Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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 public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2019	2019_755728_0023	018854-19, 019524-19	Complaint

Licensee/Titulaire de permis

Lutheran Homes Kitchener-Waterloo
2727 Kingsway Drive KITCHENER ON N2C 1A7

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

Trinity Village Care Centre
2727 Kingsway Drive KITCHENER ON N2C 1A7

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

MARIA MCGILL (728)

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): October 15-18 and 21, 2019.

Inspector, Katherine Adamski (754) attended this inspection during orientation.

The following intakes were completed in this Complaint Inspection:
Log #019524-19, related to an allegation of abuse.

The following Critical Incident System intake related to the same issue was inspected during this Complaint inspection:
Log #018854-19, related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer (COO), the Director of Resident Care (DoRC), the Assistant Director of Resident Care (ADoRC), the Clinical Auditor (CA), the HR/Scheduling Coordinator, the Manager of Cognitive Care (MoCC), the Manager of Health and Safety/Environmental Services Manager, a security company, Waterloo Regional Police Services, a massage therapy outreach student (MTOS), Payroll and Benefits staff, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, staffing schedules, employee files, videos, and relevant home documentation.

Observations were made of residents, staff to resident interactions, and resident to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of resident #001, immediately reported the suspicion and the information upon which it was based to the Director.

DoRC #101 and ADoRC #108 said that allegations of abuse should be reported to the Director immediately. DoRC #101 and ADoRC #108 said that the home's process was to complete an internal investigation to determine if the alleged incident occurred and then report to the Director based on the results of the internal investigation. ADoRC #108 said that the home rarely reports allegations that were determined to be unfounded based on the home's internal investigation.

A) A complaint was received by the Ministry of Long-term Care (MLTC), related to an allegation of abuse towards resident #001 by a staff member of the home. The complaint documented that the incident was reported by the resident to an outreach student in the home on an identified date.

An e-mail to the home dated the same day the incident was reported, from outreach student #106, documented that resident #001 had made an allegation of abuse and that

outreach student #106 and their supervisor reported it to the home immediately.

An after hours telephone call was made by the home two days later to report the allegation of abuse to the MLTC. It documented that ADoRC #108 said the incident was reported to the home on an identified date, but it was not reported to the MLTC until the home was able to meet with resident #001 and their family.

COO #100, DoRC #101, ADoRC #108, outreach student #106, RPN #107, RN 115, and MoCC #113 said that the allegation was reported to the home on an identified date but the home did not report the allegation to the Director until two days later.

The licensee failed to ensure that the allegation of abuse towards resident #001 was reported to the Director when they were made aware of it.

B) A CI was submitted to the MLTC on an identified date. The CI was submitted related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI documented a previous altercation with co-resident #004 that occurred two days prior.

The progress notes indicated that resident #002 and resident #004 had a physical altercation that resulted in resident #002 being being injured.

ADoRC #108 said that the incident was not reported immediately because it was unknown if the injury resulted from the altercation. They said that it was managed through the home's internal process, which determined it did not need to be reported.

The licensee failed to ensure that the incident of physical abuse between resident #002 and #004 was reported immediately.

C) A review of the home's binder, titled "Investigations 2019", was obtained and the most recent incident was reviewed. The incident was related to an allegation of abuse of resident #003 that was brought to the home's attention by their family.

The date that the family member called the home to report the allegation of abuse was not documented on the home's investigative forms. ADoRC stated that the phone call occurred on an identified date.

Resident #003 told their family that they suspected a staff member had taken money

from their room.

ADoRC #108 said the incident was not reported to the Director because based on the home's internal investigation there were no grounds to support that the alleged incident occurred.

The licensee failed to ensure that an allegation of abuse made by resident #003 was immediately reported to the Director.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone was immediately investigated.

A complaint and critical incident were received related to an incident of alleged staff to resident abuse that was reported by resident #001 on an identified date.

The home became aware of the alleged incident when outreach student #106 reported it to the home in person and by e-mail. The home called the substitute decision maker after the allegation was made. The home said the family requested that the home not interview resident #001 until they could be present so they did not initiate the investigation immediately. Complainant #102 said that they requested to be present and were looking to the home for guidance.

The home's investigative notes documented that the substitute decision maker's wishes were respected with regards to not initiating the interview with resident #001 immediately. However, staff interviews were not initiated until five days later. Therefore, the investigation was not initiated until resident #001 was interviewed with their family two days after the home was made aware of the allegation.

ADoRC #108 said that the allegation was brought to the home on an identified date, but because the family requested to be present for the interview with resident #001, the investigation was not initiated immediately.

The licensee failed to ensure that an allegation of abuse was investigated immediately. [s. 23. (1) (a)]

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 alleged, suspected, or witnessed incident of abuse of a resident by anyone is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

A) A complaint and critical incident were received to the MLTC related to an allegation of abuse of resident #001 on an identified date, by a staff member.

Complainant #102 said they contacted the police five days after the allegation was made to the home, to report the allegation. ADoRC #108 said they did not report the incident to the police as they found out the family had.

Detective #111 said that the home did not contact the police related to the incident.

ADoRC #108 said that police were not notified as they did not feel it was needed for this situation. DoRC #101 said the police would be notified if the situation was verified to be legitimate. COO #100 said that the decision not to contact the police was because of the timing. They said the police arrived at the home five days after the allegation of staff to resident abuse was made.

The licensee failed to ensure that the police were notified immediately upon becoming aware of an allegation of staff to resident #001 abuse, that may constitute a criminal offence.

B) A review of the home's binder, titled, "Investigations 2019", documented an investigation into an allegation of staff to resident abuse on the night shift of an identified date.

Resident #103 reported an allegation of abuse to their family member. Resident #103's family reported the allegation to the home the next day.

The investigation did not document that the police were notified.

ADoRC #108 said that the police were not notified of the incident of alleged abuse.

The licensee failed to ensure that the police were notified of an allegation of staff to resident abuse, that may constitute a criminal offence.

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

WN #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 :

The licensee failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's zero tolerance of abuse and neglect policy, titled Abuse – PM A1.10, last reviewed May 2019, directed management that staff would be sent home with pay pending an investigation and its outcome. It documented that if it was not possible, other arrangements would be put in place with parameters identified by the manager and/or Administrator.

A complaint was received to the MLTC related to an allegation of abuse of resident #001. The home became aware of the alleged incident from outreach student #106.

Two days later, resident #001 identified a staff member to be the alleged abuser.

ADoRC #108 said that identified staff members were removed from the resident home area the day the home was informed of the allegation. They said that the staff member alleged involved in the incident was not put on paid leave pending investigation because there were no prior complaints about the staff member's care. The staff member continued to work on a different resident home area after the home became aware of the allegation.

ADoRC #108 said that staff members that were involved in an allegation of abuse may be put off pending the investigation but it would depend on the circumstances.

The resident identified the staff member on an identified date and the next day the staff member worked in the home. The identified staff member was not interviewed until three days after resident #001 identified them to be the alleged abuser.

The licensee failed to ensure that PSW #117 was placed on paid leave pending investigation of an allegation of abuse.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that strategies had been developed and implemented to respond resident #001 that demonstrated responsive behaviours.

A complaint and critical incident were received to the MLTC related to an allegation of abuse.

PSW #114 and DoRC #101 said that prior to resident #001 making an allegation of abuse they demonstrated identified behaviours.

RPN #107 said that they were not aware of resident #001 previously demonstrating the identified behaviours.

The plan of care did not document the identified behaviours prior to the incident.

The resident's Minimum Data Set (MDS), completed on an identified date, noted an increase in identified behaviours and the Resident Assessment Protocol (RAP) documented that the resident was noted to be demonstrating the identified behaviours during the look back period. Their care plan was updated after the allegation occurred on an identified date. The RAPs completed prior to the allegation did not identify the behaviours reported.

DoRC #101 said the care plan did not outline the identified behaviours, nor were strategies implemented to address the behaviours, despite the behaviours being present prior to the allegation.

The licensee failed to ensure that the residents responsive behaviours had been identified and strategies developed and implemented to respond to resident #001, who demonstrated responsive behaviours. [s. 53. (4)]

Issued on this 18th day of November, 2019

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

Ministère de la Santé et 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 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) :	MARIA MCGILL (728)
Inspection No. / No de l'inspection :	2019_755728_0023
Log No. / No de registre :	018854-19, 019524-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 7, 2019
Licensee / Titulaire de permis :	Lutheran Homes Kitchener-Waterloo 2727 Kingsway Drive, KITCHENER, ON, N2C-1A7
LTC Home / Foyer de SLD :	Trinity Village Care Centre 2727 Kingsway Drive, KITCHENER, ON, N2C-1A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debby Riepert

To Lutheran Homes Kitchener-Waterloo, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / Ordre no : 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. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically, the licensee must:
a) ensure that all incidents of alleged, suspected, or witnessed abuse are immediately reported to the Director, irrespective of the completion of the home's internal investigation and its outcome.

Grounds / Motifs :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of resident #001, immediately reported the suspicion and the information upon which it was based to the Director.

DoRC #101 and ADoRC #108 said that allegations of abuse should be reported to the Director immediately. DoRC #101 and ADoRC #108 said that the home's process was to complete an internal investigation to determine if the alleged incident occurred and then report to the Director based on the results of the internal investigation. ADoRC #108 said that the home rarely reports allegations that were determined to be unfounded based on the home's internal investigation.

A) A complaint was received by the Ministry of Long-term Care (MLTC), related to an allegation of abuse towards resident #001 by a staff member of the home. The complaint documented that the incident was reported by the resident to an outreach student in the home on an identified date.

An e-mail to the home dated the same day the incident was reported, from outreach student #106, documented that resident #001 had made an allegation of abuse and that outreach student #106 and their supervisor reported it to the home immediately.

An after hours telephone call was made by the home two days later to report the allegation of abuse to the MLTC. It documented that ADoRC #108 said the incident was reported to the home on an identified date, but it was not reported to the MLTC until the home was able to meet with resident #001 and their family.

COO #100, DoRC #101, ADoRC #108, outreach student #106, RPN #107, RN 115, and MoCC #113 said that the allegation was reported to the home on an identified date but the home did not report the allegation to the Director until two days later.

The licensee failed to ensure that the allegation of abuse towards resident #001 was reported to the Director when they were made aware of it.

B) A CI was submitted to the MLTC on an identified date. The CI was submitted related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI documented a previous altercation with co-resident #004 that occurred two days prior.

The progress notes indicated that resident #002 and resident #004 had a physical altercation that resulted in resident #002 being being injured.

ADoRC #108 said that the incident was not reported immediately because it was unknown if the injury resulted from the altercation. They said that it was managed through the home's internal process, which determined it did not need to be reported.

The licensee failed to ensure that the incident of physical abuse between resident #002 and #004 was reported immediately.

C) A review of the home's binder, titled "Investigations 2019", was obtained and the most recent incident was reviewed. The incident was related to an allegation of abuse of resident #003 that was brought to the home's attention by their family.

The date that the family member called the home to report the allegation of abuse was not documented on the home's investigative forms. ADoRC stated that the phone call occurred on an identified date.

Resident #003 told their family that they suspected a staff member had taken money from their room.

ADoRC #108 said the incident was not reported to the Director because based on the home's internal investigation there were no grounds to support that the alleged incident occurred.

The licensee failed to ensure that an allegation of abuse made by resident #003 was immediately reported to the Director.

The severity of the issue was determined to be a level 2 as there was minimal risk. The scope of the issue was a level 3 as it related to three of the three incidents reviewed. The home had a level 2 compliance history as they had previous non-compliance related to different subsections.
(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020

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
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 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)
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 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 7th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria McGill

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