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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2021	2021_777731_0024	005462-21, 006009-21, 006584-21, 006832-21, 015074-21	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of St. Thomas
545 Talbot Street St Thomas ON N5P 3V7

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

Valleyview Home
350 Burwell Road St Thomas ON N5P 0A3

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

KRISTEN MURRAY (731), CHRISTINA LEGOUFFE (730)

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): October 14, 15, 18, 20, 22, 25, 26, 27 and 28, 2021.

The following Critical Incident intakes were completed within this inspection:

Related to allegations of abuse and neglect:
Critical Incident Log #005462-21 / CI M628-000006-21
Critical Incident Log #006009-21 / CI M628-000008-21
Critical Incident Log #006584-21 / CI M628-000010-21
Critical Incident Log #006832-21 / CI M628-000012-21
Critical Incident Log #015074-21 / CI M628-000023-21

An IPAC inspection was also completed during the course of the inspection.

Inspector #721821 was also present during the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Continuous Quality Improvement (CQI) Lead, the Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), student(s), a Housekeeper, the Screener, and residents.

The inspectors also observed resident rooms and common areas, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, and reviewed the home's investigation notes.

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

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

4 WN(s)
2 VPC(s)
2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents were protected from abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as “any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member”.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident”.

1) An incident of sexual abuse occurred between a PSW and a resident. The resident had a history of sexual behaviours. The DOC indicated the PSW's actions were inappropriate. There was minimal risk of harm to the resident related to the incident.

2) A PSW made negative remarks to a resident, regarding their loved one. The resident had a history of responsive behaviours. The resident became visibly upset following the negative comments made by the PSW. In separate interviews with a PSW and the RAI Coordinator, they stated it would not be appropriate to tease the resident about their loved one. The DOC stated it was common knowledge not to tease or taunt the resident because it caused them to become agitated. There was minimal risk of harm to the resident related to the PSW making negative comments about their loved one.

The home’s Abuse and Neglect policy stated that all residents have the right to live in a home environment that is free from any form of abuse or neglect at all times and in all circumstances.

Sources: The LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); the LTCH's investigation documentation; two residents' care plans; and interviews with the RAI Coordinator, the DOC and other staff. [s. 19. (1)]

2. The licensee has failed to ensure that three residents were free from neglect from staff, including a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

1) A PSW left two residents on the toilet for an extended period of time. One of the residents developed an area of altered skin integrity. In an interview with the DOC and CQI lead, they stated a resident should typically not be left on the toilet for an extended period of time.

2) A resident was left alone for an extended period of time. In an interview with the DOC and CQI lead, they stated a resident should not be left alone for an extended period of time.

The home's Abuse and Neglect policy stated that all residents have the right to live in a home environment that is free from any form of abuse or neglect at all times and in all circumstances. There was minimal risk of harm related to the three residents being neglected by staff.

Sources: The LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); the LTCH's investigation documentation; two residents' care plans; and interviews with the DOC, CQI lead, and other staff. [s. 19. (1)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Abuse and Neglect policy stated that all staff, students, and volunteers had a duty, as per the LTCHA, to report abuse of a resident by anyone, and neglect of a resident by a staff member of the home. The home's policy stated that corrective action would be taken against anyone who abuses a resident or anyone who fails to immediately report witnessed or suspected abuse once it becomes known that they have been withholding such information.

The home submitted a Critical Incident System (CIS) report to the MLTC regarding allegations of multiple staff to resident abuse and neglect incidents involving two PSWs towards nine residents. A student reported six allegations of abuse and four allegations of neglect to their College Instructor, who informed management of the home on a later date. None of the allegations were immediately reported to the home.

CQI lead indicated all the allegations were not immediately reported to management, which did not meet the home's expectation for immediate reporting. There was minimal risk of harm to the residents related to the allegations of abuse and neglect not being reported to the home immediately as per the home's policy.

Sources: CIS report; The LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); the LTCH's investigation documentation; and interviews with a student, the CQI lead, the DOC and other staff. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A PSW gathered multiple staff to enter a resident's room together to provide care, and told the resident that they were the Doctor. The resident became upset following the incident.

In separate interviews with a PSW and the RAI Coordinator, they identified that the resident had a history of responsive behaviours. The PSW and RAI Coordinator stated the resident preferred fewer staff in the room to provide care.

In an interview with the DOC and CQI lead, when asked the best way for staff to approach the resident, the CQI lead stated to have one staff at a time to get things started and when they need the second person to bring that person in at that time. DOC indicated it was not appropriate for the PSW to state they were a doctor to the resident. There was minimal risk of harm related to the resident being told by the PSW that they were the doctor and multiple staff entering the resident's room to provide care.

Sources: The LTCH's investigation documentation; a resident's care plan; and interviews with a student, the RAI Coordinator, the DOC and other staff. [s. 3. (1) 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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #4: 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 :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred by another resident that resulted in harm to the resident immediately reported the suspicion and information upon which it was based to the Director.

There was a physical altercation between two residents, resulting in injury to one of the residents. The Critical Incident System (CIS) report was submitted to the MLTC four days after the incident occurred.

The RAI Coordinator confirmed that the CIS was not immediately reported to the MLTC. There was minimal risk to the residents related to the home not immediately reporting the incident to the Director.

The home's Abuse and Neglect policy stated that mandatory reporting would be initiated immediately and included abuse of a resident by anyone that resulted in harm or risk of harm to the resident.

Sources: CIS report; the LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); two residents' progress notes; and an interview with the RAI Coordinator. [s. 24. (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 a person who has reasonable grounds to suspect abuse of a resident immediately reported the suspicion and information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 29th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KRISTEN MURRAY (731), CHRISTINA LEGOUFFE (730)
Inspection No. / No de l'inspection :	2021_777731_0024
Log No. / No de registre :	005462-21, 006009-21, 006584-21, 006832-21, 015074-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 22, 2021
Licensee / Titulaire de permis :	The Corporation of the City of St. Thomas 545 Talbot Street, St Thomas, ON, N5P-3V7
LTC Home / Foyer de SLD :	Valleyview Home 350 Burwell Road, St Thomas, ON, N5P-0A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Carroll

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 The Corporation of the City of St. Thomas, 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 # / 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with s. 19. (1) of the LTCHA.

Specifically, the licensee must:

-Ensure residents #003 and #011 are protected from abuse, and
-Ensure residents #014, #015, and #016 are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that two residents were protected from abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member".

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

1) An incident of sexual abuse occurred between a PSW and a resident. The resident had a history of sexual behaviours. The DOC indicated the PSW's actions were inappropriate. There was minimal risk of harm to the resident related to the incident.

2) A PSW made negative remarks to a resident, regarding their loved one. The resident had a history of responsive behaviours. The resident became visibly upset following the negative comments made by the PSW. In separate interviews with a PSW and the RAI Coordinator, they stated it would not be appropriate to tease the resident about their loved one. The DOC stated it was common knowledge not to tease or taunt the resident because it caused them to become agitated. There was minimal risk of harm to the resident related to the PSW making negative comments about their loved one.

The home's Abuse and Neglect policy stated that all residents have the right to live in a home environment that is free from any form of abuse or neglect at all times and in all circumstances.

Sources: The LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); the LTCH's investigation documentation; two residents' care plans; and interviews with the RAI Coordinator, the DOC and other staff. (731)

2. The licensee has failed to ensure that three residents were free from neglect from staff, including a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

1) A PSW left two residents on the toilet for an extended period of time. One of the residents developed an area of altered skin integrity. In an interview with the DOC and CQI lead, they stated a resident should typically not be left on the toilet for an extended period of time.

2) A resident was left alone for an extended period of time. In an interview with the DOC and CQI lead, they stated a resident should not be left alone for an extended period of time.

The home's Abuse and Neglect policy stated that all residents have the right to live in a home environment that is free from any form of abuse or neglect at all

times and in all circumstances. There was minimal risk of harm related to the three residents being neglected by staff.

Sources: The LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); the LTCH's investigation documentation; two residents' care plans; and interviews with the DOC, CQI lead, and other staff.

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

Severity: There was minimal risk of harm related to the incident of sexual abuse by the PSW towards the resident, the PSW making negative comments about a resident's loved one, and three residents being neglected by staff.

Scope: Out of the ten residents reviewed, five residents were not protected from abuse and neglect, demonstrating a pattern of non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 19. (1) and one written notification (WN) was issued to the home. (731)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2021

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with s. 20. (1) of the LTCHA.

Specifically, the licensee must:

-Ensure the abuse and neglect policy is complied with, including that all staff, students, and volunteers immediately report any allegations of abuse or neglect of a resident,
-Educate new and current students on the home's abuse and neglect policy, including the requirements for mandatory reporting, and
-Maintain a documented record of the training including the materials reviewed, the date completed, the names of the individuals who completed the education, and the staff member providing the education.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Abuse and Neglect policy stated that all staff, students, and volunteers had a duty, as per the LTCHA, to report abuse of a resident by anyone, and neglect of a resident by a staff member of the home. The home's policy stated that corrective action would be taken against anyone who abuses a resident or anyone who fails to immediately report witnessed or suspected abuse once it becomes known that they have been withholding such information.

The home submitted a Critical Incident System (CIS) report to the MLTC regarding allegations of multiple staff to resident abuse and neglect incidents involving two PSWs towards nine residents. A student reported six allegations of abuse and four allegations of neglect to their College Instructor, who informed management of the home on a later date. None of the allegations were immediately reported to the home.

CQI lead indicated all the allegations were not immediately reported to management, which did not meet the home's expectation for immediate reporting. There was minimal risk of harm to the residents related to the allegations of abuse and neglect not being reported to the home immediately as per the home's policy.

Sources: CIS report; The LTCH's policy "Resident Abuse and Neglect", (last revised April 2013); the LTCH's investigation documentation; and interviews with a student, the CQI lead, the DOC and other staff.

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

Severity: There was minimal risk of harm to the residents related to the allegations of abuse and neglect not being reported to the home immediately as per the home's policy.

Scope: The scope was widespread because ten out of ten allegations of abuse and neglect were not immediately reported to the home.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 20. (1) and one voluntary plan of correction (VPC) was issued to the home. (731)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 17, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kristen Murray

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