Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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5700, rue Yonge 5e étage
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Amended Public Copy/Copie modifiée 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
Jul 22, 2021	2021_780699_0006 (A1)	004528-20, 004834-20, 010801-20, 011252-20, 012811-20, 013740-20, 020641-20, 022017-20, 022465-20, 000449-21, 003741-21	Critical Incident System

Licensee/Titulaire de permis

Advent Health Care Corporation
541 Finch Avenue West North York ON M2R 3Y3

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

Valleyview Residence
541 Finch Avenue West North York ON M2R 3Y3

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 15-19, 22-26, 29, April 6-9, 2021.

The following Critical Incident System (CIS) intakes were completed:

-Log 011252-20 [CIS 2954-000013-20], 004528-20 [CIS 2954-000003-20] related to alleged abuse;

-log 022465-20 [CIS 2954-000022-20], 022017-20 [CIS 2954-000020-20], 020641-20 [CIS 2954-000019-20], 013740-20 [CIS 2954-000015-20], 012811-20 [CIS 2954-000014-20],

010801-20 [CIS 2954-000012-20], and 004834-20 [CIS 2954-000006-20] related to falls with injury; and

-log 003741-21 [CIS 2954-000003-21], and 000449-21 [CIS 2954-000001-21] related to injury with unknown cause.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Nurse manager (NM), Physiotherapist, Nurse Practitioner (NP), Registered Dietitian (RD) registered nurse (RN), registered practical nurse (RPN), personal support workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) observed staff to resident interactions, and the provision of care, reviewed health records, video footage, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **6 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

The resident was found with altered skin integrity and an assessment from the hospital showed the resident had a sustained an injury.

A PSW stated they were aware the resident required two-person assistance for care, and provided the care alone.

The NM stated the resident was not provided care as per the resident's care plan when the PSW did not provide the resident with the appropriate level of care.

[Sources: Critical Incident System (CIS) Report, video recordings, home's investigation notes, resident's hospital records, progress notes, and care plans; interviews with staff.] [s. 6. (7)]

2. The licensee has failed to ensure that a resident was provided two person assistance as specified in their plan of care.

The home submitted a CIS related to a resident sustaining an injury of unknown cause.

Resident's care records showed that on two days, on different shifts, before the resident's injury, the resident was provided one person care instead of two person care as per their plan of care.

The NM confirmed that the resident's plan of care was not followed and that it could have contributed to the resident sustaining an injury due to the resident's health condition.

Sources: CIS report notes, record review of the resident's care plan, observation/flow sheet monitoring form, and interview with staff. [s. 6. (7)]

3. The licensee has failed to ensure that staff followed the resident's plan of care.

An allegation of abuse of a resident was made regarding the resident sustaining an injury of unknown cause requiring transfer to hospital.

The resident's care plan showed staff were to ensure the resident's mobility device be in a certain position to met the resident's mobility needs. Staff were also to remove all barriers to ensure safe mobility for the resident.

Video recordings showed staff positioned the resident improperly in their mobility device. The resident was struggling for several minutes as a result, and could not mobilize.

The NM stated the resident should not have been left in the incorrect position in the doorway. They stated the resident could injure themselves when they were in that position. The DOC stated the resident was at risk of falling and injuring when left incorrectly positioned in their mobility device.

[Sources: Critical Incident System (CIS) Report, video recordings of the incident, home's investigation notes, resident's hospital records, progress notes, and care plans; interviews with staff.] [s. 6. (7)]

4. The licensee has failed to ensure that a resident's plan of care was reassessed with different approaches when they sustained a number of falls over a short period of time.

The home submitted a CIS related to a resident sustaining an injury after falling.

Over a period of 10 days, the resident had four falls. There was no reassessment of the resident's plan of care related to falls over this period of time. The resident had a behaviour that placed them at increased risk of falls, however there was no assessment of the resident's behaviours or interventions put in place to address the behaviour. The home's expectation was that if a resident continued to have falls and the plan of care was not effective, the plan of care should have been reassessed with different approaches.

Sources: Resident's care plan, progress notes, post fall assessments, and interview with the NM and PT. [s. 6. (11) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents by not ensuring appropriate physical distancing.

On December 22, 2020, the Director, LTCIB reminded licensees of the importance of maintaining physical distancing during activities and communal events. COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH), issued April 15, 2020, instructed homes to modify internal activities to promote adherence to physical distancing measures for residents.

The inspector conducted observations of the home and observed the following:
- 13 residents in TV area, 5 residents less than 6 feet away from each other. Residents were playing bingo, led by recreation staff. Signage in room indicated only a maximum of eight people allowed in the room;
- 5 residents seated by window, 2 residents less than 6 feet apart;
- 7 residents observed in TV room, 5 seated 6 ft apart, 2 residents seated together on the fourth floor.

Infection Prevention and Control (IPAC) lead indicated that the expectation was that residents maintain social distancing during activities and staff to adhere to signage of how many people can be in a room at a time.

Sources: Observations conducted by Inspector #699 , COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH) Version2 - April 15, 2020; Director's memo dated December 22, 2020, regarding Physical distancing during congregate events and interview with IPAC lead. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A resident was found with altered skin integrity and an assessment from the hospital showed the resident had sustained an injury.

The home’s investigation showed that on the evening prior to the incident, a PSW transferred the resident with a PSW student instead of with another PSW.

The home's investigation and video evidence showed staff used a transfer technique that was not appropriate for the resident to transfer the resident to the toilet.

The staff transferred the resident to the toilet despite not being safe to do so.

The Falls Lead/Clinical Manager indicated PSW students should not be the second person for transfer assistance as they are not considered staff. The falls lead indicated the resident should not have been toileted due to the resident's health condition.

The nurse manager indicated that staff did not use safe transferring techniques and should not have toileted the resident.

[Sources: CIS report, video recordings, home’s investigation notes, resident's hospital records, progress notes, and care plans; interviews with staff.] [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure direct care staff received annual falls prevention and management training in 2020.

The inspector requested to be provided the home's training record for falls prevention and management in 2020, however the home was unable to provide this to the inspector. The Administrator confirmed that the staff did not complete training for falls in 2020, as this was mistakenly omitted from their training database.

Sources: Record review of training records and interview with Administrator #100.
[s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written description of the personal support services (PSS) program that included the goals and objectives, relevant policies, procedures and protocols, and methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources.

The inspector requested to be provided the home's written description of the PSS program, however the home was unable to provide this to the inspector. The Administrator confirmed that the home did not have a formal written description of their personal support program, which included the above noted requirements, however did have policies and procedures in place related PSS.

Sources: Record review of the home's PSS policies, and interview with MDS/Rehab Manager #113 and Administrator #100. [s. 30. (1) 1.]

2. The licensee has failed to ensure restorative care program was evaluated and updated annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The inspector requested to be provided the home's evaluation of the restorative care/PSS program for 2020, however the home was unable to provide this to the inspector. The Administrator confirmed that the home did not complete an evaluation of the program in 2020.

Sources: Record review of programs evaluation, interview with Administrator #100 and MDS/Rehab Manager #113. [s. 30. (1) 3.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the outcome of an investigation was reported to the Director.

Review of the CIS showed that the outcome of the investigation was not reported to the Director until approximately one month later.

The NM confirmed that the outcome of the investigation should have been reported to the Director within the 10 days as required.

Sources: CIS report, and interview with the NM. [s. 104. (2)]

Issued on this 22nd day of July, 2021 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2021_780699_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004528-20, 004834-20, 010801-20, 011252-20, 012811-20, 013740-20, 020641-20, 022017-20, 022465-20, 000449-21, 003741-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 22, 2021(A1)
Licensee / Titulaire de permis :	Advent Health Care Corporation 541 Finch Avenue West, North York, ON, M2R-3Y3
LTC Home / Foyer de SLD :	Valleyview Residence 541 Finch Avenue West, North York, ON, M2R-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bryce

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 Advent Health Care Corporation, 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 :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

-Ensure staff provide care to resident #006, #007, and #010, as specified in the plan of care.
-Conduct meetings with direct care staff to review the above residents' care plans to ensure staff are aware of their care requirements;
- Maintain record of meetings including dates held, attendance, and resident care plan reviewed.
- Develop and implement an auditing process to ensure that staff provide two person care to residents #007, #010, and all other residents as required per their plan of care.
- Ensure that staff provide resident #006 with appropriate positioning to maintain independence with mobility;
- Maintain a record of audits conducted for a period of one month following the service date of this order which include date of audit, name of person completing the audit, resident and staff members audited, result of the audit and any corrective action taken.

Grounds / Motifs :

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

1. The licensee has failed to ensure that a resident was provided two person assistance as specified in their plan of care.

The home submitted a CIS related to a resident sustaining an injury of unknown cause.

Resident’s care records showed that on two days, on different shifts, before the resident's injury, the resident was provided one person care instead of two person care as per their plan of care.

The NM confirmed that the resident’s plan of care was not followed and that it could have contributed to the resident sustaining an injury due to the resident’s health condition.

Sources: CIS report notes, record review of the resident's care plan, observation/flow sheet monitoring form, and interview with staff. [s. 6. (7)]
(646)

2. The licensee has failed to ensure the care set out in the plan of care provided to a resident as specified in the plan.

The resident was found with altered skin integrity and an assessment from the hospital showed the resident had a sustained an injury.

A PSW stated they were aware the resident required two-person assistance for care, and provided the care alone.

The NM stated the resident was not provided care as per the resident’s care plan when the PSW did not provide the resident with the appropriate level of care.

[Sources: Critical Incident System (CIS) Report, video recordings, home’s investigation notes, resident’s hospital records, progress notes, and care plans; interviews with staff.] [s. 6. (7)] (699)

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

3. The licensee has failed to ensure that staff followed the resident's plan of care.

An allegation of abuse of a resident was made regarding the resident sustaining an injury of unknown cause requiring transfer to hospital.

The resident's care plan showed staff were to ensure the resident's mobility device be in a certain position to met the resident's mobility needs. Staff were also to remove all barriers to ensure safe mobility for the resident.

Video recordings showed staff positioned the resident improperly in their mobility device. The resident was struggling for several minutes as a result, and could not mobilize.

The NM stated the resident should not have been left in the incorrect position in the doorway. They stated the resident could injure themselves when they were in that position. The DOC stated the resident was at risk of falling and injuring when left incorrectly positioned in their mobility device.

[Sources: Critical Incident System (CIS) Report, video recordings of the incident, home's investigation notes, resident's hospital records, progress notes, and care plans; interviews with staff.] [s. 6. (7)]

Severity: Three residents were not provided the care as specified in the plan of care, which placed them at potential risk/harm.
Scope: Three out of eight residents plan of care were not followed that were reviewed, indicating a pattern of incidents.
Compliance history: 1 Voluntary Plan of Correction (VPC) was issued to the same subsection in the past 36 months. (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2021(A1)

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

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:

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

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

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

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 22nd day of July, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A1)

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

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