



**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**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

**Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670**

**Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ème</sup> étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
May 5, 2014	2014_328571_0001	O-00821- 13,O- 001254-13	Complaint

**Licensee/Titulaire de permis**

**EXTENDICARE TORONTO INC  
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2**

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

**EXTENDICARE GUILDWOOD  
60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9**

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

**PATRICIA BELL (571)**

**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): March 10, 11, and April 2, 2014**

**Two complaint inspections were completed concurrently; Log O-001254-14 and Log O-000821-13.**

**PLEASE NOTE: Two critical incident inspections were conducted concurrently by Inspector #570 for Log # O-000570-13 and O-000364-13. Findings of non-compliance from that inspection can be found in this report.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurse(RN), Registered Practical Nurse (RPN), Resident#003, and Substitute Decision Maker (SDM) of resident #003 and Medical Director.**

**During the course of the inspection, the inspector(s) Reviewed the medical records of Resident #003, complaint log, policies related to Complaints, and Medical Directives, and the critical incident report.**

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

**Critical Incident Response  
Dignity, Choice and Privacy  
Medication  
Reporting and Complaints**

**Findings of Non-Compliance were found during this inspection.**



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

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs**

Every licensee of a long-term care home shall ensure that,

(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident’s condition is assessed or reassessed in developing or revising the resident’s plan of care as required under section 6 of the Act; and

(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident’s condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :



1. The licensee failed to ensure that a medical directive used with respect to a resident was individualized to the resident's condition and needs.

The home experienced a power outage. As a result, the electronic medication administration records (eMAR) were unavailable. Therefore, a medical directive was obtained from a Physician the following morning to hold all medications except for one medication.

Resident # 003 had a medical condition requiring medication twice daily. Under the medical directive, this medication was not administered. The resident's condition deteriorated resulting in the resident requiring assessment at the hospital.

In addition, the licensee failed to follow their own policy # 11-05 written 9/2010 on Medical Directives. In the policy, a medical directive is defined as "written documents that provide orders for a group of people when certain conditions are met". The policy also states that "medical directives are different from standing orders in that standing orders are applied to all people without consideration for circumstances or conditions. Standing orders are not permitted." Also, the home's policy states that "medical directives may be used in the home as long as they are: written; contain clear statements related to when, how and for how long the directive may be used; contain clear statements that outline any contraindications for use; are based on best supporting evidence to direct care; and are approved, dated and signed by the Medical Director and the chair of the Professional Advisory Committee".

Therefore, the medical directive obtained, was not individualized to Resident #003's condition.

***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 O.Reg 79/10, s. 107. Reports re critical incidents**



**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**

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

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

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

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

**i. a breakdown or failure of the security system,**

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

**iii. a loss of essential services, or**

**iv. flooding.**

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

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

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

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

---

**Findings/Faits saillants :**



1. The licensee failed to comply with O. Reg. 107. (3) in that they failed to inform the Director no later than one business day of the following: a medication incident; a resident missing less than 3 hours with no injury; and an injury in respect of which a person is taken to hospital.

i). Related to Log O-001254-13:

A medication incident occurred that resulted in a resident to be taken to the hospital.

-the home experienced a power outage

-as a result, the electronic medication administration records were unavailable

-Resident #003 did not receive medication and subsequently was transferred to hospital for assessment due to a deterioration in the resident's condition

There is no evidence that the licensee informed the Director no later than one business day of a medication incident in respect of which a resident is taken to the hospital.

ii). Related to Log O-000364-13

A Critical Incident(CI)was submitted to the Director two days after an incident occurred regarding missing Resident #004.

-there is no evidence that the licensee informed the Director no later than one business day that the resident was missing from the home for less than three hours and returned to the home with no injury or adverse change in condition

(PLEASE NOTE: This evidence of non-compliance was found during Inspection #2014\_327570\_0001 by Inspector #570) [s. 107. (3)]

iii). Related to Log O-000570-13

A CI was submitted to the Director four days after Resident #005 fell, a fall resulting in a transfer to the hospital

-there is no evidence that the licensee informed the Director no later than one business day after an injury in respect of which a person is taken to hospital

(PLEASE NOTE: This evidence of non-compliance was found during Inspection #2014\_327570\_0001 by Inspector #570) [s. 107. (3)]



**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**

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that incidents in the home are reported to the Director in accordance with the requirements of O. Reg 79/10 s. 107 (3)1.,4., and 5. (Please note: s. 107 (3) 4. at time of CI #2164-000006-13 stated "An injury in respect of which a person is taken to hospital". The regulation has since been amended and now includes "and that results in a significant change in the resident's health condition"), to be implemented voluntarily.***

---

**WN #3: 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. Under the LTCHA 2007 s. 21, the licensee is required to ensure that they have written procedures that comply with the regulations for how the licensee deals with complaints. The licensee failed to comply with O. Reg. 79/10, 8. (1) (b) in that they failed to comply with their policy on responding to complaints.

Review of Policy: Complaints- Reference 09-04-06 - Version June 2010

To summarize, the policy defines a complaint as "an expression of grievance, dissatisfaction or resentment" and directs the following:

When a verbal complaint is received, the following will occur:

-If the investigation cannot be initiated immediately and/or resolution can not be obtained within 24 hours, the Department Manager will initiate an investigation into the complaint; the Department Manager may delegate the investigation to another departmental staff (ie ADOC). This should include a written record of the investigation



**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**

and outcome.

-at the end of the investigation, the person conducting the investigation, the Department Manager and the Administrator will meet to review the findings and complete a written response to the author of the complaint. In addition, each contact with the resident or author of the complaint will be recorded on the Contact Log by the person making the contact so that complaints can be analyzed quarterly by the CQI team and an action plan developed.

Related to Log O-001254-14:

-the home received a verbal complaint that could not be resolved within 24 hours

The home failed to comply with their policy on complaints by: not logging the complaint; not having a written record of the investigation; and not responding to the Resident #003 and the SDM in writing, the resolution or statement the the complaint was unfounded and why. [s. 8. (1) (b)]

2. Related to Log O-000570-13:

Under O. Reg. 79/10, s. 48 (1) 1. Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee policies related to falls:

1) Falls Prevention and Management Program (Policy # RESI - 10-02-01 dated April 2013).

The policy purpose is to prevent and manage the risks associated with falls and injury related to falls. To summarize:

-Registered staff to immediately complete an initial physical and neurological assessment to determine further treatment or intervention

-ongoing assessment with documentation in the progress notes required each shift for 72 hours if resident remains in home

2) Post Fall Assessment (Policy # RESI - 10-02-02 dated April 2013).

-a post fall assessment to be completed within 24 hours of a resident fall and documented on Post Fall Clinical Pathway

-if suspected head injury or unwitnessed fall then neurovital signs must be completed for every hour x 4 hours then every 8 hours for 72 hours

Review of clinical notes of Resident #005 indicated the resident sustained an





unwitnessed fall.

- No injuries were noted and resident denied pain. Resident was assisted back to bed by staff.

-Resident complained of pain two hours later and was given analgesic

-the Resident complained of severe pain several hours later and was subsequently transferred to the hospital for assessment

-there is no documented evidence that a neurological assessment was completed as per policy after an unwitnessed fall

-no documented evidence that a neurological and physical assessment was completed when the resident complained of pain

-no documented evidence of clinical monitoring done related to the unwitnessed fall sustained by resident #005 as required by the falls prevention policy and post fall assessment policy. [s. 8. (1) (b)]

3. Related to Log O-000364-13:

Under O. Reg. 79/10, s. 230 (4)1. The licensee shall ensure that the emergency plans provide for the following:

vii. situations involving a missing resident

The licensee policy involving missing residents:

Emergency Preparedness / Code Yellow (Policy # EMER-11-01-01, version March 2013).

The policy purpose is to provide clear direction that must be followed to locate a missing resident. To summarize, if the resident has not been located within 10 minutes of going missing, regardless of the completeness of current search of the resident, the incident manager ensures Code Yellow is announced, notify the police, and complete a missing person report, assist police, notify administrator who will notify the regional director

- When the police arrive, provide them with a photo of the resident and a copy of the missing person report along with a summary of the actions taken prior to their arrival.

-When a resident is found Registered staff is to assess the resident's condition and document the incident on the resident's progress notes. Records, and checklist to be maintained and report must be available for the Administrator.

The licensee failed to comply with the home's above noted policy as evidenced by:

There is no record of missing resident report and checklist for Resident #004 as required by the home's emergency preparedness policy.

Interview with administrator indicated that the charge nurse at time of incident was the



**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**

incident manager who should be completing the report. The administrator could not provide a copy of a missing resident report and checklist. The administrator confirmed that the missing resident policy at the time of incident was not followed. [s. 8. (1) (b)]

---

**Issued on this 15th day of May, 2014**

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

*Patti Bell*



**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

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité**

**Public Copy/Copie du public**

**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** PATRICIA BELL (571)

**Inspection No. /**

**No de l'inspection :** 2014\_328571\_0001

**Log No. /**

**Registre no:** O-00821-13,O-001254-13

**Type of Inspection /**

**Genre**

**d'inspection:**

Complaint

**Report Date(s) /**

**Date(s) du Rapport :** May 5, 2014

**Licensee /**

**Titulaire de permis :** EXTENDICARE TORONTO INC  
3000 STEELES AVENUE EAST, SUITE 700,  
MARKHAM, ON, L3R-9W2

**LTC Home /**

**Foyer de SLD :** EXTENDICARE GUILDWOOD  
60 GUILDWOOD PARKWAY, SCARBOROUGH, ON,  
M1E-1N9

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** ANDRE BARROS

To EXTENDICARE TORONTO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:



**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



**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

---

**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. 117. Every licensee of a long-term care home shall ensure that,  
(a) all medical directives or orders for the administration of a drug to a resident  
are reviewed at any time when the resident's condition is assessed or reassessed  
in developing or revising the resident's plan of care as required under section 6 of  
the Act; and  
(b) no medical directive or order for the administration of a drug to a resident is  
used unless it is individualized to the resident's condition and needs. O. Reg.  
79/10, s. 117.

**Order / Ordre :**

The licensee shall ensure that no medical directive or order for the  
administration of a drug to a resident is used unless it is individualized to the  
resident's condition and needs.

**Grounds / Motifs :**



**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

1. The licensee failed to ensure that a medical directive used with respect to a resident was individualized to the resident's condition and needs.

The home experienced a power outage. As a result, the electronic medication administration records (eMAR) were unavailable. Therefore, a medical directive was obtained from a Physician the following morning to hold all medications except for one medication.

Resident # 003 had a medical condition requiring medication twice daily. Under the medical directive, this was not administered. The resident's condition deteriorated resulting in the resident requiring assessment at the hospital.

In addition, the licensee failed to follow their own policy # 11-05 written 9/2010 on Medical Directives. In the policy, a medical directive is defined a "written documents that provide orders for a group of people when certain conditions are met". The policy also states that "medical directives are different from standing orders in that standing orders are applied to all people without consideration for circumstances or conditions. Standing orders are not permitted." Also, the home's policy states that "medical directives may be used in the home as long as they are: written; contain clear statements related to when, how and for how the directive may be used; contain clear statements that outline any contraindications for use; are based on best supporting evidence to direct care; and are approved, dated and signed by the Medical Director and the chair of the Professional Advisory Committee".

Therefore, the medical directive received, was not individualized to Resident #003's condition. (571)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : May 12, 2014**



**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 or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance 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 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  
Performance Improvement and Compliance  
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](http://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 SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



**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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 5th day of May, 2014**

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

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

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