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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2019	2019_679638_0001	008715-18	Follow up

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

RYAN GOODMURPHY (638), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 7 - 11 and 14 - 18, 2019.

The following intake was inspected during this Follow Up inspection;
-One log related to CO #001 from Inspection report #2018_740621_0010, s. 11 (2) of the Long-Term Care Homes Act (LTCHA), 2007, specific to the home's dietary services and hydration.

A Complaint inspection #2018_679638_0002 and a Critical Incident Systems inspection #2018_679638_0003, were conducted concurrently with this Follow Up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Environmental Manager, Consulting Nutrition Manager, Culinary Manager, Resident and Family Services Coordinator (RFSC), Life Enrichment Coordinator (LEC), Staffing Coordinator, Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitians (RD), Dietary Aids (DA), Housekeeping Aids, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs, relevant training and health care records.

The following Inspection Protocols were used during this inspection:
Food Quality
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

During Inspection #2018_740621_0010, CO #001 was issued to the home, which ordered the licensee to;

a) ensure that all dietary staff, PSWs, and RPNs who had not completed education with regards to providing safe and appropriate food choices for residents that required texture modified diets, had completed this training, with supporting documentation;
b) ensure that during meal service, nursing and dietary staff had readily available, instructions outlining each resident's dietary requirements which were clear, specific and accurate with respect to each residents plan of care; and
c) ensure that the Administrator and, in their absence, management designate(s) were prepared to speak to, and had documented evidence to support the requirements of part a) and b) of this order, by the compliance order due date.

The compliance due date of this order was May 25, 2018.

While the licensee complied with sections "a)" and "c)", non-compliance was identified with section "b)", where the licensee was directed to ensure that; during meal service, nursing and dietary staff had readily available, instructions outlining each resident's dietary requirements which were clear, specific and accurate with respect to each residents plan of care.

During separate interviews with DA #105, DA #120, DA #122, DA #148, PSW #101, PSW #134, RPN #121, and RN #103, they each indicated that staff would refer to the Master Diet list located in the Home Area's servery for specific information about each resident's diet type and texture during meals.

A) During a resident observation, Inspector #681 observed that resident #018 was served a specific texture meal (texture meal type A) at the lunch meal service and was served the same texture again at the breakfast meal service the following day.

Inspector #681 reviewed the Master Diet list that was located in the Home Area servery. The Master Diet list indicated that resident #018 was supposed to receive another specific diet with a specific texture (texture meal type B). The Inspector reviewed the

resident's electronic care plan, which indicated the resident was supposed to receive a specific diet with a different specific texture than identified in the Master Diet list. The resident's electronic care plan indicated that this diet intervention had been added to resident #018's care plan nine days earlier by RD #114.

The Inspector reviewed a progress note in resident #018's records, created by RN #103, which indicated that the resident did not like their current diet and that the resident was often refusing their meals. The progress note indicated that RN #103 spoke with resident #018's Substitute Decision Maker (SDM) who advised RN #103 that a physician at an external service provider told them to "let [the resident] eat and drink what [they] wanted". The progress note stated the resident's diet texture was being changed and would be further changed, if the resident tolerated the texture change.

The Inspector reviewed resident #018's health care records and identified an order written by RD #114, which directed staff to change the resident's diet texture. The Inspector also identified a second order written by RD #117 eight days later, which stated "change diet to [texture meal type A] (as per patient wishes)". The second RD order was different than the first RD order.

During an interview with Inspector #681, resident #018 described to the Inspector the food texture that they were previously receiving (texture meal type B) but that they were now back to consuming different textured foods (texture meal type A).

In an interview with Inspector #681, PSW #134 stated that resident #018 received a specific textured diet (texture meal type A). The Inspector reviewed the Master Diet list for the Home Area with PSW #134. The PSW stated that the Master Diet list was not updated and that they had been told by the nurse to give resident #018 the specific textured diet because their diet had changed.

The Inspector reviewed the Master Diet list for the Home Area with RPN #121. The RPN stated that the Master Diet list was not updated and that resident #018 received a specific texture diet (texture meal type A). RPN #121 stated that there had been concerns with the Master Diet lists not being updated, especially over the Christmas holidays.

The Inspector reviewed the Master Diet list for resident #018's Home Area and care plan with RPN #133. The RPN acknowledged that the two documents were different and that this did not provide clear direction to staff regarding resident #018's diet and texture type.

The RPN stated that there had been concerns related to the Master Diet list not being updated and not matching the residents' care plans. RPN #133 stated that there was usually one regular PSW working in each Home Area who knew what diet the residents were supposed to be receiving.

During an interview with Inspector #681, RN #103 stated that they changed resident #018's diet texture after speaking with the resident's SDM. The RN stated that the resident's SDM wanted the resident's diet texture changed to a specific texture (texture meal type A) if the resident was able to tolerate the current diet texture. RN #103 stated that they advised other staff about the resident #018's diet change by writing the new diet on a piece of paper and leaving it at the nursing station. RN #103 stated that they also verbally communicated the diet change to the dietary aides, as well as, the oncoming shift.

During an interview with Inspector #681, RD #115 indicated that they completed a meal observation during a meal service in the dining room of one Home Area on a specific date. RD #115 stated that, at this time, resident #018 had already been switched to a specific textured diet (texture meal type A). The RD stated that resident #018 received a specific textured meal (texture meal type A). RD #115 stated that they "did not know the resident and did not know [their] history", but that they did not identify any concerns with resident #018's chewing or swallowing abilities with the specific textured meal (texture meal type A).

The Inspector reviewed a progress note written by RD #117, which indicated that the RD was approached by a RN on the unit because resident #018 was still receiving a previously ordered specific textured diet (texture meal type B). The progress note further indicated that a previous RD had changed the resident's diet texture to a specific texture (texture meal type A), at the request of family, but that the Master Diet list had not been updated with the diet order.

During an interview with Inspector #681, the Culinary Manager indicated that the Master Diet list was used by both dietary staff and nursing staff. The Culinary Manager indicated that this document contained information about a resident's diet type and texture. The Culinary Manager stated that they were responsible for updating the Master Diet lists. The Culinary Manager stated that the Master Diet list that the Inspector obtained from the servery on resident #018's Home Area was updated and printed on a specific date. After reviewing the documentation provided by the Inspector, the Culinary Manager acknowledged that the Master Diet list for resident #018's Home Area was not updated to

reflect the changes that was made to resident #018's diet texture.

B) Inspector #681 observed that resident #015 was served a specific textured meal (texture meal type B) at two meal services on a specific date and one meal service on another specific date. During these meal observations, the Inspector also identified that the resident did not use any specific interventions to consume their meal.

The Inspector reviewed the Master Diet list that was located in the servery on the Home Area. The Master Diet list indicated that resident #015 was supposed to receive a specific diet with specific texture (texture meal type B) and that the resident was to utilize specific interventions to help them consume their meals.

The Inspector reviewed resident #015's electronic care plan, which stated to; provide a specific diet and texture type (texture meal type A) to the resident. The resident's electronic care plan indicated that this diet intervention had been revised on a specific date by RD #114. The resident's care plan also indicated that they were to utilize specific interventions during meals.

During an interview with Inspector #681, DA #105 stated that the Master Diet list indicated that resident #015 was supposed to receive a specific textured diet (texture meal type A), but that the resident had been receiving a different specific textured diet (texture meal type B) because they recently had a medical intervention completed. DA #105 also stated that resident #015 did not use any specific interventions during meals.

In an interview with Inspector #681, resident #015 indicated that they did not use any specific interventions during meals. Resident #015 reported that they had a medical intervention completed and described the change in their meal texture, which made it easier for the resident to eat their meals.

During an interview with PSW #101, they stated that resident #015 had received a specific textured diet (texture meal type B), contrary to the resident's identified specific textured diet (texture meal type A), since having had a medical intervention completed.

Inspector #681 interviewed PSW #149 who indicated that resident #015 was being served a specific textured diet (texture meal type C) by one shift, but during another shift, the resident was being served a different specific textured diet (meal texture type B). The PSW stated that one of the specific shift staff worked the other shift and identified that the resident was receiving a different diet texture at one meal than they were at the other

meals.

During an interview with Inspector #681, the Staff Educator stated that they submitted a dietary referral for resident #015 because they were told by a PSW that on one shift, the resident was eating a specific textured diet (meal texture type B) and on another shift the resident was eating a different specific textured diet (texture meal type C). The Staff Educator stated that the resident was put on a the specific texture diet (texture meal type B) following a medical intervention, but that the other shift had found that the resident medical condition had changed and were giving the resident a different specific diet texture (texture meal type C).

In an interview with Inspector #681, RD #117 stated that they completed a meal observation during a meal service on a specific date. The RD stated that resident #015 called them over. The RD stated that, at this time, resident #015 had a specific textured meal (texture meal type A) in front of them and the resident was requesting a different textured meal (texture meal type B). RD #117 stated that one of the PSWs in the dining room "did not like that [the resident] was having [specific textured meals, texture meal type B] because they did not feel that [the resident] needed it".

During an interview with Inspector #681, the Culinary Manager stated that they were unaware resident #015 was consuming a specific textured diet (texture meal type B), until they received the referral. The Culinary Manager stated that the Master Diet list should have been updated to reflect that this resident was consuming a specific diet texture (texture meal type B). The Culinary Manager also stated that the Master Diet lists were not updated while they were away on vacation over the Christmas holidays. [s. 11. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.

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

Ministère 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) :	RYAN GOODMURPHY (638), STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2019_679638_0001
Log No. / No de registre :	008715-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 29, 2019
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

To Valley East Long Term Care Centre Inc., 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2018_740621_0010, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee must be compliant with s. 11 (2) of the LTCHA, 2007.

The licensee shall prepare, submit and implement a plan to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The plan must include, but is not limited to, the following;

a) how the licensee will ensure that during meal services, nursing and dietary staff will have clear, specific and accurate instructions, readily available, outlining each resident's assessed dietary requirements; and

b) how the licensee will ensure that resident specific plans will be kept up to date when the staff member responsible for updating the plans is away.

Please submit the written plan, quoting Inspection #2019_679638_0001 and Inspector, Ryan Goodmurphy, by email to SudburySAO.moh@ontario.ca by February 13, 2019.

Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with food and

fluids that were safe, adequate in quantity, nutritious and varied.

During Inspection #2018_740621_0010, CO #001 was issued to the home, which ordered the licensee to;

a) ensure that all dietary staff, PSWs, and RPNs who had not completed education with regards to providing safe and appropriate food choices for residents that required texture modified diets, had completed this training, with supporting documentation;
b) ensure that during meal service, nursing and dietary staff had readily available, instructions outlining each resident's dietary requirements which were clear, specific and accurate with respect to each residents plan of care; and
c) ensure that the Administrator and, in their absence, management designate(s) were prepared to speak to, and had documented evidence to support the requirements of part a) and b) of this order, by the compliance order due date.

The compliance due date of this order was May 25, 2018.

While the licensee complied with sections "a)" and "c)", non-compliance was identified with section "b)", where the licensee was directed to ensure that; during meal service, nursing and dietary staff had readily available, instructions outlining each resident's dietary requirements which were clear, specific and accurate with respect to each residents plan of care.

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Inspector #681 reviewed the Master Diet list that was located in the Home Area servery. The Master Diet list indicated that resident #018 was supposed to receive another specific diet with a specific texture (texture meal type B). The

Inspector reviewed the resident's electronic care plan, which indicated the resident was supposed to receive a specific diet with a different specific texture than identified in the Master Diet list. The resident's electronic care plan indicated that this diet intervention had been added to resident #018's care plan nine days earlier by RD #114.

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During an interview with Inspector #681, RD #115 indicated that they completed a meal observation during a meal service in the dining room of one Home Area on a specific date. RD #115 stated that, at this time, resident #018 had already been switched to a specific textured diet (texture meal type A). The RD stated that resident #018 received a specific textured meal (texture meal type A). RD #115 stated that they "did not know the resident and did not know [their] history", but that they did not identify any concerns with resident #018's chewing or swallowing abilities with the specific textured meal (texture meal type A).

The Inspector reviewed a progress note written by RD #117, which indicated that the RD was approached by a RN on the unit because resident #018 was still receiving a previously ordered specific textured diet (texture meal type B). The progress note further indicated that a previous RD had changed the resident's diet texture to a specific texture (texture meal type A), at the request of family, but that the Master Diet list had not been updated with the diet order.

During an interview with Inspector #681, the Culinary Manager indicated that the

Master Diet list was used by both dietary staff and nursing staff. The Culinary Manager indicated that this document contained information about a resident's diet type and texture. The Culinary Manager stated that they were responsible for updating the Master Diet lists. The Culinary Manager stated that the Master Diet list that the Inspector obtained from the servery on resident #018's Home Area was updated and printed on a specific date. After reviewing the documentation provided by the Inspector, the Culinary Manager acknowledged that the Master Diet list for resident #018's Home Area was not updated to reflect the changes that was made to resident #018's diet texture.

B) Inspector #681 observed that resident #015 was served a specific textured meal (texture meal type B) at two meal services on a specific date and one meal service on another specific date. During these meal observations, the Inspector also identified that the resident did not use any specific interventions to consume their meal.

The Inspector reviewed the Master Diet list that was located in the servery on the Home Area. The Master Diet list indicated that resident #015 was supposed to receive a specific diet with specific texture (texture meal type B) and that the resident was to utilize specific interventions to help them consume their meals.

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During an interview with Inspector #681, DA #105 stated that the Master Diet list indicated that resident #015 was supposed to receive a specific textured diet (texture meal type A), but that the resident had been receiving a different specific textured diet (texture meal type B) because they recently had a medical intervention completed. DA #105 also stated that resident #015 did not use any specific interventions during meals.

In an interview with Inspector #681, resident #015 indicated that they did not use any specific interventions during meals. Resident #015 reported that they had a medical intervention completed and described the change in their meal texture,

which made it easier for the resident to eat their meals.

During an interview with PSW #101, they stated that resident #015 had received a specific textured diet (texture meal type B), contrary to the resident's identified specific textured diet (texture meal type A), since having had a medical intervention completed.

Inspector #681 interviewed PSW #149 who indicated that resident #015 was being served a specific textured diet (texture meal type C) by one shift, but during another shift, the resident was being served a different specific textured diet (meal texture type B). The PSW stated that one of the specific shift staff worked the other shift and identified that the resident was receiving a different diet texture at one meal than they were at the other meals.

During an interview with Inspector #681, the Staff Educator stated that they submitted a dietary referral for resident #015 because they were told by a PSW that on one shift, the resident was eating a specific textured diet (meal texture type B) and on another shift the resident was eating a different specific textured diet (texture meal type C). The Staff Educator stated that the resident was put on a the specific texture diet (texture meal type B) following a medical intervention, but that the other shift had found that the resident medical condition had changed and were giving the resident a different specific diet texture (texture meal type C).

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During an interview with Inspector #681, the Culinary Manager stated that they were unaware resident #015 was consuming a specific textured diet (texture meal type B), until they received the referral. The Culinary Manager stated that the Master Diet list should have been updated to reflect that this resident was

consuming a specific diet texture (texture meal type B). The Culinary Manager also stated that the Master Diet lists were not updated while they were away on vacation over the Christmas holidays.

The severity of this issue was determined to be a level two, as there was the potential for actual harm to the residents of the home. The scope of the issue was a level two, as it was identified that multiple residents were affected by the non-compliance. The home had a level four compliance history, as they had ongoing non-compliance with a compliance order within this section of the LTCHA that included;

-one compliance order issued April 19, 2018, during inspection #2018_740621_0010; and
-one compliance order issued January 10, 2018, during inspection 2017_657681_0018. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2019

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 29th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ryan Goodmurphy

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