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 sous la Loi de 2007 sur 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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017	2017_418615_0021	015179-17	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

THE FORDWICH VILLAGE NURSING HOME
3063 Adelaide Street Fordwich ON N0G 1V0

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

HELENE DESABRAIS (615), DEBRA CHURCHER (670)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 24, 25, 26, 27 and 28, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection:

Follow up Log# 008226-16 to a compliance order from inspection 2016_217137_0005 related to ensuring that a registered nurse is on duty and present in the home at all times, except as provided for in the regulations.

Critical Incident System (CIS) report 0995-000006-17/ Log# 009937-17 related to maintenance services;
Critical Incident System (CIS) report 0995000002-17/ Log# 002702-17 related to prevention of abuse, neglect and retaliation;
Critical Incident System (CIS) report 0995-000007-16/ Log#028469-16 related to prevention of abuse, neglect and retaliation;

Complaint IL-45540-LO/ Log# 020280-16 related to hazardous substances;

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Administrator/DOC), the Administrator Assistant (AA), one Registered Nurse/Behavioural Support Ontario (RN-BSO), two Registered Nurses (RNs), one Registered Practical Nurse/Resident Assessment Instrument Coordinator (RPN/RAI Coordinator), two Registered Practical Nurses (RPNs), seven Personal Support Workers, the Family and Residents' Council representatives, over 20 residents and three family members.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 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. 8. (3)	CO #001	2016_217137_0005	615

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to resident to resident alleged abuse.

A review of a resident's progress notes, on a specific date, stated that a PSW witnessed an incident of aggression towards another resident. The resident sustained injuries and the resident appeared very distressed at the time of the incident.

While reviewing the resident's progress notes a different incident of aggression towards another resident was found. According to the progress note, the resident had been having increasing responsive behaviours.

A review of the resident's progress notes, on a specific date, stated that the resident had been demonstrating specific behaviours.

A review of the home’s policy Behavioral Management Program/Assessment, index I.D. RCSM G-45, dated April 2016, stated "Residents with challenging and/or disruptive behaviors will have a behavioral assessment done by using one of the following accepted assessment tools including: Cohen Mansfield Agitation Inventory, Mini-Mental Assessment, Depression Assessment and/or DOS assessment to track the occurrence of behavior and implement strategies to manage the challenging behavior. The tool will be used for new admissions with a known behavior and/or when residents display a change in behavior which becomes challenging and/or disruptive".

A review of the resident's last responsive behaviour assessment, indicated that the resident was not exhibiting the specific behaviours. There was no documented evidence that the resident was reassessed for responsive behaviours before the incidents occurred.

A review of the home's BSO documented list of residents demonstrating responsive

behaviours and followed by the BSO team did not include the resident.

During interviews, a RN, a RPN and a PSW, said that the resident had been demonstrating the increasing behaviours for a specified time frame, that it was a change in behaviour and no responsive behaviour assessment was completed. The RPN stated that the resident was referred to the BSO team only months after the incidents occurred.

During interviews, the AA and the RN, both said that it was the home's expectation that when a resident demonstrated responsive behaviours, they would be assessed to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between the resident and other residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

The severity was determined to be a level 3 as there was actual harm. The scope of this issue was determined to be a isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 54. (a)]

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. (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 that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of a resident Minimum Data Set (MDS) assessment, on a specific date, stated that the resident was frequently incontinent. During the same time the resident's Continence assessment, stated that the resident was incontinent and care plan, stated that the resident was continent.

A review of the home's policy RCSM D-10 Continence Care: Bowel and Bladder Management, last updated April 2016, stated "each resident has an individualized plan as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment. The plan is then implemented and updated as required".

During an interview, an RPN acknowledged that the resident's condition had changed and the resident was now frequently incontinent and stated that the care plan was not accurately updated to reflect the resident's condition and needs.

During an interview, a RN stated that it would be the home's expectation that the resident's care plan would be updated to reflect their current condition and needs.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

A CIS report was submitted by the home to the MOHLTC, on a specific date, related to resident to resident alleged abuse.

A review of the CIS stated that the alleged abuse of a resident to another resident took place on a specific date was only reported to the MOHLTC two days later.

During this inspection, the Inspector, found a different incident of abuse while reviewing a resident progress notes, at a earlier date. According to the progress note, the resident had been having increasing responsive behaviours. This incident was not reported to the Director.

A review of the home's abuse policy Index I.D. LGM A-10, dated March 2014, stated in part, when resident abuse is suspected: on becoming aware of abuse or suspected abuse, the person first having knowledge of this shall immediately inform the Administrator, or if not available, the Director of Nursing/or Delegate. The Administrator or Director of Nursing must inform the family or responsible party for the resident of the

incident and immediate action(s) taken. The Administrator or Director of Nursing must inform the family or responsible party for the resident of the incident and immediate action(s) taken. The Administrator or Director of Care must notify the Police, Ministry of Health-Director, and the CEO".

During interviews, the an RN and a RPN stated that both incidents were abuse and that the home's expectation was that they should have been reported immediately to the Director.

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

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was submitted by the home to the MOHLTC, on specific date, related to resident to resident alleged abuse.

During this inspection, the inspector found a different incident of alleged abuse while reviewing a resident's progress notes, at a earlier date. According to the progress note, the resident had been having increasing responsive behaviours. This incident was not reported to the Substitute Decision Maker (SDM) and there was no documented evidence that the residents SDM or family had been notified.

A review of the home’s abuse policy Index I.D. LGM A-10, dated March 2014, stated in part, "when resident abuse is suspected: on becoming aware of abuse or suspected abuse, the person first having knowledge of this shall immediately inform the Administrator, or if not available, the Director of Nursing/or Delegate. The Administrator or Director of Nursing must inform the family or responsible party for the resident of the incident and immediate action(s) taken".

During interviews, the AA, a RN, a RPN and a PSW, stated that the incident was abuse, that the SDM was not notified and the home's expectation was that the SDM or family should have been notified.

The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

A CIS report was submitted by the home to the MOHLTC, on a specific date, related to resident to resident alleged abuse.

A review of a resident's progress notes, on a specific date, stated that a PSW witnessed an incident of aggression towards another resident. The resident appeared to be very aggressive. The other resident sustained injuries and appeared very distressed at the time of the incident. There was no documented evidence that a police force was notified of the incident.

A review of the home’s abuse policy Index I.D. LGM A-10, dated March 2014, stated in part, when resident abuse is suspected: on becoming aware of abuse or suspected abuse, the person first having knowledge of this shall immediately inform the Administrator, or if not available, the Director of Nursing/or Delegate. The Administrator or Director of Nursing must inform the family or responsible party for the resident of the incident and immediate action(s) taken. The Administrator or Director of Care must notify the Police, Ministry of Health-Director, and the CEO".

During interviews, the AA, a RN, a RPN and a PSW, stated that the incident was abuse, the police was not notified and the home's expectation was that the appropriate police force should have been notified.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 98.]

Issued on this 24th day of November, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HELENE DESABRAIS (615), DEBRA CHURCHER (670)
Inspection No. / No de l'inspection :	2017_418615_0021
Log No. / No de registre :	015179-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 23, 2017
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	THE FORDWICH VILLAGE NURSING HOME 3063 Adelaide Street, Fordwich, ON, N0G-1V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacques Dupuis

To ATK CARE INC., 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

Specifically, the home will ensure that a specific resident and other residents demonstrating challenging and/or disruptive behaviors will receive an interdisciplinary assessment, or reassessment, completed to identify factors that could potentially trigger such altercations; and identifying and implementing interventions. Demonstrate responsible person(s) and methods for communicating with staff.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to resident to resident alleged abuse.

A review of a resident's progress notes, on a specific date, stated that a PSW witnessed an incident of aggression towards another resident. The resident sustained injuries and the resident appeared very distressed at the time of the incident.

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A review of the home's policy Behavioral Management Program/Assessment, index I.D. RCSM G-45, dated April 2016, stated "Residents with challenging and/or disruptive behaviors will have a behavioral assessment done by using one of the following accepted assessment tools including: Cohen Mansfield Agitation Inventory, Mini-Mental Assessment, Depression Assessment and/or DOS assessment to track the occurrence of behavior and implement strategies to manage the challenging behavior. The tool will be used for new admissions with a known behavior and/or when residents display a change in behavior which becomes challenging and/or disruptive".

A review of the resident's last responsive behaviour assessment, indicated that the resident was not exhibiting the specific behaviours. There was no documented evidence that the resident was reassessed for responsive behaviours before the incidents occurred.

A review of the home's BSO documented list of residents demonstrating responsive behaviours and followed by the BSO team did not include the resident.

During interviews, a RN, a RPN and a PSW, said that the resident had been demonstrating the increasing behaviours for a specified time frame, that it was a change in behaviour and no responsive behaviour assessment was completed. The RPN stated that the resident was referred to the BSO team only months after the incidents occurred.

During interviews, the AA and the RN, both said that it was the home's expectation that when a resident demonstrated responsive behaviours, they would be assessed to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between the resident and other residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

The severity was determined to be a level 3 as there was actual harm. The scope of this issue was determined to be a isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 54. (a)] (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2017

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 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, 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
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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

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 October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Helene Desabrais

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