

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

**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**

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

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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2019	2019_755728_0024 (A1)	019264-19	Complaint

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Additional evidence provided. Home in compliance with s. 6 (5). WN will be revoked.

Issued on this 19th day of November, 2019 (A1)

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

Original report signed by the inspector.

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 28-29, 2019.

The following intakes were completed in this complaint inspection:

Log #019264-19 related to administration of drugs, alleged emotional abuse, falls, and continence.

During the course of the inspection, the inspector(s) spoke with the Administrator/DOC, Registered Nurses (RN), and Personal Support Workers (PSW).

The inspector reviewed clinical records and plans of care and relevant home documentation.

Observations were made of residents, staff to resident interactions, and resident care provision.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

During the course of the original 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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.)</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's

dignity. 2007, c. 8, s. 3 (1).

2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

3. Every resident has the right not to be neglected by the licensee or staff.
2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed
and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

5. Every resident has the right to live in a safe and clean environment. 2007, c.
8, s. 3 (1).

6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3
(1).

7. Every resident has the right to be told who is responsible for and who is
providing the resident's direct care. 2007, c. 8, s. 3 (1).

8. Every resident has the right to be afforded privacy in treatment and in caring
for his or her personal needs. 2007, c. 8, s. 3 (1).

9. Every resident has the right to have his or her participation in decision-
making respected. 2007, c. 8, s. 3 (1).

10. Every resident has the right to keep and display personal possessions,
pictures and furnishings in his or her room subject to safety requirements and
the rights of other residents. 2007, c. 8, s. 3 (1).

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of
his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her
consent is required by law and to be informed of the consequences of giving or
refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her
care, including any decision concerning his or her admission, discharge or
transfer to or from a long-term care home or a secure unit and to obtain an
independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the
Personal Health Information Protection Act, 2004 kept confidential in
accordance with that Act, and to have access to his or her records of personal
health information, including his or her plan of care, in accordance with that
Act. 2007, c. 8, s. 3 (1).

12. Every resident has the right to receive care and assistance towards
independence based on a restorative care philosophy to maximize
independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited
circumstances provided for under this Act and subject to the requirements

provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

24. Every resident has the right to be informed in writing of any law, rule or

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policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that resident #001's right to have their participation in decision making respected and to have their personal health information kept confidential in accordance with the Personal Health Information Act, 2004.

Prior to resident #001's placement in long-term care (LTC), the resident was admitted to hospital. The physicians consultation letter indicated that they were advised that complainant #104 was not the resident's power of attorney (POA) for care. The discharge letter stated that consideration for involvement of a public guardian trustee (PGT) was encouraged and discussed with resident #001's spouse.

Documentation provided to the home prior to resident #001's admission stated that resident #001's spouse was their POA.

Power of Attorney documentation found in resident #001's clinical record signed by resident #001, their spouse, and their lawyer, stated that resident #001's spouse was their legal power of attorney for personal care and property. Administrator/DOC #100 said that the home had deemed the spouse to be the resident's POA when they were admitted.

Resident #001's plan of care documented that complainant #104 had made care decisions for resident #001. These included decisions involving care and finances. At times, complainant #104 was contacted and the resident's spouse/POA was not contacted by the home.

Administrator/DOC #100 acknowledged that staff contacted complainant #104 for

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care decisions, which involved the sharing of personal health information, related to resident #001, despite the fact that the resident's spouse/POA should be the contact. Administrator/DOC #100 said that there had been concerns with several of their decisions.

Administrator/DOC #104 said that the home had not contacted the PGT office, as recommended, because it would require a capacity assessment which was expensive; nor had they contacted supports in the community regarding concerns with complainant #104's involvement in resident #001's care decisions when there was no formal documentation to support their inclusion.

The licensee failed to ensure that resident #001's choice for their care decisions was respected and personal health information was protected when they included complainant #104 in decisions related to personal care and finances for resident #001 without including resident #001's spouse and appointed power of attorney for personal care and property.

Additional Required Actions:

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

(A1)

The following Non-Compliance has been Revoked: WN #2

**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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Issued on this 19th day of November, 2019 (A1)

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

Original report signed by the inspector.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de
longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** Amended by MARIA MCGILL (728) - (A1)

**Inspection No. /
No de l'inspection :** 2019_755728_0024 (A1)

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

**Log No. /
No de registre :** 019264-19 (A1)

**Type of Inspection /
Genre d'inspection :** Complaint

**Report Date(s) /
Date(s) du Rapport :** Nov 19, 2019(A1)

**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 :** Susan Jaunezmis

To ATK Care 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

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

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or

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l'article 154 de la *Loi de 2007 sur les
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another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with s. 3 (1) 9. and 3 (1) 11 iv., of the LTCHA.

Specifically, the licensee must:

- a) stop contacting complainant #104 in relation to resident #001's care and financial decisions;
- b) ensure complainant #104 is not provided personal health information related to resident #001; and,
- c) ensure that the appropriate steps are taken to ensure the assigned designate for personal care and financial decisions is included in resident #001's care or the appropriate steps occur to have a legal designate in their place.

Grounds / Motifs :

- 1. The licensee failed to ensure that resident #001's right to have their participation in decision making respected and to have their personal health information kept confidential in accordance with the Personal Health Information Act, 2004.

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

Prior to resident #001's placement in long-term care (LTC), the resident was admitted to hospital. The physicians consultation letter indicated that they were advised that complainant #104 was not the resident's power of attorney (POA) for care. The discharge letter stated that consideration for involvement of a public guardian trustee (PGT) was encouraged and discussed with resident #001's spouse.

Documentation provided to the home prior to resident #001's admission stated that resident #001's spouse was their POA.

Power of Attorney documentation found in resident #001's clinical record signed by resident #001, their spouse, and their lawyer, stated that resident #001's spouse was their legal power of attorney for personal care and property. Administrator/DOC #100 said that the home had deemed the spouse to be the resident's POA when they were admitted.

Resident #001's plan of care documented that complainant #104 had made care decisions for resident #001. These included decisions involving care and finances. At times, complainant #104 was contacted and the resident's spouse/POA was not contacted by the home.

Administrator/DOC #100 acknowledged that staff contacted complainant #104 for care decisions, which involved the sharing of personal health information, related to resident #001, despite the fact that the resident's spouse/POA should be the contact. Administrator/DOC #100 said that there had been concerns with several of their decisions.

Administrator/DOC #104 said that the home had not contacted the PGT office, as recommended, because it would require a capacity assessment which was expensive; nor had they contacted supports in the community regarding concerns with complainant #104's involvement in resident #001's care decisions when there was no formal documentation to support their inclusion.

The licensee failed to ensure that resident #001's choice for their care decisions was respected and personal health information was protected when they included complainant #104 in decisions related to personal care and finances for resident #001 without including resident #001's spouse and appointed power of attorney for

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2007, c. 8

Ordre(s) de l'inspecteur

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personal care and property.

The severity of the issue was determined to be a level 3 as there was actual risk of harm. The scope of the issue was a level 1 as it related to one of three resident's reviewed. The home had a level 2 compliance history as they had previous non-compliance related to different subsections. (728)

This order must be complied with by /

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

Jan 06, 2020

Order(s) of the Inspector

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

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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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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.

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 19th day of November, 2019 (A1)

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

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

Amended by MARIA MCGILL (728) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*,
L. O. 2007, chap. 8

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

Central West Service Area Office