Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 4, 2017	2017_575214_0015	021507-17, 021557-17, 021908-17	Critical Incident System

Licensee/Titulaire de permis

859530 Ontario Inc. (operating as Jarlette Health Services)
c/o Jarlette Health Services, 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Royal Rose Place
635 Prince Charles Drive North WELLAND ON 000 000

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

CATHY FEDIASH (214), KELLY CHUCKRY (611), ROBIN MACKIE (511)

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): September 20, 21, 22, 26, 27, October 3, 5, 10, 11, 12, 17, 2017.

PLEASE NOTE: Critical Incident System inspection #023219-17, related to allegations of abuse was conducted simultaneously with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Co-Director of Care (Co-DOC); Staff Educator/Resident Assessment Instrument (RAI) Coordinator; Personal Support Workers(PSW); Niagara Regional Police Detective; and residents. During the course of the inspection, the Inspectors reviewed Critical Incident Systems (CIS); reviewed resident clinical records; reviewed policies and procedures; reviewed employment records; reviewed the home's investigative notes and observed residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of a Critical Incident System (CIS) that was submitted by the home on an

identified date, indicated that resident #001 had informed a person who was visiting them the day prior, that staff #104 had conducted an identified action toward them. A review of the home's investigative notes indicated that the visitor asked the resident what they were talking about and the resident repeated their statement. The visitor brought the information to staff #116 to review and informed them what the resident had verbalized to them. The home's investigative notes indicated that staff #125 was present at this time and was made aware of the resident's statement. Staff #125 spoke with the resident approximately 20 minutes later and asked the resident what had happened when staff #104 came to their room. The resident indicated that the staff member had conducted an identified action. The CIS indicated that staff #104 had provided care to resident #001 by themselves and that this contradicted the plan of care.

An interview with staff #125 on two identified dates, confirmed that they had viewed information provided on a specified date. Staff #125 confirmed they observed staff #104 perform an identified physical action to resident #001 and confirmed that staff #104 transferred resident #001 from an identified mobility device to their bed and provided an identified activity of daily living (ADL) by themselves. Staff #125 confirmed that this incident had occurred on a specified shift over three consecutive identified dates.

An interview with staff #116 on two identified dates, confirmed that they had viewed information provided on a specified date. Staff #116 confirmed they observed staff #104 perform an identified physical action to resident #001 and confirmed that staff #104 transferred resident #001 from an identified mobility device to their bed and provided an identified ADL by themselves. Staff #116 confirmed that this incident had occurred on a specified shift over three consecutive identified dates.

A review of the resident's written plan of care provided by the home, indicated under an identified ADL focus that the resident required two staff to perform the identified ADL. The resident's plan of care for another identified ADL indicated that two staff members were to be present during the performing of the identified ADL. The resident's plan of care identified under a specified responsive behaviour focus that two staff members were to provide all care and explain all procedures. The resident's plan of care and kardex, under another identified responsive behaviour focus indicated that the resident required two female staff to provide care and when the resident made identified responsive behaviour statements, staff were to provide reminders that staff were there to help.

An interview with staff #116 and # 125 on an identified date confirmed that resident #001 required two staff to provide an identified ADL and the identified information that they had

viewed on a specified date had identified staff #104 to provide an identified ADL to resident #001 by themselves. An interview with the Administrator confirmed that they had interviewed staff #104 on a specified date and that the staff member confirmed they provided care to resident #001 by themselves. The Administrator confirmed that the care set out in the plan of care, specifically, the intervention of two female staff to provide all care to resident #001, had not been provided to the resident as specified in the plan. [s. 6. (7)]

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. 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 failed to ensure that all residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long-Term Care Homes Act, 2007,

"physical abuse" means, subject to subsection (2),

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;
("mauvais traitement d'ordre physique").

"sexual abuse" means,

(a) 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, or
(b) Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitement d'ordre sexuel").

A review of a CIS that was submitted by the home on an identified date, indicated that resident #001 had informed their friend who was visiting them the day prior that staff #104 had conducted an identified action toward them. A review of the home's investigative notes indicated that the visitor asked the resident what they were talking about and the resident repeated their statement. The visitor brought the information to staff #116 to review and informed them what the resident had verbalized to them. The home's investigative notes indicated that staff #125 was present at this time and was made aware of the resident's statement. Staff #125 spoke with the resident approximately 20 minutes later and asked the resident what had happened when staff #104 came to their room. The resident indicated that the staff member had conducted an identified action. The CIS indicated that information provided identified staff #104 to have performed an identified physical action to resident #001.

During an interview with resident #001 on an identified date, they verbalized that staff #104 had performed identified actions to them and further verbalized specific actions that had not taken place. The resident denied being hurt and that they enjoyed and wanted the identified action to occur. The resident verbalized that they did not know why they had verbalized that a specified action had occurred; that no one told them to say that but that identified persons were upset. The resident verbalized that they were unable to recall when this interaction occurred.

An interview with staff #125 on two identified dates, confirmed that they had viewed information on a specified date and confirmed they observed staff #104 perform an identified physical action to resident #001 and indicated that they were unable to confirm whether or not another identified action had occurred. Staff #125 confirmed that this incident had occurred sometime over three consecutive identified dates.

An interview with staff #116 on two identified dates confirmed that they had viewed information provided on a specified date and confirmed they observed staff #104 perform an identified physical action to resident #001 and indicated that they were unable to confirm whether or not another identified action had occurred Staff #116 confirmed that this incident had occurred sometime over three consecutive identified dates.

An interview with PSW #112 on an identified date, indicated that they provided an identified ADL to resident #001 on an identified date occurring the day following the above three consecutive identified dates. PSW #112 indicated that during the performance of the identified ADL, alteration to the resident's skin integrity was identified to a specified area above the resident's neck which was normal for the resident and a result of dry skin.

A review of the resident's clinical record indicated that identified assessments were completed on three identified dates within one week of the observed actions of staff #104. The first assessment indicated that alterations to the resident's skin integrity were identified to specified areas on their body and that one of the identified areas was diminishing. No documentation of an alteration to the resident's skin integrity to the identified area in which staff #104 was observed to have performed an identified physical action was noted. An interview with staff #125 who completed the identified assessment, indicated that they were unsure if the identified alterations to the resident's skin were caused by an identified ADL action and that they had asked the resident how the altered skin integrity had occurred and that the resident was unable to recall. Staff #125 indicated that the identified alteration to the resident's skin integrity was very small and appeared to be going away.

An interview with the Administrator confirmed that staff #104 was no longer working at the home following an investigation completed by the home and that an investigation by an identified authority into this allegation had also been conducted.

Staff #116 and #125 confirmed that resident #001 had not been protected from abuse. [s. 19. (1)]

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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of a CIS submitted by the home on an identified date, indicated that staff #116 received a note under their door on the same date, from staff #183. The CIS indicated the note was dated three days prior.

The CIS indicated that approximately two weeks prior, staff #104 was called to assist staff #183 in providing care to resident #002. Staff #183 alleged that resident #002 demonstrated identified actions towards staff #104. Staff #183 thought this was strange at the time and did not report this information. The CIS indicated that staff #183 had for identified reasons, believed that something may have happened to resident #002 that involved staff #104. The CIS indicated that staff #183 could not recall the date that they and staff #104 provided care to resident #002 and the resident demonstrated the identified actions.

A copy of this note, provided by the Administrator was reviewed. The note indicated that staff #183 identified that resident #002 had demonstrated identified actions towards staff #104 when they entered the resident's room to provide care and that this was completely out of character. The note indicated that staff #183 reported this information to registered staff #113 who contacted staff #116, who in turn spoke with staff #183.

During an interview on an identified date, staff #116 shared that they had a verbal conversation with staff #183 four days prior to the date of the CIS submission and were told by staff #183 they had walked into resident #002's room while staff #104 was alone

with the resident and the resident demonstrated identified actions that were out of character. Staff #116 indicated that they had asked staff #183 to document their information in writing. Staff #116 indicated that the day after, they had not received the information in writing and contacted staff #183. Staff #116 indicated that they received the written information under their door four days later.

On an identified date, the home interviewed staff #183. An identified form that was completed by the Administrator identified an allegation of a specified nature by staff #104.

A review of the home's policy titled, "Resident Rights, Care And Services-Abuse-Zero-Tolerance Policy for Resident Abuse and Neglect-Zero-Tolerance Policy for Resident Abuse and Neglect" (Resident Care Manual and dated with a revised date of June 2, 2017) indicated the following:

Under Duty to Report

i) 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 Ministry of Health and Long Term Care:

- Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident

- Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident

Under Procedure: Investigating and Responding to Alleged Abuse and Neglect:

i) Staff members, volunteers, substitute decision-makers, family members or any other person who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse if no manager is on site at the Home. Note: Staff members, volunteers, substitute decision-makers, family members or any other person has the right to notify the Ministry of Health and Long Term Care directly by way of the Ministry of Health Action Line posted in the home however the most Senior Administrative Personnel on site has the delegated responsibility to report to the Ministry of Health and Long Term Care immediately and will do so as required.

An interview with the Administrator on an identified date, indicated that they had not been made aware of an identified allegation towards resident #002 until the date of the CIS. An interview with staff #116 confirmed that they had been made aware of an identified allegation toward resident #002 four days prior to the CIS date, during a conversation with #183. Staff #116 confirmed they were aware of an identified home policy and that the identified allegation had not been immediately reported to the Ministry of Health and Long Term Care as directed in the home's identified policy. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with, to be implemented voluntarily.

Issued on this 18th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY CHUCKRY (611), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2017_575214_0015
Log No. / No de registre :	021507-17, 021557-17, 021908-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 4, 2017
Licensee / Titulaire de permis :	859530 Ontario Inc. (operating as Jarlette Health Services) c/o Jarlette Health Services,, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Royal Rose Place 635 Prince Charles Drive North, WELLAND, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Helen Jovicich

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 859530 Ontario Inc. (operating as Jarlette Health Services), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents including resident #001, specifically in relation to the provision of care, as specified in resident #001's plan of care.

The home shall provide education to all staff who provide direct care to all residents including resident #001 to ensure that all direct care staff are aware of the care set out in the residents plan of care, including resident #001 and that care is provided as specified in their plans.

The licensee shall conduct auditing activities at a frequency and schedule as they determine to ensure that the care set out in the residents plan of care, including resident #001 is provided to the residents as specified in their plans.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (2), scope (1) and Compliance history of (4) in keeping with s. 299(1) of the Regulation, in respect to the potential for actual harm to resident #001, the scope of an isolated incident and the licensee's history of ongoing non-compliance (VPC), February 9, 2017, Resident Quality Inspection related to s.6(7); (VPC), August 25, 2016, Complaint Inspection related to s.6(7); (VPC), August 25, 2016, Critical Incident System Inspection related to s.6(7).

The licensee 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 a Critical Incident System (CIS) that was submitted by the home on an identified date, indicated that resident #001 had informed a person who was visiting them the day prior, that staff #104 had conducted an identified action

toward them. A review of the home's investigative notes indicated that the visitor asked the resident what they were talking about and the resident repeated their statement. The visitor brought the information to staff #116 to review and informed them what the resident had verbalized to them. The home's investigative notes indicated that staff #125 was present at this time and was made aware of the resident's statement. Staff #125 spoke with the resident approximately 20 minutes later and asked the resident what had happened when staff #104 came to their room. The resident indicated that the staff member had conducted an identified action. The CIS indicated that staff #104 had provided care to resident #001 by themselves and that this contradicted the plan of care.

An interview with staff #125 on two identified dates, confirmed that they had viewed information provided on a specified date. Staff #125 confirmed they observed staff #104 perform an identified physical action to resident #001 and confirmed that staff #104 transferred resident #001 from an identified mobility device to their bed and provided an identified activity of daily living (ADL) by themselves. Staff #125 confirmed that this incident had occurred on a specified shift over three consecutive identified dates.

An interview with staff #116 on two identified dates, confirmed that they had viewed information provided on a specified date. Staff #116 confirmed they observed staff #104 perform an identified physical action to resident #001 and confirmed that staff #104 transferred resident #001 from an identified mobility device to their bed and provided an identified ADL by themselves. Staff #116 confirmed that this incident had occurred on a specified shift over three consecutive identified dates.

A review of the resident's written plan of care provided by the home, indicated under an identified ADL focus that the resident required two staff to perform the identified ADL. The resident's plan of care for another identified ADL indicated that two staff members were to be present during the performing of the identified ADL. The resident's plan of care identified under a specified responsive behaviour focus that two staff members were to provide all care and explain all procedures. The resident's plan of care and kardex, under another identified responsive behaviour focus indicated that the resident required two female staff to provide care and when the resident made identified responsive behaviour statements, staff were to provide reminders that staff were there to help.

An interview with staff #116 and # 125 on an identified date confirmed that resident #001 required two staff to provide an identified ADL and the identified information that they had viewed on a specified date had identified staff #104 to provide an identified ADL to resident #001 by themselves. An interview with the Administrator confirmed that they had interviewed staff #104 on a specified date and that the staff member confirmed they provided care to resident #001 by themselves. The Administrator confirmed that the care set out in the plan of care, specifically, the intervention of two female staff to provide all care to resident #001, had not been provided to the resident as specified in the plan. (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2018

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 Health and 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 4th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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