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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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 2, 2020	2020_640601_0020	014867-20, 018700-20, 019472-20	Complaint

Licensee/Titulaire de permis

Trent Valley Lodge Limited
195 Bay Street TRENTON ON K8V 1H9

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

Trent Valley Lodge
195 Bay Street TRENTON ON K8V 1H9

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 22, 23, 24, 25, 29, 30, October 1, 2, 5, and 6, 2020.

The following intakes were completed in this Complaint Inspection:

Two logs with the same issue related to allegations of neglect, staffing and care concerns.

A log related to staffing and care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurse/Nursing Manager (RPN/NM), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector also reviewed resident health care records, master staffing plans, time sheets, applicable policies and observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- 5 WN(s)
- 4 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident

#003 related to continence care was provided to the resident, as specified in the plan.

The resident's continence care plan directed for the resident to receive total assistance from two staff for continence care.

PSW #106 indicated they recalled a shift within the past month when the resident was incontinent and was requesting to be transferred to bed. PSW #106 reported that a second PSW was not available and the resident had to wait to have continence care provided. PSW #131 indicated the resident didn't routinely receive continence care as directed in the care plan. The PSW acknowledged that the resident had not received continence care as directed in the care plan twice on a shift due to the PSWs working below staffing complement.

The Registered Practical Nurse/Nurse Manager (RPN/NM) indicated the resident should receive continence care according to their care plan and they were not aware of anytime the resident had not received continence care.

The resident was at risk for altered skin integrity when continence care was not provided to the resident, as specified in the care plan due to the resident being incontinent.

Sources: Resident's care plan and progress notes, interviews with PSW #106, PSW #131, and PSW #135, and the RPN/NM. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #004 related to continence care was provided to the resident, as specified in the plan.

The resident's continence care plan directed for the resident to receive total assistance from two staff for continence care.

PSW #120 and PSW #135 indicated the resident didn't routinely receive continence care as directed in the care plan and they both acknowledge there was usually not enough staff working on their shift to provide the resident's continence care more than once. PSW #132 and PSW #135 indicated the resident didn't routinely receive continence care as directed in the care plan.

The Registered Practical Nurse/Nurse Manager (RPN/NM) indicated the resident should receive continence care according to their care plan and they were not aware of anytime the resident had not received continence care.

The resident was at risk for altered skin integrity when continence care was not provided as specified in the care plan due to the resident being incontinent.

Sources: Resident's care plan and progress notes, interviews with PSW #120, PSW #132, and PSW #135, and RPN/NM. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #010 related to continence care was provided to the resident, as specified in the plan.

The resident's continence care plan directed for the resident to receive total assistance from two staff for continence care.

PSW #120 indicated the resident didn't routinely receive continence care as directed in the care plan due to their not being enough staff to provide the resident's continence care more than once on their shift. PSW #122 indicated that on a shift they worked the resident did not receive continence care as directed in the care plan.

The Registered Practical Nurse/Nurse Manager (RPN/NM) indicated the resident should receive continence care according to their care plan and they were not aware of anytime the resident had not received continence care.

The resident was at risk for altered skin integrity when continence care was not provided as specified in the care plan due to the resident being incontinent.

Sources: Resident's care plan and progress notes, interviews with PSW #120, PSW #122, and RPN/NM. [s. 6. (7)]

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. 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 environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding the proper use of the surgical procedure mask and maintaining two meters distance from others while not a wearing a mask.

Physical distancing was not being maintained and staff were observed to be within two meters of others with no surgical procedure mask or with the mask not covering their mouth and/or nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 dated September 9, 2020, all staff of long-term care homes must always wear a surgical procedure mask for the duration of their shift. When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical procedure mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19.

The Director of Care (DOC) acknowledged they had observed staff to be within two meters of others with no surgical procedure mask or with the mask not covering their mouth and/or nose.

The lack of adherence to Directive #3 related to the use of surgical/procedure mask and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective date September 9, 2020), observations throughout the home, and interview with the DOC. [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 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 abuse policy was complied with related to reporting and documentation of allegations of neglect of a resident continence care.

Review of the licensee's abuse policy directed that all staff were to immediately notify the Registered Nurse in charge of the home, who was to immediately notify the Director of Care (DOC) or the Administrator of any alleged or witnessed abuse. The DOC or designate will notify the Ministry of Long-Term Care Director according to protocols established for reporting of abuse and critical incidents.

A resident's Substitute Decision Maker (SDM) reported allegations of neglect to the RPN and RPN/NM. The DOC indicated the Critical Incident System (CIS) report was submitted to the Director when they were made aware of the allegations. The DOC also indicated an investigation was immediately initiated by the RPN and the RPN should have been immediately notified them of the allegation and the Director should have been immediately notified.

Sources: CIS report, Abuse and Neglect of a Resident – Actual or Suspected policy, progress notes, the homes internal investigation, and interviews with RPN/NM and the DOC. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The licensee’s Continence Guidelines for Care policy directs to have an individualized program of continence care developed and documented on the resident’s plan of care to be completed upon admission, at the time of quarterly review, during the annual assessment and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning.

The resident’s clinical health record identified the resident was incontinent and the resident had not received a continence assessment that was specifically designed for the assessment of incontinence.

The RPN/NM indicated they were the lead for the continence care program and residents should receive a continence assessment upon admission and they were not aware of resident’s receiving any further continence assessments.

The resident was at risk for altered skin integrity when continence care was not provided according to their patterns due the resident being incontinent.

Sources: Record review of continence assessments, the resident's plan of care, Continence Guidelines for Care policy, interview with the RPN/NM. [s. 51. (2) (a)]

2. The licensee has failed to ensure that resident #004 who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument

that was specifically designed for assessment of incontinence.

The licensee’s Continence Guidelines for Care policy directs to have an individualized program of continence care developed and documented on the resident’s plan of care to be completed upon admission, at the time of quarterly review, during the annual assessment and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning.

The resident’s clinical health record identified the resident was incontinent and the resident had not received a continence assessment that was specifically designed for the assessment of incontinence.

The RPN/NM indicated they were the lead for the continence care program and residents should receive a continence assessment upon admission and they were not aware of resident’s receiving any further continence assessments.

The resident was at risk for altered skin integrity when continence care was not provided according to their patterns due the resident being incontinent.

Sources: Record review of continence assessments, the resident's plan of care, Continence Guidelines for Care policy, Interview with the RPN/NM. [s. 51. (2) (a)]

3. The licensee has failed to ensure that resident #010 who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The licensee’s Continence Guidelines for Care policy directs to have an individualized program of continence care developed and documented on the resident’s plan of care to be completed upon admission, at the time of quarterly review, during the annual assessment and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning.

The resident’s clinical health record identified the resident was incontinent and the resident had not received a continence assessment that was specifically designed for the assessment of incontinence.

The RPN/NM indicated they were the lead for the continence care program and residents should receive a continence assessment upon admission and they were not aware of

resident’s receiving any further continence assessments.

The resident was at risk for altered skin integrity when continence care was not provided according to their patterns due the resident being incontinent.

Sources: Record review of continence assessments, the resident's plan of care, Continence Guidelines for Care policy, Interview with the RPN/NM. [s. 51. (2) (a)]

4. The licensee has failed to ensure that resident #009 who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The licensee’s Continence Guidelines for Care policy directs to have an individualized program of continence care developed and documented on the resident’s plan of care to be completed upon admission, at the time of quarterly review, during the annual assessment and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning.

The resident’s clinical health record identified the resident was incontinent and the resident had not received a continence assessment that was specifically designed for the assessment of incontinence.

The RPN/NM indicated they were the lead for the continence care program and residents should receive a continence assessment upon admission and they were not aware of resident’s receiving any further continence assessments.

The resident was at risk for altered skin integrity when continence care was not provided according to their patterns due the resident being incontinent.

Sources: Record review of continence assessments, resident #009's plan of care, Continence Guidelines for Care policy, Interview with the RPN/NM. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident who is incontinent receives an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member who co-ordinated the infection prevention and control program had the education and experience in infection prevention and control practices including infectious disease; cleaning and disinfection; data collection and trend analysis reporting protocols and; outbreak management.

The Director of Care (DOC) indicated they were the designated lead for infection control

in the home. The DOC also indicated that they do not have specialized education or experience in infection prevention, outbreak management and control practices related to infectious diseases, cleaning and disinfecting, data collection and trend analysis. There is a risk that the required outbreak management and infection control practices may not be implemented when the designated infection prevention lead does not have the required infection prevention and control education.

Sources: Interview with the DOC. [s. 229. (3)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE).

The long-term care home's infection control policy, Recommended Steps for Putting on and Taking off Personal Protective Equipment included requirements for staff to put on PPE with five steps starting with hand hygiene; gown; mask; protective eye wear; and fit the gloves over the gown's cuff. Taking off PPE included six steps starting with removing gloves; using a glove to glove, skin to skin technique; remove the gown in a manner that prevents contamination of clothing or skin; perform hand hygiene; remove eye protection; remove mask; and perform hand hygiene.

A resident required droplet and contact precautions as per the posted signage.

The PSW was observed exiting a resident's bedroom and removed their gloves and disposable gown at the same time. The PSW acknowledged that they should have removed the gloves before the disposable gown.

The RPN was observed entering a resident bedroom, the RPN touched the medication cart, reached for a disposable gown, touched their hair, donned their disposable gown, put on gloves, touched the medication cart, applied goggles. The RPN indicated they could not recall the order in which they had applied their gloves and goggles. The RPN exited the resident's bedroom, removed their gloves, gown, goggles, and used hand sanitization. The RPN did not perform hand hygiene prior to removing their goggles. The RPN also indicated they didn't think about the order in which they had donned and doffed the PPE, as it just came naturally.

The PSW and RPN failed to participate in the implementation of the IPAC program which presented actual risk of infection to a resident.

Sources: Observations and interviews with the PSW and RPN, posted signage for a resident, the licensee’s infection control policy, Recommended Steps for Putting on and Taking off Personal Protective Equipment. [s. 229. (4)]

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 designated staff member who co-ordinates the infection prevention and control program has the education and experience in infection prevention and control practices including infectious disease; cleaning and disinfection; data collection and trend analysis reporting protocols and; outbreak management, to be implemented voluntarily.

Issued on this 13th day of November, 2020

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KARYN WOOD (601)
Inspection No. / No de l’inspection :	2020_640601_0020
Log No. / No de registre :	014867-20, 018700-20, 019472-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 2, 2020
Licensee / Titulaire de permis :	Trent Valley Lodge Limited 195 Bay Street, TRENTON, ON, K8V-1H9
LTC Home / Foyer de SLD :	Trent Valley Lodge 195 Bay Street, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Kelly Slawter

To Trent Valley Lodge Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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:

1. All interventions included in resident #003, #004, and #010's plan of care related to continence care are implemented by all direct care staff as outlined in the plan of care.

2. Perform daily audits of continence care being provided to resident #003, #004, and #010 to ensure they are receiving continence care, as specified in the plan of care.

3. Document the audits and continue auditing until resident #003, #004, and #010's are consistently receiving continence care, as specified in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #003 related to continence care was provided to the resident, as specified in the plan.

The resident's continence care plan directed for the resident to receive total assistance from two staff for continence care.

PSW #106 indicated they recalled a shift within the past month when the resident was incontinent and was requesting to be transferred to bed. PSW #106 reported that a second PSW was not available and the resident had to wait

to have continence care provided. PSW #131 indicated the resident didn't routinely receive continence care as directed in the care plan. The PSW acknowledged that the resident had not received continence care as directed in the care plan twice on a shift due to the PSWs working below staffing complement.

The Registered Practical Nurse/Nurse Manager (RPN/NM) indicated the resident should receive continence care according to their care plan and they were not aware of anytime the resident had not received continence care.

The resident was at risk for altered skin integrity when continence care was not provided to the resident, as specified in the care plan due to the resident being incontinent.

Sources: Resident's care plan and progress notes, interviews with PSW #106, PSW #131, and PSW #135, and the RPN/NM. [s. 6. (7)]
(601)

2. The licensee has failed to ensure that the care set out in the plan of care for resident #004 related to continence care was provided to the resident, as specified in the plan.

The resident's continence care plan directed for the resident to receive total assistance from two staff for continence care.

PSW #120 and PSW #135 indicated the resident didn't routinely receive continence care as directed in the care plan and they both acknowledge there was usually not enough staff working on their shift to provide the resident's continence care more than once. PSW #132 and PSW #135 indicated the resident didn't routinely receive continence care as directed in the care plan.

The Registered Practical Nurse/Nurse Manager (RPN/NM) indicated the resident should receive continence care according to their care plan and they were not aware of anytime the resident had not received continence care.

The resident was at risk for altered skin integrity when continence care was not provided as specified in the care plan due to the resident being incontinent.

Sources: Resident's care plan and progress notes, interviews with PSW #120, PSW #132, and PSW #135, and RPN/NM. [s. 6. (7)] (601)

3. The licensee has failed to ensure that the care set out in the plan of care for resident #010 related to continence care was provided to the resident, as specified in the plan.

The resident's continence care plan directed for the resident to receive total assistance from two staff for continence care.

PSW #120 indicated the resident didn't routinely receive continence care as directed in the care plan due to their not being enough staff to provide the resident's continence care more than once on their shift. PSW #122 indicated that on a shift they worked the resident did not receive continence care as directed in the care plan.

The Registered Practical Nurse/Nurse Manager (RPN/NM) indicated the resident should receive continence care according to their care plan and they were not aware of anytime the resident had not received continence care.

The resident was at risk for altered skin integrity when continence care was not provided as specified in the care plan due to the resident being incontinent.

Sources: Resident's care plan and progress notes, interviews with PSW #120, PSW #122, and RPN/NM. [s. 6. (7)]

An order was made taking the following factors into account:

Severity: There was potential harm of skin issues with three residents related to their continence care not being provided as specified in the care plan.

Scope: This non-compliance was widespread as three residents were reviewed, and continence care was not being provided as specified in the plan of care for all three residents.

Compliance History: In the last 36 months, the licensee was found to be non-

compliant with LTCHA 2007, c. 8, s. 6 (7) and a compliance order was issued to the home related to the same section of the legislation in the past 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of November, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Karyn Wood

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