Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 4, 2021	2021_781729_0013	005173-21	Complaint

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street Creemore ON L0M 1G0

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

KIM BYBERG (729), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 24 - 26, 29 - 31, April 1, 6 - 9, 12 - 16, 19, 2021.

The following intakes were completed within the complaint inspection:

Log #005173-21, related to an allegation of resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), RAI - Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Wound Specialist, Foot Care Nurse, Practical Nursing Student (PNS), PrimaCare Director of Compliance and Clinical Operations (DOCCO).

During this inspection, inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, and observed the general maintenance, cleanliness, safety and condition of the home.

This inspection was completed concurrently with critical incident inspection #2021_781729_0012.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident, received an assessment for an area of impaired skin integrity by a member of the registered nursing staff and immediate treatment and interventions to promote healing.

A complaint was received at the Ministry of Long Term Care with an allegation of neglect, specifically related to the care and treatment a resident received for areas of impaired skin integrity.

Staff members documented on point of care (POC) that the resident had a new area of impaired skin.

A skin and wound assessment and treatment of the area was not initiated until 19 days later.

The wound specialist recommended referring the resident to an occupational therapist

(OT); however this referral was not completed at the time of the assessment and the resident was not assessed by the OT for several weeks.

The lack of assessment and treatment resulted in tissue necrosis, pain and deterioration of the resident's identified area of impairment.

Sources: Observations, interviews with PSW's, Registered Staff, ADOC, RAI-Coordinator, record review of POC documentation, Skin and Wound assessments V3 dated September 19, 2020, Skin and Wound evaluation V6 dated September 23, 2020, Creedan Valley specific policy titled “Skin and Wound Care Management Protocol, reference policy #VII-G-10.90, and progress notes. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure that the equipment needed for a resident was available, and implemented to offload pressure.

A resident was identified to have an area of impaired skin through a head to toe skin assessment. The area deteriorated over the course of four months. In addition, they had three other areas of impaired skin that were documented as deteriorating.

The wound care specialist recommended offloading with a specific device to reduce pressure to the area of impaired skin integrity.

Observations at the time of the inspection showed that the resident was not wearing the recommended offloading device. The wound specialist confirmed that the device the resident was wearing did not have pressure offloading capabilities.

Not offloading pressure for the resident immediately upon identification of the impaired skin integrity, may have contributed to the ongoing deterioration of the wounds and pain experienced by the resident.

Sources: Observations during inspection, interviews with PSW's, Registered Staff, ADOC, RAI-Coordinator, Wound Specialist, record review of Skin and Wound assessments V3, Skin and Wound evaluation V6, Creedan Valley specific policy titled “Skin and Wound Care Management Protocol, reference policy #VII-G-10.90, surgical consult notes, progress notes and manufacture guidelines for pressure reduction device. [s. 50. (2) (c)]

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was ordered oxygen to keep their oxygen saturation level about 90 percent (%), that the resident was reassessed and the responses to the interventions were documented.

A resident was assessed and noted to have low oxygen saturation. The physician ordered oxygen two to four liters (L) per minute by nasal cannula to keep the resident's oxygen saturation above 90%. Oxygen was initially started at two L per minute via nasal cannula. There was no documentation on the evening or night shift to indicate that the resident was receiving oxygen, and oxygen saturation levels were not checked during the night. The following day, it was noted that the resident's oxygen was on at 4 L per minute however, there was no reassessment of the resident done to indicate why or when the oxygen was increased from 2L to 4L per minute. There was no reassessment of the resident's chest until over twenty-four hours later when the resident was sent to the hospital because they were short of breath and congested.

The licensee not ensuring that a resident's response to oxygen administration was reassessed and documented may have delayed their transfer to hospital for further treatment.

Sources: progress notes, vital signs, medication administration record, interviews with DOC and other staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received preventive, and basic foot care services, that included the cutting of their toenails to ensure comfort and prevent infection.

A resident was not provided foot care that included cutting their toe nails for ten months.

On two occasions, written one month apart, documentation stated that the resident's toenails were dry, thick, yellow and staff were unable to cut them with regular nail clippers. After nine months without routine basic foot care, the resident's family was concerned that the resident's toenails were overgrown and causing discomfort.

The resident, was not provided routine toe nail care for ten months, and as a result their toe nails were overgrown, thick and a source of discomfort for the resident.

Sources: Interviews with staff, ADOC, RAI-Coordinator, Foot Care Nurse, and DOCCO, record review of the resident progress notes, and the home's policy titled "Hygiene, personal care and grooming" dated April 2019, emails from the home's foot previous care provider. [s. 35. (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 each resident of a home receives preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any operational or policy directives issued by the Minister with respect to long-term care homes where the Minister considered it to be in the public interest to do so was complied with, in relation to assessing, isolating and testing residents for COVID-19.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22 and 30, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

Directive #3, dated December 7, 2020, required long-term care home licensees to assess residents for symptoms of COVID-19. Any resident with symptoms was required to be isolated and tested for COVID-19.

After Directive #3 was issued, a resident’s progress notes indicated that on 2 occasions they where shivering and feeling cold. There was no immediate action taken to determine why the resident was shivering and feeling cold. As a result the resident was not isolated, assessed or tested for COVID-19.

Eight days later the resident was transferred and admitted to the hospital due to a decline in health status.

The licensee not ensuring that the resident was assessed, isolated and tested for COVID-19 according to operational or policy directives issued by the Minister increased the risk of infectious disease transmission to all residents, health care providers, and visitors of the home.

Sources: progress notes, vital signs records, assessments and interviews with RPN #103 and other staff and record review of the daily active screening for covid-19 assessment. [s. 174.1 (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was afforded privacy in their treatment and in caring for their personal needs.

A resident had multiple areas of impaired skin integrity that required the home to complete weekly skin and wound assessments.

The home used a specific IPAD that had a skin and wound program downloaded to the device that allowed the registered staff to assess and take photos of residents impaired skin integrity.

Registered staff had been taking pictures of the resident's areas of impaired skin integrity with their personal cell phones.

Taking pictures with a personal cell phone poses minimal risk of a breach of a resident’s privacy. The personal electronic device did not have the home’s security safeguards in place to protect personal information for residents.

Sources: Interviews with staff, ADOC, DOCCO, record review and the home’s policy titled “Skin and Wound Care Management Protocol” Reference #VII-G-1-.90, reviewed January 2021. [s. 3. (1) 8.]

Issued on this 11th day of May, 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) :	KIM BYBERG (729), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2021_781729_0013
Log No. / No de registre :	005173-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 4, 2021
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 Mary Street, Creemore, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sadie Friesner

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 50 (2)
Specifically, the licensee must:

A) Ensure that initial assessments for residents with altered skin integrity are completed.

B) Ensure that immediate treatment and interventions are initiated for residents with altered skin integrity.

C) Ensure that equipment, including pressure relieving devices, for a specific resident are implemented.

D) Ensure the home's Director of Care, Associate Director of Care, and skin and wound lead review RNAO's Clinical Best Practice Guidelines, March 2013, Assessment and Management of Foot Ulcers for People with Diabetes, Second Edition.

E) A record of the review must be kept in the home and include the date, and signatures of team members completing the review.

F) Ensure the home implements skin and wound assessments, treatments and interventions based on current best practices for residents with diabetes.

Grounds / Motifs :

1. The licensee failed to ensure that a resident, received an assessment for an area of impaired skin integrity by a member of the registered nursing staff and immediate treatment and interventions to promote healing.

A complaint was received at the Ministry of Long Term Care with an allegation of neglect, specifically related to the care and treatment a resident received for areas of impaired skin integrity.

Staff members documented on point of care (POC) that the resident had a new area of impaired skin.

A skin and wound assessment and treatment of the area was not initiated until 19 days later.

The wound specialist recommended referring the resident to an occupational therapist (OT); however this referral was not completed at the time of the assessment and the resident was not assessed by the OT for several weeks.

The lack of assessment and treatment resulted in tissue necrosis, pain and deterioration of the resident's identified area of impairment.

Sources: Observations, interviews with PSW's, Registered Staff, ADOC, RAI-Coordinator, record review of POC documentation, Skin and Wound assessments V3 dated September 19, 2020, Skin and Wound evaluation V6 dated September 23, 2020, Creedan Valley specific policy titled "Skin and Wound Care Management Protocol, reference policy #VII-G-10.90, and progress notes.

(729)

2. The licensee failed to ensure that the equipment needed for a resident was available, and implemented to offload pressure.

A resident was identified to have an area of impaired skin through a head to toe skin assessment. The area deteriorated over the course of four months. In addition, they had three other areas of impaired skin that were documented as deteriorating.

The wound care specialist recommended offloading with a specific device to reduce pressure to the area of impaired skin integrity.

Observations at the time of the inspection showed that the resident was not wearing the recommended offloading device. The wound specialist confirmed that the device the resident was wearing did not have pressure offloading capabilities.

Not offloading pressure for the resident immediately upon identification of the impaired skin integrity, may have contributed to the ongoing deterioration of the wounds and pain experienced by the resident.

Sources: Observations during inspection, interviews with PSW's, Registered Staff, ADOC, RAI-Coordinator, Wound Specialist, record review of Skin and Wound assessments V3, Skin and Wound evaluation V6, Creedan Valley specific policy titled "Skin and Wound Care Management Protocol, reference policy #VII-G-10.90, surgical consult notes, progress notes and manufacture guidelines for pressure reduction device.

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

Severity: Failing to ensure the resident was assessed and provided with comprehensive and timely treatment resulted in actual harm to the resident.

Scope: The scope of the issue was isolated.

Compliance History: The home had a level 3 history non-compliance with this subsection of the Act. Four Written Notifications (WN), one Voluntary Plans of Correction (VPC) and two Compliance Orders (CO) were issued to the home related to this subsection of legislation in the past 36 months.

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 4th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kim Byberg

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