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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Mar 23, 2022	2022_947752_0004	000286-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

Trilogy LTC Inc.
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road Scarborough ON M1J 3P4

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

LUCIA KWOK (752), MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): February 28, March 1, 2, 3, 4, 7, and 8, 2022.

A log related to the Proactive Compliance Inspection (PCI).

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Nursing Manager, Registered Nurses (RN), Registered Practical nurses (RPN), Registered Dietitian (RD), Environmental Services Manager (ESM), housekeeper, recreation aide (RA), dietary aides (DA), and Personal Support Worker (PSW).
The inspector conducted a tour of the home, observed the provision of care, and resident and staff interactions. The inspector reviewed pertinent clinical records, and relevant policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **6 WN(s)**
- **5 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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 :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.
Observations were conducted throughout the inspection and noted the following:
-On several occasions in different resident home areas (RHAs), staff were double masked with two surgical masks and/or a surgical mask with a N95 respirator.
-The personal protective equipment (PPE) caddie outside of an additional precautions resident room was not fully stocked with the required PPE. Registered Practical Nurse (RPN) #108 confirmed that not all of the PPE were available in the caddie.
-In an additional precautions resident room, a staff was observed conversing with the resident without the required PPE. The staff acknowledged that they did not wear the correct PPE.
-On one occasion, Inspector #752 observed five staff in the elevator. The signage posted by and in the elevator indicated maximum capacity was three people per elevator and to maintain 2 meters distance.
-In an additional precautions room, two visitors were observed interacting with the resident without wearing the required PPE.

The home’s IPAC lead, RPN #126, stated double masking was not the expectation for staff as it was not in accordance with best practice. The home’s expectation was for staff and visitors to follow additional precautions and PPE signage posted outside of resident rooms for the appropriate PPE to don/doff. Further, the RPN stated that PPE caddies outside of additional precaution resident rooms should be fully stocked with the required PPE.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations conducted throughout the inspection; Interviews with direct care staff, registered staff, home's IPAC lead and other staff; Long-Term Care homes (LTCH)'s IPAC policies and procedures. [s. 229. (4)] (752)

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. 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 :

The licensee has failed to ensure that the plan of care is being followed with regards to Activities of Daily Living (ADL) for three residents.

a) A resident's care plan indicated that they required two-person for assistance their ADL. The Personal Support Worker (PSW) documentation record indicated that on multiple occasions, the resident received one-person assistance with their ADL in February. PSW #117 indicated that that they provided assistance to the resident by themselves. RPN #116 indicated that the resident may require one- or two-person assistance their ADL, depending on their condition.

Assistant Director of Care (ADOC) #115 indicated that the resident required two-person assistance their ADL due to their medical condition.

b) A resident's care plan indicated that they required two-person for assistance in their ADL. The PSW documentation record from February indicated that the resident received one-person assistance for their ADL. PSW #120, and RPN #118 indicated that the resident could be provided care with one person and would require two-person assistance depending on their condition.

ADOC #115 indicated that the resident required two staff assistance their ADLs due to their medical condition.

c) A resident's care plan indicated that they required two-person for assistance in their ADL. The PSW documentation record from February indicated the resident received one staff assistance on occasion. PSW #118, and RPN #123 indicated that the resident could be provided ADL assistance with one person depending on their condition.

ADOC #115 indicated that the resident required two staff assistance for their ADL, due to their medical condition.

As a result, the three residents were at risk for having negative consequences due to the care plan not being followed.

Sources: Residents' care plans; PSW documentation February 2022; Interviews with PSWs #117, #118, #120, RPNs #116, #118, #123, and ADOC #115 [s. 6. (7)] (762)

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to ensure that the doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being used.

During the initial tour, Inspector #762 observed an electrical room door unlocked and accessible. The room contained multiple wiring, an electrical panel, side rail and the room was very warm. The room was unsupervised as the staff were in the lunch room at the time. In an interview, RPN #125 indicated that the door was accessible and not supervised, hence should have been locked. The Director of Care (DOC) indicated that the electrical room was not safe for residents. As a result, there was a risk for residents to go into the room and have a potential injury.

Sources: Observations; Interviews with RPN #125 and DOC. [s. 9. (1) 2.] (762)

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 the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee has failed to ensure that three residents' dietary interventions were implemented to mitigate and manage their nutritional risk.

a) A resident was identified as high nutritional risk and was to received modified texture foods.

During lunch observation, Inspector #752 observed that they received a regular texture entree. PSW #107 stated the home's process was to notify the unit nurse when the resident refused or requested another texture. Dietary aide (DA) #103 stated that they were to follow the information on the diet list when serving resident meals. DA #103 acknowledged they did not liaise nor notify the unit nurse when the resident requested regular texture. Registered Dietitian (RD) #111 stated that the resident should not have received regular textured foods and the expectation was for registered staff to send a referral to the RD for re-assessment.

b) A resident was identified at high nutritional risk and required total assistance with eating. The resident's nutrition care plan and the diet list documented that they were to receive an oral nutritional supplement at meals.

During lunch observation, the resident did not receive their oral nutritional supplement. Recreation Aide (RA) #104, who provided feeding assistance to the resident, indicated that the resident was not provided with the oral nutritional supplement at lunch.

c) A resident was identified at moderate nutritional risk. The resident's nutrition care plan documented that they were to receive a fortified beverage at lunch and dinner.

During lunch observation, the resident was not provided with the fortified beverage. DA #127 confirmed that no residents received the fortified beverage and no staff asked for the fortified beverage for the resident at lunch service.

As a result of the three residents not being provided with their dietary interventions as ordered, their nutritional risks were not minimized and reduced and potentially impacting their nutritional status.

Sources: Observations on February 28, and March 1, 2022; Interviews with RD #111, DAs #103, #127, PSW #107, RA #104; Diet order and supplements policy, Residents' care plans, home's diet list as of February 28, 2022 and March 1, 2022. [s. 68. (2) (c)] (752)

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 nutrition care and hydration programs programs include the implementation of interventions to mitigate and manage those risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that staff were using proper techniques when providing feeding assistance to residents.

During a nourishment pass, two staff were observed providing feeding assistance to two different residents while standing up. The staff were not at eye level to the residents. The residents were observed to stretch their necks upwards to consume the nourishment.

RD #111 and PSW #107 stated staff should be seated at the eye level of residents when providing feeding assistance.

As a result, there was potential risk of choking for residents as staff did not use proper techniques for safe feeding.

Sources: Observation on March 1, 2022; Interviews with PSW #107, and RD #111. [s. 73. (1) 10.] (752)

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 has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee failed to ensure that controlled substances are stored in a separate double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart

Inspector #762 observed RPN #121 provided an opioid medication a locked drawer in the medication cart to a resident. During the observation period the RPN was seen leaving the medication cart in the hallway for a prolonged time period. The medication cart was locked, however, the opioid medication was not in a double locked cabinet in the locked medication cart. RPN #121 indicated that they had pre-poured the medication before lunch and that they had left the medication cart locked in the hallway a few times during the period. In an interview, ADOC #115 indicate that the opioid medication should not be pre-poured. As a result, there was a risk of the medication being removed from the medication cart.

Sources: Medication administration policy; observation; Interviews with RPN #121 and ADOC #115 [s. 129. (1) (b)] (762)

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

Issued on this 25th day of March, 2022

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) :	LUCIA KWOK (752), MOSES NEELAM (762)
Inspection No. / No de l'inspection :	2022_947752_0004
Log No. / No de registre :	000286-22
Type of Inspection / Genre d'inspection:	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Mar 23, 2022
Licensee / Titulaire de permis :	Trilogy LTC Inc. 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Trilogy Long Term Care Residence 340 McCowan Road, Scarborough, ON, M1J-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sihle Mudlongwa

To Trilogy LTC Inc., 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

Ordre(s) de l'inspecteur

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

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 :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

2. Ensure caddies with personal protective equipment (PPE) are fully stocked at all times.

3. Conduct audits to ensure staff's compliance to donning and doffing the appropriate PPE for additional precaution rooms. Keep a documented record of the audits conducted, including the date and location of the audit, the person who conducted the audit, and the person who was audited. Analyze the results of the audits and provide further education to any staff who did not adhere to donning and doffing the appropriate PPE for additional precautions. Keep a documented record of the additional education provided.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.
Observations were conducted throughout the inspection and noted the following:
-On several occasions in different resident home areas (RHAs), staff were double masked with two surgical masks and/or a surgical mask with a N95 respirator.
-The personal protective equipment (PPE) caddie outside of an additional precautions resident room was not fully stocked with the required PPE. Registered Practical Nurse (RPN) #108 confirmed that not all of the PPE were

available in the caddie.
-In an additional precautions resident room, a staff was observed conversing with the resident without the required PPE. The staff acknowledged that they did not wear the correct PPE.
-On one occasion, Inspector #752 observed five staff in the elevator. The signage posted by and in the elevator indicated maximum capacity was three people per elevator and to maintain 2 meters distance.
-In an additional precautions room, two visitors were observed interacting with the resident without wearing the required PPE.

The home's IPAC lead, RPN #126, stated double masking was not the expectation for staff as it was not in accordance with best practice. The home's expectation was for staff and visitors to follow additional precautions and PPE signage posted outside of resident rooms for the appropriate PPE to don/doff. Further, the RPN stated that PPE caddies outside of additional precaution resident rooms should be fully stocked with the required PPE.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations conducted throughout the inspection; Interviews with direct care staff, registered staff, home's IPAC lead and other staff; Long-Term Care homes (LTCH)'s IPAC policies and procedures.

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

Severity: There was actual risk of harm to the residents because there was actual risk of transmission of infectious agents due to the staff and visitors not participating in the implementation of the IPAC program and PPE not being fully stocked outside of resident rooms.

Scope: The scope of this non-compliance was patterned because the IPAC related concerns were identified during the inspection and from observations throughout multiple resident home areas.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO#001 was issued on July 13, 2021, (Inspection # 2021_882760_0025) with a compliance due date of July 31, 2021. CO #002 was issued on May 17, 2021, (Inspection # 2021_598570_0011) with a compliance due date of May 24, 2021. CO #001 was issued on December 31, 2020, (Inspection # 2020_715672_0023) with a compliance due date of January 7, 2021.
(752)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 2022

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 23rd day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lucia Kwok

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