program Manager of Personal Care (PMPC) and the Program Manager of Resident Care (PMRC), on resident sexual abuse, including the definition of sexual abuse and the licensee's policy for response and reporting of abuse. Specifically, the training should provide for clarity on how to recognise resident sexual abuse allegations and their responsibilities.

4. Keep a record of the training, date occurred, who provided the training, the persons who attended and the resources material used.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from the sexual abuse by a staff.

Section 2 (1) of the Ontario Regulation 79/10 defines Sexual abuse as subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a

resident by a licensee or staff member.

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to alleged staff to resident sexual abuse incident. The CIR indicated that a video footage was obtained that showed an incident of sexual abuse by a staff member to resident #001.

On the previous day to the above critical incident, an Activities Coordinator reported to the Program Manager of Personal Care (PMPC) that a Long -Term Care (LTC) helper witnessed inappropriate behaviour of a staff member to resident #003 in the resident lounge. The staff member seemed to be startled and quickly jumped when they noticed the LTC helper walk into the resident lounge. On the same day after few hours, the Activities Coordinator went again to report to the PMPC that they witnessed the staff member inappropriate behaviour towards resident #003. When the staff member noticed the Activities Coordinator, they quickly jumped and grabbed a clothing protector off the table and continued clearing the table. The Activities Coordinator reported to the PMPC that they and the LTC helper were concerned about the staff member's behaviour on the unit.

During the interview, the Activities Coordinator stated that the LTC helper discussed with them that they witnessed inappropriate behaviour of the staff member to resident #003. The Activities Coordinator indicated that the LTC helper was concerned about the staff member's behaviour and the incident on the unit. The Activities Coordinator stated that they reported this incident to the PMPC. The Activities Coordinator indicated that on the same day after few hours, they went again to report to the PMPC that they witnessed the staff member inappropriate behaviour to resident #003. The Activities Coordinator indicated to the inspector that they suspected the staff member's behaviour towards the resident was sexually inappropriate in nature. The Activities Coordinator indicated that the PMPC communicated to them, that with the information what was provided it was determined that the allegations did not meet the home's definition of sexual abuse. The Activities Coordinator indicated to the inspector that the staff member's suspicious behaviour and reactions made them to suspect that something was wrong. Furthermore, they indicated that next day they decided to set up a video camera in the resident lounge to capture the staff member's strange behaviour on the unit.

During the interview, the Program Manager of Personal Care stated to the inspector that, the Activities Coordinator reported the LTC helper's and their concerns about the staff member's behaviour and the incident on the unit. The PMPC indicated that they discussed with the Program Manager of Resident Care (PMRC), reviewed the licensee's resident abuse policy and the decision trees. The PMPC indicated to the inspector, that at that time with the information what was provided to them it was determined that the reported incidents did not fall under allegation of sexual abuse. The PMPC stated that an investigation was not initiated, nor did they speak with the LTC helper. The PMPC stated that since it was determined that it was not an allegation of sexual abuse, they did not report to the Ministry of Long- Term Care. Furthermore, the PMPC indicated that the Manager of Hospitality Services had planned to talk with the staff member on the next day, to not take their breaks on the residents' unit.

The failure to identify the allegations of the staff member's inappropriate behaviour with resident #003, lead to no actions being taken by the licensee to protect resident #001 from the sexual abuse by the staff member.

Sources: the licensee's investigation notes, interviews with the Activities Coordinator, the Program Manager of Personal Care, and other staff.

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

Severity: There was actual harm to resident #001, as there was sexual abuse by a staff to the resident.

Scope: The scope of non- compliance was isolated involving resident #001, no other incidents of sexual abuse were identified during this inspection.

Compliance History: There has been no non- compliance issued to this section in the past 36 months.

(573)

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 10th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Anandraj Natarajan

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