Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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347 Preston St Suite 420
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2017;	2017_603194_0016 (A1)	004483-17, 004488-17, 004799-17, 005055-17	Follow up

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Written Request to extend compliance date to August 11, 2017 was received by the home and approved by the inspector #194

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 13 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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195 BAY STREET TRENTON ON K8V 1H9

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

CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 09, 10, 11, 15, 16, 18 and 19, 2017

The following logs were inspected #0044883-17 follow up to s. 19 , #004488-17 follow up to r. 15, #005505-17 related to allegations of staff to resident neglect, #004799-17 related to allegations of sexual abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Maintenance, Registered Practical Nurse (RPN), Personal Support Worker (PSW),

and Residents.

The inspector also reviewed internal abuse investigations, staff educational records related to abuse, responsive behaviour communication tool, relevant policies and bed system evaluation records. A tour of the home related to bed rails and observation of staff to resident provision of care were completed.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

Sufficient Staffing

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

5 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2017_603194_0004	194

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	Legendé 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and the bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On February 21, 2017 the Licensee was served a Compliance Order to O. Reg 79/10 s. 15(1). The order type was per LTCHA, 2007 s. 153(1)(a), in that the Licensee was ordered to take specified action to achieve compliance. The Compliance Order was to have been complied with by May 5, 2017.

On May 18, 2017 during interview with inspector #194, DOC has indicated that where bed rails are used, the residents have not been assessed and the bed system evaluated in accordance with evidence-based practices. DOC indicated during same interview that review of an assessment tool was currently being completed by an interdisciplinary team and would be implemented in the near future.

Resident #003, #002 and #006 and #036 were observed by inspector #194, with bed rails in use when residents were in bed. Clinical heath records for resident #003, #002, #006 and #036 were reviewed identifying the resident's as being at high risk for falls. On May 11, 2017 during Interviews with PSW #107 and #105, PSW staff indicated the use of the bed rails for the above noted residents while in bed was to assist with repositioning [s. 15. (1) (a)]

2. The licensee has failed to ensure that steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Review of the licensee's current bed system evaluation was conducted by inspector #194. All identified entrapment zone previously identified in the December 2016's evaluation have been addressed, except for resident #036's bed. ESM and Maintenance staff indicated that resident #036 was provided an alternate bed with no bed rails on an identified date to address Zone 4 for entrapment. Inspector #194 was not provided any evidence to support any measures in place to address Zone 6 (head of the bed) entrapment zone for resident #036. ESM and Maintenance staff explained that resident #036 was not happy with the change in beds and wanted the previous bed and rails returned. Interview with DOC also supported that the SDM for resident #036 did not want any change to the bed system for resident #036. A care conference was held with the SDM on an identified date to further discuss the risks identified with entrapment but again the SDM indicated that no change be made to resident #036's bed. No further attempts have been made to minimize the identified entrapment zones for resident #036. At the time of the inspection resident #036 was still occupying the bed identified with entrapment zones 4 and 6.

The plan of care for resident #036 indicated bed rails and bed alarm in place when in bed. Resident #036 requires a mechanical lift, 2 staff assist for all transfers, toileting and bed mobility. Resident #036 requires 30 minute checks while in bed for safety and is at high risk for falls.

PSW #106 also indicated that during the day resident #036 will attempt to get out of the lower part of the bed to try and stand. PSW #106 indicated that resident #036 is at risk for falls, but has not had any recent falls. PSW#106 also indicated that resident #036 is a two staff assist with mechanical lift for all transfers, had limited ability to roll independently while in bed requiring 2 staff assist, was provided with bed alarm while in bed and was able to use the call bell but was not always aware that the bell had been activated when staff responded.

Interview with RAI-coordinator was completed by inspector #194 on an identified date related to resident #036's falls. RAI coordinator has provided a report with all falls for resident #036 since 2014, with only two falls identified.

First fall was in 2014 where the progress notes reviewed by inspector describe the

fall as the resident being "found in room with legs underneath side rails near the end of the bed". The identified fall resulted in injury from the bed rails.

The second fall was in 2016 were progress notes indicated that resident #036 was found on the floor beside the bed with both rails in place. The identified fall resulted in injury from the bed rail".

Resident #036 remains at risk for falls, with a history of entrapment risk and remains at risk of possible entrapment as no alternatives action has been taken by the home to address the identified entrapment zones 4 and 6. [s. 15. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 #010 related to continence was provided specified in the plan.

Log #005055-17 involving resident #010;

Resident #010 is cognitively able to direct care needs with good recall of care being provided by staff, able to utilize the call bell, is able to mobilize independently with use mobility aide. Resident #010 requires 2 staff assist with all ADL's.

The plan of care for resident #010 related to continence directs that staff assist resident #010 with continence and ensure that the call bell is in the resident's hand before leaving.

A Critical Incident (CI) was submitted to the Director for incident of alleged neglect involving resident #010 occurring on an identified date. The CI indicated that staff had left resident #010 and the call bell was not accessible during continence care. During interview with inspector on May 15, 2017 resident #010 reported that an other incident had also occurred.

Review of the abuse investigation directed that the PSW staff involved in the initial incident forgot to place the call bell where resident #010 would be able to access it. During interviews with PSW #111 and RPN #112, staff confirmed that there had been an other incident where the call bell was not left accessible for resident #010.

The plan of care for resident #010 was not provided when the call bell was not left accessible for the resident when being assisted with continence care. [s. 6. (7)]

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 by ensuring that resident #010 is provided access to the call bell when assisted to the bathroom by staff., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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. Log #005055-17 involving resident #010;

Resident #010 reported to inspector #194 during interview on May 15, 2017 remembering two recent incidents when being left without the call bell within reach during continence care. One incident had been reported by the home in a Critical Incident Report. Further interviews with PSW #111 and RPN #112 indicated that another incident had occurred but neither staff were able to remember the exact date of the incident. PSW #111 indicated during interview with inspector #194 that the incident was reported to RPN #112 . On an identified date during interview RPN #112 indicated recalling the incident stating that the Charge nurse was not notified, an investigation was not initiated, the resident was not assessed and the incident was not documented..

Review of the licensee's "Abuse and Neglect of a resident -Actual or suspected", Policy # VII-G-10.00 dated January 2017 directs that:
-If a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, or co-worker, the following steps must be taken;
-safeguard the resident immediately
-notify the Nurse

The Nurse will:
-Safeguard the resident immediately - assess injuries, provide medical interventions if indicated
-Notify the RN in Charge of the home
-Immediately notify the DOC/Administrator
-Initiate the Nursing checklist for reporting and investigating Alleged abuse
-assess and evaluate the injuries and document each shift for a minimum for 72 hours post incident

RPN #112 failed to comply with the licensee's abuse policy when PSW #111 reported an allegation of neglect involving resident #010 and the Charge nurse was not notified, resident #010 was not assessed, the DOC/Administrator was not notified and the incident was not documented. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (ii) Neglect of a resident by the licensee or staff

Log #005055-17 involving resident #010;

Resident #010 reported to inspector #194 during interview on an identified date remembering two recent incidents of being without the call bell within reach during continence care. One incident had been reported by the home in a Critical Incident Report. Further interviews with PSW #111 and RPN #112 indicated that another incident had occur but neither staff were able to remember the exact date of the incident. PSW #111 indicated during interview with inspector #194 that the incident was reported to RPN #112 . On an identified date during interview RPN #112 indicated recalling the incident but stated that an immediate investigation into the allegations of neglect for resident #010 was not initiated. [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Log #005055-17 involving resident #010;

Resident #010 reported to inspector #194 during interview on an identified date remembering two recent incidents of being left without the call bell within reach during continence care. Resident #010 was not able to provide exact dates for each of the incidents. One incident had been reported by the home in a Critical Incident Report. Inspector #194 reported the allegations of neglect to the DOC following the interview with Resident #010. Further interviews with PSW #111 and RPN #112 indicated that another incident had occurred but neither staff were able to remember the exact date of the incident. PSW #111 indicated during interview with inspector #194 that the incident was reported to RPN #112 . On an identified date during interview RPN #112 indicated recalling the incident but stated that the Charge nurse had not been informed of allegations of neglect by resident #010. The Director was not notified of the allegations of staff neglect of the resident on the evening shift in April 2017. [s. 24. (1)]

Issued on this 13 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHANTAL LAFRENIERE (194) - (A1)

Inspection No. / No de l'inspection : 2017_603194_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 004483-17, 004488-17, 004799-17, 005055-17 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jul 13, 2017;(A1)

Licensee / Titulaire de permis : TRENT VALLEY LODGE LIMITED
195 Bay Street, TRENTON, ON, K8V-1H6

LTC Home / Foyer de SLD : TRENT VALLEY LODGE LIMITED
195 BAY STREET, TRENTON, ON, K8V-1H9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Bill Weaver

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 TRENT VALLEY LODGE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_603194_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee is ordered to:

1. Immediately implement measures to minimize the risk of entrapment to Resident # 036 identified in the Facility Entrapment testing completed in December 2016. Ensure that steps are immediately implemented to minimize the risk of entrapment to residents identified in future Facility Entrapment testing conducted at the home.

2. Develop and implement a documented multidisciplinary team assessment process for all residents with one or more bed rails in use, and for all residents for which the use of one or more bed rails are being considered. The process shall include a sleeping environment assessment and the observation of the resident in bed, for a specified period of time.
The individual resident assessment and sleeping environment assessment shall specifically include all factors, elements and conditions as outlined in

the prevailing practices document Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

3. Ensure that the multidisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or changes are trialed if appropriate and dependent on the residents assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from use of any bed rails.

4. Ensure that the multidisciplinary team reassesses residents with one or more bed rails in use, at a minimum, whenever there is a change in the residents' health status.

5. Ensure that the multidisciplinary team clearly documents the final results of the assessment/reassessment, including the risk-benefit analysis and ensuing recommendation

6. Update the written plan of care based on the residents assessment/ reassessment by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document.

7. Develop and deliver education to all staff who have involvement with the use of bed rails in the home with regards to Ontario Regulation 79/10, s. 15 (1) (a), related to the assessment of the resident in accordance with the FDA 2003 clinical guidance document, to minimize risk to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and the bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On February 21, 2017 the Licensee was served a Compliance Order to O. Reg 79/10 s. 15(1). The order type was per LTCHA, 2007 s. 153(1)(a), in that the Licensee was ordered to take specified action to achieve compliance. The Compliance Order was to have been complied with by May 5, 2017.

On May 18, 2017 during interview with inspector #194, DOC has indicated that where bed rails are used, the residents have not been assessed and the bed system evaluated in accordance with evidence-based practices. DOC indicated during same interview that review of an assessment tool was currently being completed by an interdisciplinary team and would be implemented in the near future.

Resident #003, #002 and #006 and #036 were observed by inspector #194, with bed rails in use when residents were in bed. Clinical heath records for resident #003, #002, #006 and #036 were reviewed identifying the resident's as being at high risk for falls. On May 11, 2017 during Interviews with PSW #107 and #105, PSW staff indicated the use of the bed rails for the above noted residents while in bed was to assist with repositioning [s. 15. (1) (a)]
(194)

2. The licensee has failed to ensure that steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Review of the licensee's current bed system evaluation was conducted by inspector #194. All identified entrapment zone previously identified in the December 2016's evaluation have been addressed, except for resident #036's bed. ESM and Maintenance staff indicated that resident #036 was provided an alternate bed with no bed rails on an identified date to address Zone 4 for entrapment. Inspector #194 was not provided any evidence to support any measures in place to address Zone 6 (head of the bed) entrapment zone for resident #036. ESM and Maintenance staff

explained that resident #036 was not happy with the change in beds and wanted the previous bed and rails returned. Interview with DOC also supported that the SDM for resident #036 did not want any change to the bed system for resident #036. A care conference was held with the SDM on an identified date to further discuss the risks identified with entrapment but again the SDM indicated that no change be made to resident #036's bed. No further attempts have been made to minimize the identified entrapment zones for resident #036. At the time of the inspection resident #036 was still occupying the bed identified with entrapment zones 4 and 6.

The plan of care for resident #036 indicated bed rails and bed alarm in place when in bed. Resident #036 requires a mechanical lift, 2 staff assist for all transfers, toileting and bed mobility. Resident #036 requires 30 minute checks while in bed for safety and is at high risk for falls.

PSW #106 also indicated that during the day resident #036 will attempt to get out of the lower part of the bed to try and stand. PSW #106 indicated that resident #036 is at risk for falls, but has not had any recent falls. PSW#106 also indicated that resident #036 is a two staff assist with mechanical lift for all transfers, had limited ability to roll independently while in bed requiring 2 staff assist, was provided with bed alarm while in bed and was able to use the call bell but was not always aware that the bell had been activated when staff responded.

Interview with RAI-coordinator was completed by inspector #194 on an identified date related to resident #036's falls. RAI coordinator has provided a report with all falls for resident #036 since 2014, with only two falls identified.

First fall was in 2014 where the progress notes reviewed by inspector describe the fall as the resident being "found in room with legs underneath side rails near the end of the bed". The identified fall resulted in injury from the bed rails.

The second fall was in 2016 were progress notes indicated that resident #036 was found on the floor beside the bed with both rails in place. The identified fall resulted in injury from the bed rail".

Resident #036 remains at risk for falls, with a history of entrapment risk and remains at risk of possible entrapment as no alternatives action has been taken by the home to address the identified entrapment zones 4 and 6. [s. 15. (1) (b)] (194)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

Aug 11, 2017(A1)

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 or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13 day of July 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHANTAL LAFRENIERE

Service Area Office /
Bureau régional de services : Ottawa