



**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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Oct 15, 2018	2018_565647_0027	023084-17, 008206-18	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection



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

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

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 1 - 5, 2018.

The following complaints were completed during this inspection:

- two related to staff shortages affecting resident care.

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), Staffing Coordinator, Restorative Care Coordinator, Staff Educator, Residents, Family Members and Substitute Decision Makers.

During the course of the inspection, the inspector(s) conducted observation in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Personal Support Services

Sufficient Staffing

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

4 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).

(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

The Director received four separate complaints, all regarding staff shortages and concerns over resident care and safety needs that were not met.

A review of the direct care staffing schedule from an identified period of time, indicated that there were between 69.5 (6.0 per cent) and 28 (2.5 per cent) unfilled direct care staff shifts.

In an interview with the Staffing Coordinator, they reviewed the nursing schedule and acknowledged the indicated unfilled shifts. The Staffing Coordinator further indicated that an unfilled shift was defined as a direct care shift that was not filled either due to a sick call, vacation time, or lack of staff to fill the shift and had not been isolated to a specific unit or shift.

During interviews with the above mentioned complainants, they indicated that staff worked without a full complement of direct care staff members and the following resident care was not accomplished:

- resident scheduled baths were not given,
- several call bells rang and staff were unable to answer them promptly,
- resident are incontinent in their briefs while waiting to use the washroom, and
- resident had been unable to return to bed as requested between meals.

In interviews with one family member (#118) and one resident (#001), they reported to the Inspector that they were concerned about the staffing "crisis" in the home and that residents' care needs were not being met. Family member #118 provided Inspector #647 an example of their parent not receiving assistance after the call bell had been ringing for 30 minutes. This family member further indicated to the Inspector that they had called the home several times before reaching a nurse to see if their parent got the help they needed. Resident #001 indicated to Inspector #647 that they had not received the care they needed and that this was an ongoing concern.

During interviews with Registered staff #100 and #109, and direct care staff #107, #110, #111, #112, #113, and #114, with the Inspector; they indicated that they often are forced to work short-handed due to sick calls, or no shows. They acknowledged that when they are short staffed they are required to prioritize resident care. These staff members indicated that due to the lack of staff, residents do not consistently get their scheduled



baths or showers, they are not able to return to bed between meals if they request, and if they have a toileting plan, it is not complied with.

During the same interview, direct care staff member #111 indicated that the most recent example was a weekend, there had been two out of four direct care staff members working and the scheduled baths could not be completed for residents #003, #004, #005, and #006. Direct care staff member #111 further indicated that these scheduled baths or showers were unable to be rescheduled as the following shifts were also short staffed.

A review of the documentation for resident's #003, #004, #005, and #006, confirmed that these residents had not received their scheduled baths or showers.

In an interview with the Administrator, they indicated that there were currently 11 direct care positions on the schedule that were vacant and confirmed that the home was currently short staffed four to five times per week. The Administrator further indicated that they do not access available agencies to assist them in filling the vacant lines. The Administrator confirmed during the interview that with the current number of vacant lines, resident care is not able to be consistently completed and resident care needs had not been met. [s. 8. (1) (b)]

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 plan of care was 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 of care was no longer necessary.

Inspector #647 reviewed a complaint submitted to the Director regarding concerns from resident #001 which related to lack of staff which resulted in resident care not being completed.

In an interview with resident #001, they indicated that they are often left for an extended period of time as there are not enough staff to return and complete care. Resident #001 completed the interview by stating there was a staffing problem in the home.

Inspector #647 reviewed the electronic plan of care, which indicated staff were to complete an identified intervention to indicate that there was a task left to be completed.

During observations by Inspector #647, there had not been the identified intervention of resident #001's room visible. Inspector #647 asked resident #001 if these had been current interventions to ensure resident #001 did not have to wait an extended period of time to complete their care. The resident stated that those interventions had stopped several months ago because they were not effective.

In an interview with Registered staff #115, they indicated that the identified intervention that had been put in place to ensure staff don't forget to return to resident #001 to complete care, had not been an effective intervention and should have been discontinued on the plan of care. This Registered staff member verified with Inspector #647 that it had not be "resolved" on the plan of care and the plan of care should have been revised to remove that intervention.

Together, Inspector #647 and the Director of Care (DOC) reviewed resident #001's most recent care plan and identified that the plan of care for resident #001's had not been revised with current interventions. [s. 6. (10) (b)]

2. Inspector #647 reviewed a complaint submitted to the Director regarding concerns related to the use of an identified mobility device by resident #002.

In an interview with the complainant, they indicated that they had concerns that resident #002 had been left with the identified mobility device for extended periods of time without supervision which had posed a risk of resident #002 falling. The complainant further



indicated that the mobility device had since been discontinued.

Inspector #647 reviewed the electronic plan of care, which indicated that the identified mobility device for resident #002 was still in place and had remained as a current intervention.

In an interview with Registered staff member #116, they indicated that the identified mobility device for resident #002 had been discontinued, and had no longer been a current intervention. This Registered staff member verified with Inspector #647 that it had not be resolved on the plan of care, and the plan of care should have been revised to remove that intervention.

Together, Inspector #647 and the DOC reviewed resident #002's most recent care plan and identified that the plan of care for resident #002's had not been revised with current interventions. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :



1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Director received four separate complaints, all regarding staff shortages and concerns over resident care and safety needs that were not met.

Together, with the Administrator, a review was completed of the staffing plan evaluations for 2017 and 2018 which indicated they were missing required information. The staffing plan evaluation that had been completed October 20, 2016, for implementation in 2017, had not included due dates of action items, summary of changes implemented, or dates that items had been implemented. The staffing plan evaluation that had been completed October 4, 2017, for implementation in 2018, had not been completed with due dates, action items or an outcome or evaluation. [s. 31. (4)]

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:**

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Director received four separate complaints, all regarding staff shortages and concerns over resident care and safety needs that were not met.

During interviews with Registered staff #100 and #109, and direct care staff #107, #110, #111, #112, #113, and #114, they indicated that when they are short staffed they are required to prioritize resident care. These staff members indicated that due to the lack of staff, residents do not consistently get their scheduled baths or showers.

During the same interview, direct care staff #111 indicated that there had been a recent weekend there had been two out of four direct care staff members working and the scheduled baths could not be completed for residents #003, #004, #005, and #006. This direct care staff member further indicated that these scheduled baths or showers were unable to be rescheduled as the following shifts were also short staffed.

Inspector #647 completed a record review of the bathing and shower schedule from an identified period of time. During this record review it had been identified that residents #003, #004, #005, and #006, had not been provided their scheduled bath or shower over the above indicated weekend.

This record review further indicated that these residents had not been rescheduled for their missed bath or shower and had not received their second required bath or shower in the week as per this legislation.

During an Interview with the Administrator, they were not aware that the above indicated residents had not received their scheduled bath or shower, however did confirm that the home had been short staffed approximately four to five times per week leaving the staff to prioritize care which did not include offering residents their scheduled bath or shower.
[s. 33. (1)]



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

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

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 26th day of October, 2018

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

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 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) : JENNIFER BROWN (647)

Inspection No. /

No de l'inspection : 2018_565647_0027

Log No. /

No de registre : 023084-17, 008206-18

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Oct 15, 2018

Licensee /

Titulaire de permis : Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services, 5 Beck Boulevard,
PENETANGUISHENE, ON, L9M-1C1

LTC Home /

Foyer de SLD : Roberta Place
503 Essa Road, BARRIE, ON, L4N-9E4

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Megan Merz

To Barrie Long Term Care Centre 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 # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The Licensee must be compliant with s. 8. (1) (b) of the Long-Term Care Home Act.

The licensee shall prepare, submit and implement a plan to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

The plan must include, but is not limited, to the following:

- Review, revise and implement a staffing plan to ensure that assessed resident care and safety needs are met;
- Develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that is missed is followed up with; and
- Improve the communication between staff and management to determine gaps in providing resident care, safety issues, and actions taken by providing and recording monthly staff meetings.

Please submit the written plan for achieving compliance for inspection 2018_565647_0027 to Jennifer Brown, LTC Homes Inspector, MOHLTC, by email to SAO.generalmail@ontario.ca by October 31, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

The Director received four separate complaints, all regarding staff shortages and concerns over resident care and safety needs that were not met.

A review of the direct care staffing schedule from an identified period of time, indicated that there were between 69.5 (6.0 per cent) and 28 (2.5 per cent) unfilled direct care staff shifts.

In an interview with the Staffing Coordinator, they reviewed the nursing schedule and acknowledged the indicated unfilled shifts. The Staffing Coordinator further indicated that an unfilled shift was defined as a direct care shift that was not filled either due to a sick call, vacation time, or lack of staff to fill the shift and had not been isolated to a specific unit or shift.

During interviews with the above mentioned complainants, they indicated that staff worked without a full complement of direct care staff members and the following resident care was not accomplished:

- resident scheduled baths were not given,
- several call bells rang and staff were unable to answer them promptly,
- resident are incontinent in their briefs while waiting to use the washroom, and
- resident had been unable to return to bed as requested between meals.

In interviews with one family member (#118) and one resident (#001), they reported to the Inspector that they were concerned about the staffing "crisis" in the home and that residents' care needs were not being met. Family member #118 provided Inspector #647 an example of their parent not receiving assistance after the call bell had been ringing for 30 minutes. This family member further indicated to the Inspector that they had called the home several times before reaching a nurse to see if their parent got the help they needed. Resident #001 indicated to Inspector #647 that they had not received the care they needed and that this was an ongoing concern.

During interviews with Registered staff #100 and #109, and direct care staff #107, #110, #111, #112, #113, and #114, with the Inspector; they indicated that they often are forced to work short-handed due to sick calls, or no shows. They acknowledged that when they are short staffed they are required to prioritize



**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*

resident care. These staff members indicated that due to the lack of staff, residents do not consistently get their scheduled baths or showers, they are not able to return to bed between meals if they request, and if they have a toileting plan, it is not complied with.

During the same interview, direct care staff member #111 indicated that the most recent example was a weekend, there had been two out of four direct care staff members working and the scheduled baths could not be completed for residents #003, #004, #005, and #006. Direct care staff member #111 further indicated that these scheduled baths or showers were unable to be rescheduled as the following shifts were also short staffed.

A review of the documentation for resident's #003, #004, #005, and #006, confirmed that these residents had not received their scheduled baths or showers.

In an interview with the Administrator, they indicated that there were currently 11 direct care positions on the schedule that were vacant and confirmed that the home was currently short staffed four to five times per week. The Administrator further indicated that they do not access available agencies to assist them in filling the vacant lines. The Administrator confirmed during the interview that with the current number of vacant lines, resident care is not able to be consistently completed and resident care needs had not been met.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm to the residents. The scope of the issue was determined to be a level three as it related to more than 67 per cent of the affected residents reviewed. The home had a level two compliance history as they had one or more unrelated non-compliances in the last 36 months. (647)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018



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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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



**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*

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.



**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*

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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603



**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*

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 15th day of October, 2018

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



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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Inspector /

Nom de l'inspecteur :

Jennifer Brown

Service Area Office /

Bureau régional de services : Sudbury Service Area Office