

**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 West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2020	2020_739694_0015 (A1)	003151-20, 004428-20, 005438-20, 006668-20, 007058-20	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

Amended by AMANDA COULTER (694) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date has been extended to October 4, 2020.

Issued on this 17th day of September, 2020 (A1)

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

Original report signed by the inspector.

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

Amended by AMANDA COULTER (694) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 2, 7, 8, 9, 10, 13, 14, and 15, 2020.

**This inspection was conducted concurrently with Complaint Inspection
#2020_739694_0014.**

The following intakes were completed during this inspection:

**Follow up inspection to CO#001 from inspection #2020_826606_0002, related to
LTCHA, 2007, c.8, s. 6 (7) related to plan of care.**

Critical Incident (CI) system intakes:

Log #004428-20, related to a medication incident,

Log #005438-20, Log #006668-20, and Log #007058-20, related to fall prevention.

**During the course of the inspection, the inspector(s) spoke with the
Administrator, Director of Care (DOC), Registered Nurses (RN), Registered
Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping aid,
laundry aid, physiotherapy assistant (PTA), family members and residents.**

**The inspectors also toured the home, observed the provision of care and
services , reviewed relevant documents, including but not limited to clinical
records, policies and procedures, internal investigation and training records.**

The following Inspection Protocols were used during this inspection:

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**Critical Incident Response
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation**

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

**6 WN(s)
2 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.O. 2007, c.8 s. 6. (7)	CO #001	2020_826606_0002	694

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.)</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131.
Administration of drugs**

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

Inspection Report under
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durée

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A critical incident (CI) system report was submitted to the Director regarding a medication incident where a specific resident did not receive prescribed medication over several days.

The resident's clinical record identified that the resident was assessed by a nurse practitioner related to signs and symptoms of an infection. Diagnostic tests were to be completed and the resident was prescribed a medication. The resident was reassessed a few days later and a new medication was prescribed. External agencies were to provide nursing support for the medication administration. The electronic medication administration record (eMAR) and progress notes showed the resident did not receive their prescribed dose on a number of dates, and was transferred to hospital.

The resident was hospitalized and received treatment.

The DOC said registered staff should have notified the nurse practitioner or physician on call when the resident did not receive the prescribed medication and had worsening symptoms.

The licensee failed to ensure that drugs were administered to a resident in accordance with the direction for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

(A1)

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

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.
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.**
- 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.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

Findings/Faits saillants :

Inspection Report under
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durée

1. The licensee has failed to ensure the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm, immediately report the suspicion and information upon which it was based to the Director.

A) Critical Incident (CI) system report was submitted to the Director related to a specific resident who sustained injuries as a result of an incident of alleged improper care. The resident was transferred to the hospital immediately for further medical assessment.

B) A CIS report was submitted to the Director regarding a specific resident who sustained injuries during the provision of care.

DOC #101 acknowledged both incidents were not reported immediately to the Director.

The licensee has failed to ensure the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm immediately report the suspicion and information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm immediately report the suspicion and information upon which it was based to the Director,, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure staff used safe transferring techniques when assisting a resident.

A CI report was submitted to the Director related to a resident who sustained injuries during a transfer.

The home's records documented that staff did not use the proper technique when applying equipment which resulted in the resident falling.

Staff interviewed said it was difficult to apply the equipment properly.

Review of the equipment instruction sheet identified that staff did not follow the safety guidelines.

The DOC said the staff should have ensured the environment was safe before completing the transfer.

The licensee has failed to ensure staff used safe transferring techniques when transferring a resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff used safe transferring techniques when assisting a resident,, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was revised when the resident's care needs changed.

A CI was submitted to the Director related to an incident that occurred where a resident sustained injuries during a transfer.

The resident's care plan documentation and interviews with staff said the resident required a different type of equipment for the transfer.

Registered staff said they assessed the resident for the new equipment, but had forgotten to update the resident's care plan.

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed related to the sling type and size required for transfers. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of a medication incident for which a resident is taken to hospital.

A Critical incident (CI) system report was submitted to the Director reporting a medication incident.

A resident was prescribed a medication on a specific date and the resident did not receive the medication for a number of days. The resident was transferred to hospital.

The DOC acknowledged they submitted the CI report regarding a medication incident when the resident returned to the home from hospital, a number of days after the incident was discovered.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of a medication incident for which a resident was sent to hospital. [s. 107. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1). (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A resident's clinical record was reviewed which showed that the resident had not received a number of doses of a medication that was prescribed.

Registered staff were interviewed and told the Long-Term Care Homes (LTCH) inspector that medication errors were to be immediately reported to the supervisor, an incident report was to be completed (and sent to pharmacy, the resident or substitute decision maker (SDM) notified and the doctor or nurse practitioner that prescribed the medication notified. The DOC acknowledged they were not aware of the missed medication doses until a number of days later, when the resident's condition required a transfer to hospital for medical treatment.

The licensee failed to ensure that a medication incident involving a resident was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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foyers de soins de longue
durée**

Issued on this 17th day of September, 2020 (A1)

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

Original report signed by the inspector.

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

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**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** Amended by AMANDA COULTER (694) - (A1)

**Inspection No. /
No de l'inspection :** 2020_739694_0015 (A1)

**Appeal/Dir# /
Appel/Dir#:**

**Log No. /
No de registre :** 003151-20, 004428-20, 005438-20, 006668-20,
007058-20 (A1)

**Type of Inspection /
Genre d'inspection :** Critical Incident System

**Report Date(s) /
Date(s) du Rapport :** Sep 17, 2020(A1)

**Licensee /
Titulaire de permis :** Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, MARKHAM,
ON, L3R-4T9

**LTC Home /
Foyer de SLD :** Extendicare Halton Hills
9 Lindsay Court, Georgetown, ON, L7G-6G9

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** Emily Bosma

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 Extencicare (Canada) Inc., you are hereby required to comply with the following
order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # /

No d'ordre: 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg., 2007, s. 131(2)
Specifically, the licensee shall ensure that:

- a) Resident #002 shall be administered medication in accordance with the directions specified by the prescriber; and
- b) All registered staff shall receive education related to the home's medication management policies and procedures, specifically, the reporting of medication incidents. When external agencies are unable to provide necessary nursing support for intravenous (IV) medication administration, the education should include clear direction to registered staff of what to do.

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term
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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

Grounds / Motifs :

(A1)

1. The licensee failed to ensure that every medication incident involving a resident is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A resident's clinical record was reviewed which showed that the resident had not received a number of doses of a medication that was prescribed.

Registered staff were interviewed and told the Long-Term Care Homes (LTCH) inspector that medication errors were to be immediately reported to the supervisor, an incident report was to be completed (and sent to pharmacy, the resident or substitute decision maker (SDM) notified and the doctor or nurse practitioner that prescribed the medication notified. The DOC acknowledged they were not aware of the missed medication doses until a number of days later, when the resident's condition required a transfer to hospital for medical treatment.

The licensee failed to ensure that a medication incident involving a resident was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

The severity of this issue was a level 3 as there was actual harm. The scope was level 1 as it involved one out of three residents. The home had a level 3 history of a previous non compliance (NC) to the same subsection with a Voluntary Plan of Correction (VPC) during a Resident Quality Inspection (RQI) #2017_482640_0013 issued on October 26, 2017.

(694)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Oct 04, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
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2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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

**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, 11^e 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

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foyers de soins de longue durée*, L.O.
2007, chap. 8

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
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 17th day of September, 2020 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

Amended by AMANDA COULTER (694) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Central West Service Area Office