Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 7, 2018	2018_594624_0009	008082-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

BAIYE OROCK (624), JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 7 - 11, 14 - 17, and 22 - 25, 2018

The following critical incident system (CIS), complaint and follow up intakes were inspected concurrently during this inspection.

CIS:
Log #022335-17 – Related to allegation of resident to resident abuse

Complaints:
Log #027127-17– Related to transferring and positioning, bathing, oral care and skin care concerns,
Log #029170-17, log #029447-17, log # 002341-18, and log #007756-18 – Anonymous complaints related to short staffing, continence care, infection prevention and control, medication administration, and wound care,
Log #004222-18 – Related to the care of a resident, and
Log #004249-18 and log #004560-18 – Related to anonymous complaint about alleged abuse of residents.

Follow Up:
Log # 023701-17 – Follow up of inspector orders related to protecting residents from abuse by other residents, from report #2017_644507_0010, issued to the home on September 26, 2017.

During the course of the inspection, the inspector(s) spoke with the Regional Director of the licensee, the Administrator, the Directors of Care (DOCs), the Dietary Manager (DM), the Manager of Personal Support Services, the Programs Manager, a Medical Doctor, the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), a Registered Dietitian (RD), a Physiotherapist, a Registered Social Worker, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, a Housekeeper, a Restorative Aide, a Support Service Aide, the president of Residents' Council, family members and residents.

A tour of the home was completed and observations were made of resident to resident interactions, staff to resident interactions during care provision, and medication administration. A review was also completed of residents' health records, medication incidents reports, the licensee's staffing plan, Residents' Council meeting minutes, as well as relevant policies and procedures related to accommodation services, continence care, falls prevention, nutrition and hydration, management of complaints, skin and wound care, and zero tolerance of abuse and neglect.

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_644507_0010	607

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there is a written plan of care that sets out the planned care for resident #014 and resident #017 related to the use of a specified intervention.

During stage 1 of the Resident Quality Inspection (RQI) resident #014 and resident #017 triggered for Minimizing of Restraining.

On two identified dates and times, Inspector #624 observed a specified intervention applied in a specified manner on the beds of resident #014 and resident #017.

In separate interviews on an identified date with Inspector #624, resident #014 and resident #017 both appeared confused and not able to tell why the specified interventions were applied to their bed, but indicated that they needed the specified intervention.

In separate interviews on an identified date with PSW #119 and PSW #120, related to resident #014; PSW #121 and RN #120, related to resident #017, all staff members acknowledged that both residents use the specified interventions. All the above staff members indicated that it was the expectation of the home that the use of the specified intervention should be included in the written plan of care for the resident. All staff members, after reviewing the respective written plan of care for the residents, indicated

that there was no focus, goals or interventions related to the use of the specified intervention by resident #014 and #017.

A review of the current written plan of care for resident #014 and resident #017 did not set out the planned care related to the use of the specified intervention by both residents.

In an interview with the Director of Care (DOC) #001 and DOC #002 by Inspector #624 on an identified date, both DOCs indicated that the expectation of the home is that whenever a resident is using the specified intervention, those interventions have to be included in the written plan of care. DOC #002, after reviewing the respective written plans of care for both residents, indicated that the written plan of care for resident #014 mentions the intervention but did not specify the type of intervention being used while the written plan of care for resident #017 did not include the use of the intervention.

The licensee has failed to ensure that the written plan of care for resident #014 and resident #017 sets out the planned care for both residents related to the use of the specified intervention.

2. The licensee has failed to ensure that there was a written plan of care that sets out the planned care for resident #001 related to the use of a specified intervention.

On an identified date and time, Inspector #607 observed resident #001's bed with two specified interventions in use.

During an interview on an identified date, with Inspector #607, resident #001 indicated they needed and used both interventions for their wellbeing.

During separate interviews with RN #102 and RPN #105, both indicated that the resident uses both interventions for their wellbeing.

A review of the resident's current written plan of care did not set out the planned care related to the use both specified interventions.

During an interview with DOC #001 and DOC #002 on an identified date, both indicated to Inspector #607 that the expectation of the home was that whenever residents were using the specified interventions, those interventions were to be included in the written plan of care.

The licensee failed to ensure that the use of both specified interventions by resident #001 was included in the written plan of care of the resident.

3. The licensee has failed to ensure that plan of care set out clear directions to staff and others who provide direct care to the resident.

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time for an incident of an alleged resident to resident abuse that occurred two days prior to the date it was reported to the Director. The CIR indicated that resident #026 was observed on the date of the incident to have been involved in an incident with resident #025, leading to an injury to resident #026. A complaint was also submitted to the Director on another specified date, approximately six months after the first identified date, related to the above identified residents, regarding the resident to resident interaction.

Resident #025 was observed during the inspection and there were no identified responsive behaviors noted. Resident #026 was not observed during the inspection as they were not in the home during the course of the inspection.

A review of resident #025's written plan of care at the time of the incident and currently in place, indicated the resident exhibited specified responsive behaviors, with specific directions on what to do with a specified device that the resident used, related to the exhibited behavior. There were also specified directions on the frequency of monitoring of the specified device.

Further review of the same written plan of care indicated that the resident was at potential risk for the identified responsive behaviors when identified statements were made. The plan of care also gave specified directions to staff on what to do when the identified statements were made by the resident. At the request of the SDM, the specified intervention was discontinued related to a specified health condition.

During an interview on an identified date, PSW #129 indicated to Inspector #607 that resident #025 continues to exhibit the behavior the specified device above was meant to prevent.

During an interview on an identified date, RN #107 indicated to Inspector #607 that resident #025 no longer used the specified device mentioned above. RN #107 indicated

that resident #025's written plan of care interventions related to the identified responsive behavior above required updating and did not provide clear directions to staff. The RN also indicated that the resident's written plan of care was to be updated on weekly basis by the RNs.

4. The licensee failed to ensure that resident #025 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan was no longer necessary.

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time for an incident of an alleged resident to resident abuse that occurred two days prior to the date it was reported to the Director. The CIR indicated that resident #026 was observed on the date of the incident to have been involved in an identified interaction with resident #025, leading to an injury to resident #026. A complaint was also submitted to the Director on another specified date, approximately six months after the first identified date, related to the above identified residents, regarding the resident to resident interaction.

A review of resident #025's written plan of care at the time of the incident and currently in place indicated that the resident used a specified mobility aide with specific directions to staff on the level of assistance to provide to the resident vis-à-vis the mobility aide.

On two identified dates and on several occasions, resident #025 was observed to be mobilizing with the use of a completely different mobility aide.

During an interview, resident #025 indicated to Inspector #607 that previously they used the first identified mobility aide but that they had stopped using the said aide and was now using a different mobility aide.

During an interview on an identified date, PSW #129 indicated to Inspector #607 that resident #025 was currently using the last mentioned mobility aide.

During an interview, RN #107 indicated to Inspector #607 that resident #025 did no longer used the first identified mobility aide but currently used another mobility aide. RN #107 indicated that resident #025's written plan of care interventions related to the use of the mobility aide were not current and required updating. The RN also indicated that the resident's written plan of care were to be updated on weekly basis by the RNs.

During an interview, DOC #002 indicated to Inspector #607 that if a resident's interventions in the written plan of care were no longer applicable the licensees expectation was that the interventions be discontinued from the written plan of care.

The licensee failed to ensure that when care set out in the plan of care was no longer necessary related to the use of a specified mobility aide by resident #025, that the resident was assessed and the plan of care was reviewed and revised.

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

According to Ontario Regulation (O. Reg) 79/10 s. 45 (2), an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Exceptions to the requirement to have a registered nurse on duty and present in the home at all times can be found in Ontario Regulations section 45 and applies to homes with fewer than 129 beds. This home has a bed capacity of 169 beds.

Complaints were submitted to the MOHLTC in December of 2017 related to short staffing and no RN in the building. These included log #029447-17, and log #029170-17.

During the course of the inspections, an anonymous staff member indicated to Inspector #624 that on an identified date, there was no RN in the building for the day and night shift. The staff member also indicated that the home was always short staffed.

A review, of the licensee registered staff schedule for a two week period of a first specified month, was completed with the Director of Care (DOC) #002 and it revealed that there was no RN present and in the building for part of the day shift on an identified date during the first reviewed period. On the date identified above by the anonymous staff member, the reviewed staff schedule indicated that there was no RN on duty and present in the home for the day and night shift.

In an interview with the Director of Care (DOC) #002, the DOC indicated that it is the licensee expectation that there be an RN present and in the building at all times. The DOC further acknowledged that on the first identified date, the Clinical Coordinator (CC) who is an RN worked part of the day shift but was unable to tell what part of the shift the CC worked. For the day and night shifts on the second identified day, the DOC indicated that there were two RPNs in the building while the DOC was on call.

The DOC also indicated that there was no emergency on the above identified dates and shifts that could have prevented an RN from getting to the long term care home.

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, 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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

Ontario Regulation (O. Reg). 79/10 s. 30. (1) 1. states: Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

O.Reg. 79/10, s 48. (1) 2: Every licensee of a long-term care home shall ensure that the

following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The licensee policy, "Skin and Wound Program - Prevention of Skin Breakdown," policy # RC-23-01-01 last updated February 2017 was reviewed by Inspector #624. The reviewed policy, under section "Daily on all shifts" stated:
"Document altered skin integrity in daily care record or electronic equivalent."

A review of the home's medication management policy by Inspector #624, entitled, Medication Management, policy #RC-16-01-07 last updated in February of 2017, stated Under Required documents:
“TAR/eTAR – Paper or electronic format to be used to document all treatments given to a resident”
Under Procedures/Nurse Administration:
“18. Immediately document all medication administered, refused, or omitted after administration on the MAR/eMAR and TAR/eTAR using the proper codes by the administering nurse.”

On an identified date, complaint log #002341-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC). According to the complainant, who did not identify any specific residents, they indicated that residents did not receive a specific care treatments as there was no qualified person in the home to provide the care in question.

A review was completed of the Treatment Administration Records (TAR) of three randomly selected residents who needed the specified care above, in the month the complaint was made. Of the chosen residents, resident #023, admitted on an identified date, was noted to have two specified active orders on the TAR for identified month above, related the the identified care above.

A review of the resident’s TAR for the identified month indicated that on an identified shift on an identified date, there was no signature on the TAR to indicate whether or not the first active order was provided to the resident. During identified shifts on four other identified dates for the same month, there was no signatures on the same TAR to indicate whether or not the second active order was provided to the resident. A review of the progress notes indicated that resident #023 was present and in the home on the identified dates and times above.

In separate interviews, with RPN #104, who worked identified shifts on three of the identified dates above, and RPN #126 who worked identified shifts on two of the identified dates above, both RPNs indicated that the expectation in the home is that when the identified care was provided to residents, the expectation is that the staff completing the identified care has to sign on the TAR to indicate that the care is completed. Both RPNs indicated that, if the identified care is not provided for any reason, the Charge Nurse or Registered Nurse (RN), who is usually in-charge of the identified care in the home is to document on the TAR why the identified care was not provided.

In an interview with Charge Nurse RN #107 who worked identified shifts on three of the five identified dates above, the Charge RN indicated, as earlier stated by RPN #104 and RPN #126, that provision of the identified care in question is the responsibility of the charge nurse. RN #107 indicated no recollection of whether or not they provided the identified care to resident #023 on the dates they were charge nurse. The RN indicated also that it is the expectation of the home that the TAR should be completed by registered staff to indicate whether or not the identified care is provided to the resident. In a review of resident #023's TAR for concerned month, all staff members indicated that there was no signatures on the above mentioned dates to indicate whether or not the resident received the identified care as ordered.

In an interview with the Director of Care (DOC) #001, the DOC indicated that the licensee 's expectation is that when residents require specific treatments, registered staff are to immediately document the care provided on the resident's TAR. The DOC also indicated that if treatment is not provided, the TAR has to be completed to indicate the reason why care was not provided.

After reviewing the TAR for resident #023 for concerned month, DOC #001 indicated that there was no signatures on the TAR for the assigned dates and staff failed to comply with the policy to document on the TAR whether or not care was provided to resident #023.

The licensee failed to comply with its skin and wound as well as its medication management policy by not documenting whether or not resident #023 received ordered treatments on five identified dates.

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 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, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that appropriate action was taken in response to an allegation of abuse of residents by the DOC.

A written complaint related to log #004560-18 was received by the MOHLTC on and identified date. As per the complaint, the complainant accused the Director of Care (DOC) #002 of allegedly abusing residents. According to the complainant, DOC #002 worked as an RN on an identified shift, on an identified date. As per the complainant, DOC #002 failed to administer medications scheduled at a specified time, for a number of residents. The complainant also alleged that DOC #002 failed to properly staff the home with registered staff on identified shifts on five specified dates, two months before the date of the complaint. According to the complainant, this led to several residents not receiving their medications scheduled at a specified time. According to the complainant, this constituted neglect of the residents.

A complaint letter alleging abuse by the DOC #002 was received by the Regional Director (RD) for the licensee on an identified date with the stated allegations described above.

In an interview with the RD on an identified date, the RD indicated that upon receipt of the letter alleging abuse, they had the letter forwarded immediately to the Administrator of the home for immediate investigation.

In an interview with the Administrator of the home, they acknowledged receiving the said letter on the date it was sent to the RD and meeting with the accused DOC #002 the same day. The Administrator indicated that upon their review with DOC #002 on the same day, the specific resident medication which the DOC was accused of not having administered, had actually been administered.

The Administrator also acknowledged that they only investigated the specifics related to the medications the DOC was accused of not administering on the specified day. The Administrator indicated that there was no investigation or any other actions taken related to the other concerns raised on the missing medication/signatures on all the other identified dates.

The licensee failed to ensure that appropriate action was taken related to alleged incidents of abuse and neglect of residents on five identified dates.

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,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident;, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Ontario regulation 79/10, s. 5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A written complaint related to log #004560-18 was received by the MOHLTC on and identified date. As per the complaint, the complainant accused the Director of Care (DOC) #002 of allegedly abusing residents. According to the complainant, DOC #002 worked as an RN on an identified shift, on an identified date. As per the complainant, DOC #002 failed to administer medications scheduled at a specified time, for a number of residents. The complainant also alleged that DOC #002 failed to properly staff the home with registered staff on identified shifts on five specified dates, two months before the date of the complaint. According to the complainant, this led to several residents not receiving their medications scheduled at a specified time. According to the complainant, this constituted neglect of the residents.

A review of the licensee schedule for a two week period was done by Inspector #624 and DOC #002. This review revealed that on identified shifts, on 10 out of 14 days, there was one RN present and in the building on one identified home area, instead of two RNs as specified by the licensee staffing plan which indicated that on the identified shifts, there are supposed to be two RNs in the building, one on the identified home area and another in a separate identified home of the home.

A review was completed by Inspector #624 of the Medication Administration Records (MARs) for the month containing the identified two week period above. Three randomly chosen residents (#031, #033, and #035) on the second identified home area, who had scheduled medication for the specified time in question.

Resident #031 was admitted in the home on an identified date and had three separate medications, all of which had to be administered at the specified time above.
Resident #033 and resident #035 were each admitted in the home on separate identified dates and each had one medication that needed to be administered at the specified time above.

A review of the MAR for all three residents for the month in question indicated that

scheduled medication was not signed on the MAR as administered on five identified dates, at the specified time above. Several unsuccessful attempts were made to contact RN #145 who worked the identified shifts on the five identified dates.

A review of the licensee records indicated that on another identified date, an anonymous allegation of abuse letter had been faxed to Extendicare head office and was eventually directed to the Regional Director (RD). A review of the faxed letter outlined the same concerns as that received by the MOHLTC.

In an interview with the RD, the RD indicated that they had received the said fax on the identified date alleging abuse and neglect by the DOC. The RD indicated the letter was forwarded to the Administrator of the home immediately, once it was received. The RD also indicated that it is the licensee expectation that if any allegation of abuse or neglect of residents is brought to the attention of the licensee, the MOHLTC (i.e. the Director) is immediately notified of the allegation by completing a Critical Incident Report. The RD acknowledged that this allegation of abuse and neglect complaint letter was never reported immediately to the MOHLTC as legislated.

In an interview with the Administrator of the home, the Administrator confirmed that the expectation in the home is that any allegation of abuse or neglect should be reported immediately to the MOHLTC. The Administrator indicated that this allegation of abuse and neglect was never reported to the MOHLTC.

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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aides such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During stage 1 of the RQI, Inspectors #607 and #624 made the following observations:

- On an identified date and time in a specified room, one tooth brush and basin unlabelled in a shared bathroom.
- About an hour later, in another room, one basin, a urine hat, a bed pan and two soap bars, was noted to be unlabelled in a shared bathroom.
- The following day, in the second identified room above, one urine hat and a bed pan was noted to be unlabelled in a shared bathroom.

During interviews with PSW #108 and PSW #109, by Inspector #607, both indicated that resident care items are to be labelled.

During an interview with RPN #105 by Inspector #607, the RPN indicated that PSWs are responsible for labelling residents personal items and further indicated that the licensee expectations was that all residents' personal items are to be labelled.

On the first identified date, at separate time, a used and unlabelled urinal was observed on top of the toilet tank in the shared washroom of another identified resident room. The following day, the urinal was observed to be in the same position. PSW #106, was interviewed by Inspector #624 and the PSW indicated the expectation in the home is that

all resident personal care items should be labelled. The PSW and inspector went into the washroom of the identified resident room and the PSW confirmed that the urinal was not labelled and should have been labelled.

On the first identified day above, a used and unlabeled toothbrush was observed inside a transparent cup stored on top of toilet tank in this two resident shared washroom of another specified resident room. The toothbrush was observed on the same spot and remained unlabelled the following day. Charge Nurse RN #107 was interviewed and she indicated that the expectation in the home is that all resident personal items have to be labelled. The RN and inspector went into the washroom of the identified resident room and the RN confirmed that the toothbrush was unlabeled and should have been labeled.

On a specified day, DOC #001 and DOC #002 were interviewed and they confirmed the licensee expectation that all resident care items should be labelled with the resident's name.

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 every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On an identified date, compliance order (CO) #001 from inspection #2017_644507_0010, made under LTCHA, 2007, c.8 s.19. (1), was served:

The licensee was ordered to prepare, submit and implement a plan to ensure that all residents were protected from abuse from other residents. The plan was to include, but not be limited to the following:

1) The development and implementation of a system of ongoing monitoring to ensure staff complete the analysis of the dementia observation system monitoring record, and the evaluation of the residents planned interventions on the care plans in addressing the residents aggressive behaviors towards other residents,

2) Review the plan of care of resident #013 and other residents who exhibited behaviors towards other residents to include a focus, goal, and interventions to address the behaviors and ensure staff are aware of the content of the care plan, and

3) Provide education to all registered staff to ensure that all dementia observation system monitoring are analyzed and the planned interventions are evaluated for effectiveness.

The compliance date was December 08, 2017.

a) Resident #029 was added to the sample of resident's being inspected related to the follow-up to the order related section 19 of the LTCHA, 2007, duty to protect.

A review of resident #029's health records indicated the resident had specified responsive behaviors. As per the same records, on an identified date and time, resident #029 was involved in a resident to resident interaction with resident #026 which did not lead to any injuries due to timely intervention of staff.

On another identified date and time, resident #029 was observed to be involved in another interaction with resident #026. There were no indication resident #026 was assessed for injury after this incident with resident #029.

On a third identified date and time, resident #029 was again involved in an interaction with a resident over a specified device in the room. Staff were noted to intervene, redirect resident #029 and explained the expectations in the home to resident #029.

On a fourth identified date, resident #029 was observed to place a specified item in the personal space of resident #031's.

During interviews, both a Personal Support Worker and Registered Practical Nurse #104, indicated to Inspector #607 that they were not aware of resident #029's demonstrated behaviours.

A review of resident #029's written plan of care for a six month period (including the four identified incidents above), had no documented evidence of goals, focus and interventions to address the resident's demonstrated behaviours.

During an interview, DOC #002, indicated to Inspector #607 that if a resident has the demonstrated behaviors, the licensee's expectation was that the resident should be assessed for identified triggers and interventions developed and implemented to manage those behaviors.

The licensee failed to complete item #2 of CO# 001 by not ensuring that when resident #029's exhibited specified behaviours directed towards resident #026 and resident #031, that the plan of care had been reviewed to include a focus, goal and interventions to manage the demonstrated behaviors.

b) On an identified date and time, two registered staff (#104 and #107) were asked about training related to the dementia observations system monitoring tool and its analysis and they were not aware of the training related to this tool. RPN #104 also indicated to Inspector #607 that only RNs analyze the dementia observation tool, and the planned interventions for residents and their effectiveness.

During an interview with DOC #002, when Inspector #607 asked about the training on the dementia observation tool for registered staff, the DOC confirmed that training had not been completed to all registered staff.

The licensee failed to complete item #3) of CO #001 to train all registered staff on the dementia observation system monitoring.

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 the licensee complies with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A written complaint related to log #004560-18 was received by the MOHLTC on an identified date. As per the complaint, the complainant accused the Director of Care (DOC) for allegedly abusing residents. As per the complainant, DOC #002 worked as an RN on an identified shift, on an identified date, approximately two months prior to the date the complaint was received by the MOHLTC. As per the complainant, DOC #002 failed to administer medications scheduled at a specified time, for a number of residents on a specified resident home area.

A review was completed by Inspector #624 of the Medication Administration Records (MARs) of three randomly chosen residents (#031, #033, and #035) on the specified resident home area above, who had medication to be administered at the specified time above.

Resident #031 was admitted in the home on an identified date and had three separate medications, all of which had to be administered at the specified time above.

Resident #033 and resident #035 were each admitted in the home on separate identified dates and each had one medication that needed to be administered at the specified time above.

A review of the MAR for all three residents for the month in question indicated that on the day the DOC was accused of not administering medication at the specified time, the medication was signed as administered for resident #031 but not signed for resident #033 and resident #035.

In an interview with DOC #002, the DOC acknowledged that they had worked the identified shift on the day in question as the RN and also acknowledged not administering the medications at the specified scheduled time to resident #033 and resident #035.

The licensee failed to ensure that resident #033 and resident #035 received their medications at the specified time, as per the prescriber's orders.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee has failed to ensure that written complaints received about the care of residents in the home was immediately forwarded to the Director.

A written complaint related to log #026587-17 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date and time by a family member of resident #027 in which the complainant enumerated several concerns about the care of resident #027. During an interview with the complainant, the complainant indicated that they have never received a response to any of the complaints they have made in writing to the home.

A review of the licensee complaint logs revealed three recent letters submitted to the home spanning a four month period from the time the MOHLTC received the written complaint above. Though the licensee was found to have responded to the complainant on each occasion, there was no indication any of these letters about the care of resident #027 was ever forwarded to the Director.

In an interview with the Administrator of the home related to the three letters above, the Administrator acknowledged receiving the most recent letter but not the other two letters which were sent to the home at the time the Administrator was not working for the home. The Administrator also indicated that the licensee expectation is that any written complaints received by the licensee has to be immediately forwarded to the MOHLTC. The Administrator indicated that the complaint letter they received was never forwarded to the MOHLTC but was unable to speak to the previous two letters.

Another written complaint related to log #004560-18 was received by the MOHLTC on an identified date. As per the complaint, the complainant accused the Director of Care (DOC) for allegedly abusing residents.

A review of the licensee records indicated that the written complaint related to log #004560-18 was sent anonymously to Extendicare head office and was eventually directed to the Regional Director (RD).

In an interview with the RD, the RD indicated that they had received the said letter on an identified date. The RD also indicated that it is the licensee expectation that any written complaint about the care of residents in the home be forwarded immediately to the MOHLTC. The RD acknowledged that this complaint letter was not forwarded immediately to the MOHLTC as legislated.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident.

A Critical Incident Report was submitted to the Director on an identified date for an incident of an alleged resident to resident abuse. The CIR indicated that resident #026 was involved in an altercation with resident #025 which eventually led to resident #026 sustaining an injury to a specified body part.

A review of the CIR indicated that the name of RN #142 who was present and responded to the above identified incident, was not included in the CIR.

During an interview, DOC #002 indicated that the name of the RN who was present at the time of the above identified incident, should have been included in the CIR.

Issued on this 7th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BAIYE OROCK (624), JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2018_594624_0009
Log No. / No de registre :	008082-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 7, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
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 :	Susanne Babic

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The Licensee must be compliant with s. 6 (1) of the LTCHA.

Specifically, the licensee shall ensure the following:

1. Residents #001, #014, #017, and any other residents using the specified intervention in question, have a written plan of care that sets out the planned care for the use of the the specified intervention, with specific focus, goals and interventions related to the use of the identified intervention.

2. Keep a record in the home of all activities carried out under item 1 above.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care that sets out the planned care for resident #001 related to the use of a specified intervention.

On an identified date and time, Inspector #607 observed resident #001's bed with two specified interventions in use.

During an interview on an identified date, with Inspector #607, resident #001 indicated they needed and used both interventions for their wellbeing.

During separate interviews with RN #102 and RPN #105, both indicated that the resident uses both interventions for their wellbeing.

A review of the resident's current written plan of care did not set out the planned care related to the use both specified interventions.

During an interview with DOC #001 and DOC #002 on an identified date, both indicated to Inspector #607 that the expectation of the home was that whenever residents were using the specified interventions, those interventions were to be included in the written plan of care.

The licensee failed to ensure that the use of both specified interventions by resident #001 was included in the written plan of care of the resident. (607)

2. The licensee has failed to ensure that there is a written plan of care that sets out the planned care for resident #014 and resident #017 related to the use of a specified intervention.

During stage 1 of the Resident Quality Inspection (RQI) resident #014 and resident #017 triggered for Minimizing of Restraining.

On two identified dates and times, Inspector #624 observed a specified intervention applied in a specified manner on the beds of resident #014 and resident #017.

In separate interviews on an identified date with Inspector #624, resident #014 and resident #017 both appeared confused and not able to tell why the specified interventions were applied to their bed, but indicated that they needed the specified intervention.

In separate interviews on an identified date with PSW #119 and PSW #120, related to resident #014; PSW #121 and RN #120, related to resident #017, all staff members acknowledged that both residents use the specified interventions. All the above staff members indicated that it was the expectation of the home that the use of the specified intervention should be included in the written plan of care for the resident. All staff members, after reviewing the respective written plan of care for the residents, indicated that there was no focus, goals or interventions related to the use of the specified intervention by resident #014 and #017.

A review of the current written plan of care for resident #014 and resident #017

did not set out the planned care related to the use of the specified intervention by both residents.

In an interview with the Director of Care (DOC) #001 and DOC #002 by Inspector #624 on an identified date, both DOCs indicated that the expectation of the home is that whenever a resident is using the specified intervention, those interventions have to be included in the written plan of care. DOC #002, after reviewing the respective written plans of care for both residents, indicated that the written plan of care for resident #014 mentions the intervention but did not specify the type of intervention being used while the written plan of care for resident #017 did not include the use of the intervention.

The licensee has failed to ensure that the written plan of care for resident #014 and resident #017 sets out the planned care for both residents related to the use of the specified intervention.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to all three residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this section of the legislation that included:

- Written Notification (WN) issued October 1, 2015 (2015_324567_0008)
- Voluntary plan of Correction (VPC) issued May 5, 2016 (2016_302600_0004)
- VPC issued September 26, 2017 (2017_644507_0010). (624)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 10, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Baiye Orock

Service Area Office / Bureau régional de services : Central East Service Area Office