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 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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 1, 2019 | 2019_765541_0006 | 030862-18 | Critical Incident System |

### Licensee/Titulaire de permis

Gibson Holdings (Ontario) Ltd.
343 Amherst Drive Amherstview ON K7N 1X3

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

Helen Henderson Nursing Home
343 Amherst Drive Amherstview ON K7N 1X3

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

AMBER LAM (541)

### 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): February 20 and 21, 2019**

**Log #030862-18 (Critical Incident #2728-000009-18) - a resident fall with significant change in health status was inspected.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), a Registered Nurse, Registered Practical Nurses, Personal Support Workers and residents. In addition, the inspector reviewed resident health care records and the home's Fall Prevention and Management policy.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy the policy was complied with.

In accordance with O.Reg 79/10 s. 48(1)1 the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management policy effective May 2018 which is part of the licensee's Fall prevention and management program.

The licensee's Falls Prevention and Management policy stated that Post Falls Assessment the registered staff will:
- Notify the resident's POA of the fall.
- Initialize the Head Injury Routine (HIR) if head injury is suspected or if the resident fall is not witnessed. The attached HIR policy stated that vitals and neuro assessment is to be completed every 1 hour for 4 hours, then every 4 hours for the next 24 hours OR as determined by the physician.
- Re-evaluate and update Care Plan/Kardex's with fall and appropriate interventions required
- Review and update Falls Risk Assessment in PCC

Under Evaluation, the policy further stated a monthly review and compilation of falls will be completed and presented to the Restorative Care Team. A review of causes, frequent fallers, interventions, trends will be reviewed by the restorative team.

As described in WN #2, resident #001 sustained an unwitnessed fall on a specified date and time. Resident #001's vitals were obtained immediately following the fall and their blood pressure was noted to be high. The resident's vitals were obtained every 1 hour for 4 hours following the fall. Approximately six hours following the fall, resident #001 had emesis and a high blood pressure. Vitals were obtained as scheduled at a specified time but were not taken again until eight hours later when the resident's blood pressure remained high. A progress note indicated resident #001 was having nausea and vomiting again a specified time and their blood pressure remained high.

Over 24 hours after resident #001's fall, RN #111 assessed resident #001 and contacted their POA to obtain consent to send the resident to hospital to investigate a possible injury as a result of the fall. Resident #001's POA indicated not being aware of the resident's fall which occurred over 24 hours prior.

Resident #001's physician was not contacted regarding the resident's fall or change in vital signs until a specified time, a day and a half following the fall, therefore had not provided direction to staff regarding monitoring of resident's vitals.

Inspector #541 interviewed DOC #101 who stated that resident #001's vitals were not taken as described in the policy. RPN #103 worked the day shift following residents fall. When asked by Inspector #541 why resident #001's POA was not contacted regarding the fall, RPN #103 stated that they had thought the RN working the previous night had done this. ADOC #102 indicated the expectation would have been for RPN #103 to contact the POA on the day shift as resident #001's fall occurred late at night. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #003 sustained a fall on a specified date and time and was observed by staff to have hit their head. Resident #003's vitals were taken immediately following the fall at a specified time and every one hour for four hours and again four hours later at a specified time. The resident's vitals were not obtained again until eight hours later and then were not taken again until over 24 hours later.

A progress note written 24 hours following resident #003's fall, included information indicating it was possible resident #003 was showing signs of a head injury.

When the on-call physician was notified of resident #003's condition, the physician noted the resident could be demonstrating signs of a head injury but would require further

investigation to determine.

Inspector #541 interviewed DOC #101 who stated that resident #003's vitals were not taken as described in the policy. The DOC stated that the home has recently switched to electronic documentation for monitoring vitals for HIR as staff requested the electronic notification to remind them to complete the task.

Inspector reviewed resident #003's assessments to determine the resident's fall risk. It was noted that resident #003's fall risk assessment was not completed following the resident's fall on November 23, 2018.

3. As per WN #2, resident #002 had a fall on a specified date and time. Inspector reviewed resident #002's assessments to determine the resident's fall risk. It was noted that resident #002's fall risk assessment was not completed following the resident's fall.

Inspector reviewed resident #003's assessments to determine the resident's fall risk. It was noted that resident #003's fall risk assessment was not completed following the resident's fall on the specified date.

During an interview with inspector #541, the DOC further stated it is the expectation of registered staff to update the fall risk assessment following a residents' fall.

Inspector #541 requested the home's monthly review of falls by the restorative care team from DOC #101. Upon review of the information provided it was noted that there was no meeting held in a specified month to review the falls for residents #001, 002 and 003 that occurred the month prior. There was a meeting held in two months later however the falls that occurred in the specified month were not discussed. It is noted the home had a total of 48 resident falls in a one month specified time period that were not discussed by the restorative care team.

The licensee failed to follow their fall prevention and management policy in that:

- Resident #001 and #003 did not have their vitals taken every 4 hours for the 24 hours following fall as directed by the HIR policy, when both residents exhibited signs of a head injury.
- Resident #001's POA was not notified of the resident's fall until over 24 hours after it had occurred.
-Following resident #002 and #003's falls, an updated falls risk assessment was not

completed.
- There was no monthly meeting held to discuss the 48 falls in the home that occurred in a specified month, including the falls of residents #001, 002 and 003. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**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 care set out in resident #001's plan of care was provided to the resident as specified in the plan.

Resident #001 was identified to be at risk of falls and the resident's plan of care for falls indicated the resident was to have a specified fall prevention intervention in place.
On a specified date and time, staff were notified that resident #001 had fallen when the resident's roommate rang the call bell. Resident #001 was found on the floor beside the bed.

The post-fall assessment tool completed following the fall indicated the resident's specified fall prevention intervention was not functioning at the time of the fall.
Inspector #541 interviewed ADOC #102 who submitted the critical incident report. The

ADOC confirmed resident #001's specified fall prevention intervention was not functioning at the time of the fall.

As a result of the fall, resident #001 sustained a specified injury.

The licensee failed to ensure that resident #001's specified fall prevention intervention was in place and functioning, as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that resident #002's plan of care related to falls prevention was updated when the care set out in the plan was no longer necessary.

Resident #002 is identified at risk of falls due to pain and decreased strength. Resident #002 sustained a fall on November 13, 2018 at 2250 hours.

A review of resident #002's health care record indicated a specified fall prevention intervention was initiated as a fall prevention intervention on a specified date. On a later specified date, fall prevention intervention was discontinued as it was not an effective fall prevention intervention.

Interviews with RN #111 and PSWs #107, 108 and 109 confirmed that resident #002 had not had the specified fall prevention intervention in place since a specified date. RN #111 further stated another fall prevention intervention was tried but this was also ineffective. The RN and PSWs interviewed stated that the resident does have one specified intervention in place for fall prevention.

Resident #002's current care plan related to falls was reviewed. Under interventions, the plan stated the resident is to have all three above noted fall prevention interventions in place, including the one that had been discontinued and the other that was trialed but not implemented. Resident #002's kardex was reviewed and there are no interventions present related to fall prevention.

PSW #104 was asked by Inspector #541 where resident specific fall prevention interventions can be located and stated they would be found in both the resident's care plan or the resident's kardex. PSW #110 was unsure where this information would be found and stated that they would ask a registered staff member.

RPN #112 stated that fall prevention interventions are located in the resident care plan and the kardex, which the front line staff have access to via their electornic

documentation system.

The Director of Care (DOC) #101 was interviewed and confirmed that resident #002 no longer has two specified interventions in place for falls prevention. DOC #101 further stated that the kardex or care plan would direct staff to resident specific fall prevention interventions. DOC confirmed that resident #002 has no interventions in the kardex related to falls and the care plan has not been updated to reflect the discontinuation of a clip and bed alarm.

The licensee failed to ensure that when resident #002's specified fall prevention interventions were discontinued that the care plan was updated to reflect the change and failed to ensure that resident #002's kardex reflected the fall prevention interventions in place. [s. 6. (10) (b)]

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**Issued on this 1st day of March, 2019**

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

**Original report signed by the inspector.**

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

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

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

**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) :** | AMBER LAM (541) |
| **Inspection No. / No de l'inspection :** | 2019_765541_0006 |
| **Log No. / No de registre :** | 030862-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Mar 1, 2019 |
| **Licensee / Titulaire de permis :** | Gibson Holdings (Ontario) Ltd.<br>343 Amherst Drive, Amherstview, ON, K7N-1X3 |
| **LTC Home / Foyer de SLD :** | Helen Henderson Nursing Home<br>343 Amherst Drive, Amherstview, ON, K7N-1X3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lisa Gibson |

To Gibson Holdings (Ontario) Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

**Ministère 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

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**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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with O. Reg 79/10 s. 8(1).

Specifically, the licensee must comply with their policy titled Falls Prevention and Management by ensuring:
a.) Residents #001 and 002 and any other resident who requires fall prevention interventions, have an updated plan of care and kardex to reflect the current fall prevention interventions in place.
b.) Registered nursing staff, as per the Falls Prevention and Management policy, complete an updated fall risk assessment post-fall for every resident that sustains a fall.
c.) When a resident falls and a serious injury is suspected, the resident's POA is contacted as soon as possible.
d.) The restorative care team shall meet on a monthly basis to review resident falls, causes, frequent fallers, interventions and trends related to falls. This review shall be documented.
e.) Ensure that any resident who sustains an unwitnessed fall or is known to have hit their head, shall have the Head Injury Routine initiated, completed and documented as required under the licensee's policy Falls Prevention and Management.

In addition, the licensee shall ensure:
- That resident #001 and any other resident who requires a specific fall prevention intervention, has the intervention in place.

**Grounds / Motifs :**

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy the policy was complied with.

In accordance with O.Reg 79/10 s. 48(1)1 the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management policy effective May 2018 which is part of the licensee's Fall prevention and management program.

The licensee's Falls Prevention and Management policy stated that Post Falls Assessment the registered staff will:
- Notify the resident's POA of the fall.
- Initialize the Head Injury Routine (HIR) if head injury is suspected or if the resident fall is not witnessed. The attached HIR policy stated that vitals and neuro assessment is to be completed every 1 hour for 4 hours, then every 4 hours for the next 24 hours OR as determined by the physician.
- Re-evaluate and update Care Plan/Kardex's with fall and appropriate interventions required
- Review and update Falls Risk Assessment in PCC

Under Evaluation, the policy further stated a monthly review and compilation of falls will be completed and presented to the Restorative Care Team. A review of causes, frequent fallers, interventions, trends will be reviewed by the restorative team.

As described in WN #2, resident #001 sustained an unwitnessed fall on a specified date and time. Resident #001's vitals were obtained immediately following the fall and their blood pressure was noted to be high. The resident's vitals were obtained every 1 hour for 4 hours following the fall. Approximately six hours following the fall, resident #001 had emesis and a high blood pressure. Vitals were obtained as scheduled at a specified time but were not taken again until eight hours later when the resident's blood pressure remained high. A progress note indicated resident #001 was having nausea and vomiting again a

specified time and their blood pressure remained high.

Over 24 hours after resident #001's fall, RN #111 assessed resident #001 and contacted their POA to obtain consent to send the resident to hospital to investigate a possible injury as a result of the fall. Resident #001's POA indicated not being aware of the resident's fall which occurred over 24 hours prior.

Resident #001's physician was not contacted regarding the resident's fall or change in vital signs until a specified time, a day and a half following the fall, therefore had not provided direction to staff regarding monitoring of resident's vitals.

Inspector #541 interviewed DOC #101 who stated that resident #001's vitals were not taken as described in the policy. RPN #103 worked the day shift following residents fall. When asked by Inspector #541 why resident #001's POA was not contacted regarding the fall, RPN #103 stated that they had thought the RN working the previous night had done this. ADOC #102 indicated the expectation would have been for RPN #103 to contact the POA on the day shift as resident #001's fall occurred late at night.
(541)

2. Resident #003 sustained a fall on a specified date and time and was observed by staff to have hit their head. Resident #003's vitals were taken immediately following the fall at a specified time and every one hour for four hours and again four hours later at a specified time. The resident's vitals were not obtained again until eight hours later and then were not taken again until over 24 hours later.

A progress note written 24 hours following resident #003's fall, included information indicating it was possible resident #003 was showing signs of a head injury.

When the on-call physician was notified of resident #003's condition, the physician noted the resident could be demonstrating signs of a head injury but would require further investigation to determine.

Inspector #541 interviewed DOC #101 who stated that resident #003's vitals

were not taken as described in the policy. The DOC stated that the home has recently switched to electronic documentation for monitoring vitals for HIR as staff requested the electronic notification to remind them to complete the task.

Inspector reviewed resident #003's assessments to determine the resident's fall risk. It was noted that resident #003's fall risk assessment was not completed following the resident's fall on November 23, 2018.

3. As per WN #2, resident #002 had a fall on a specified date and time. Inspector reviewed resident #002's assessments to determine the resident's fall risk. It was noted that resident #002's fall risk assessment was not completed following the resident's fall.

Inspector reviewed resident #003's assessments to determine the resident's fall risk. It was noted that resident #003's fall risk assessment was not completed following the resident's fall on the specified date.

During an interview with inspector #541, the DOC further stated it is the expectation of registered staff to update the fall risk assessment following a residents' fall.

Inspector #541 requested the home's monthly review of falls by the restorative care team from DOC #101. Upon review of the information provided it was noted that there was no meeting held in a specified month to review the falls for residents #001, 002 and 003 that occurred the month prior. There was a meeting held in two months later however the falls that occurred in the specified month were not discussed. It is noted the home had a total of 48 resident falls in a one month specified time period that were not discussed by the restorative care team.

The licensee failed to follow their fall prevention and management policy in that:

- Resident #001 and #003 did not have their vitals taken every 4 hours for the 24 hours following fall as directed by the HIR policy, when both residents exhibited signs of a head injury.
- Resident #001's POA was not notified of the resident's fall until over 24 hours after it had occurred.

-Following resident #002 and #003's falls, an updated falls risk assessment was not completed.
- There was no monthly meeting held to discuss the 48 falls in the home that occurred in a specified month, including the falls of residents #001, 002 and 003.

In addition, the licensee failed to comply with:
- LTCHA s. 6(7) as it relates to falls (See Written Notification #002)
- LTCHA s. 6(10) as it relates to falls (See Written Notification #002)

The severity of this issue was determined to be a level 2 as there is a potential for resident harm.The scope of the issue was a level 3 as licensee's Fall Prevention and Management policy was not followed for three out of three residents reviewed who sustained falls The home had a level 3 compliance history as there was one related non-compliance in the past 36 months that included:
- Written Notification (WN) issued June 22, 2016 (2016_236622_0017) (541)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 01, 2019

## 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
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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 1st day of March, 2019**

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

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

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