Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2020	2019_595110_0014 (A1)	022477-19, 022480-19	Follow up

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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requests an extension to the due date. New due date March 31, 2020.

Issued on this 24th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Extendicare Guildwood
60 Guildwood Parkway SCARBOROUGH ON M1E 1N9

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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 16 (am), 17, 18(pm), 19, 20(am) and 31, 2019.

The purpose of this inspection was to follow-up on Compliance Order (CO) #001 and #004 served November 25, 2019, in report #2019_702197_0025 with a compliance due date of December 13, 2019.

During this inspection the inspector conducted resident observations, bed and chair alarms, resident health records, relevant home polices and resident interviews

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Physiotherapist, Clinical Coordinator, Registered Nurses, Personal Support Workers

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

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

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
O.Reg 79/10 s. 8. (1)	CO #004	2019_702197_0025	110

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

This Inspection Protocol (IP) was initiated in follow-up to a written Compliance Order (CO) #001, served November 25, 2019, in report #2019_702197_0025 with a compliance due date of December 13, 2019.

A record review of the 'Assessment History Report' provided by the DOC identified residents at high risk for falls. Resident #003 was selected from the list. The report identified the resident was assessed utilizing the Scott Fall Risk Screen. The resident's score was identified with a note 'high risk for falls and unsafe ambulation'.

An interview with physiotherapist (PT) #111 shared that the Scott Fall Risk Scale was a standardized scale used by Extendicare to evaluate a resident's risk of falling. The PT confirmed that resident #003's score and stated their score was in the highest risk category for falls.

A review of the resident's current written plan of care included a fall focus.
The interventions were identified in the written plan of care and kardex as follows:
1. Use of a fall prevention device in two locations.
2. Individualized routines geared to fall prevention with "e.g." examples identified.
3. Monitor daily for change in mental status and ability to remember and follow instructions.
4. Coordinate with appropriate staff to ensure a safe environment with i.e.

examples identified.
5. Identify root causes of falls and work with resident, family and team to develop strategies to address.

Intervention #1
- Use of a fall prevention device in two locations.

On December 19, 2019 at 1305 hours (hrs) an observation was made of resident #003 and the resident's room. The fall prevention device was identified in one of the two locations.

An interview with full time days PSW #106 shared their understanding of the application of the resident's fall prevention device.

An interview with full time nights PSW #109 shared another interpretation of the application of the device and stated the resident's plan of care was not clear as at the start of their shift they identified the previous shift had applied the safety device in the opposite manner to their understanding and approach.

An interview with RPN #105 shared their understanding of the application of the resident's fall prevention device.

An interview with Clinical Coordinator shared that they had run short of the safety devices and that in the interim the application was similar to how PSW #106 was applying it.

A final interview with PT #111 shared that resident #003 was at high risk for falls and their recommendations included the use of the fall prevention device and explained the intended application. The PT stated that the safely device was not intended to be used in the manner that PSW #106 or the clinical coordinator had stated and in reading the resident's plan of care stated direction was not clear to staff.

The DOC confirmed the resident's plan of care for the use of a fall prevention device was not clear.

Intervention #2
- Individualized routines geared to fall prevention with "e.g." examples identified.
In separate interviews PSW #106, RN #116 and PT #111 all shared that they

were unclear of the direction related to intervention #2 in preventing resident #003 from falls.
An interview with the DOC confirmed that the direction in the plan of care related to 'e.g examples and falls prevention was not clear.

Intervention #4
- Coordinate with appropriate staff to ensure a safe environment with "i.e." examples identified.

An interview with PSW #106 shared they used one of the fall prevention interventions identified in the "i.e" examples in the resident's plan of care.
An interview with full time night PSW #110 also confirmed that they used the same fall prevention intervention but was unclear as to why explaining reasons not to use the intervention for resident #003. The PSW shared the care plan was not clear.
An interview with RN #116 shared that staff were not to use the fall prevention intervention listed under the "i.e" examples in the resident's plan of care, explaining a rationale that would make it unsafe for the resident.
An interview with PT #111 shared the same response as RN #116 that the intervention used as described by PSW #106 and #110 should not be used for resident #003 as it was unsafe to do so. The PT stated that the 'i.e' in the resident's written plan of care did not provide clear direction to staff.
In separate interviews RN #116, PSW #110 and PSW #106, all shared that they were unclear of the direction and role related to providing another "i.e" intervention for fall prevention.

The DOC confirmed that the plan of care does not set out clear directions to staff and others who provide direct care to the resident by ensuring consistent information throughout the plan of care that is understood and followed by direct care staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This IP was opened in response to an interview with PT #111. During the interview the PT shared that there were two types of an identified fall prevention device used in the home. Inspector #110 requested the PT to demonstrate a

resident utilizing one of the two devices. PT #111 identified resident #007.

A record review of the 'Assessment History Report' provided by the DOC identified resident #007 at high risk for falls. A review of the resident's written plan of care, directed staff to utilize of a fall prevention device in two locations.

On December 30, 2019 resident #007 was observed along with PT #111 in the dining room. The resident's fall prevention device was not in place.
An interview with PSW #112, who provided care to the resident that shift confirmed that the resident did not have the safely device in either of the two locations. The PSW also shared that they did not know where the safety device was and had not reported it missing to a charge nurse leaving resident #007 without the device.

The PT confirmed that the resident's care, as set out in their plan of care had not been provided to resident #007 as planned. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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:

Conditions of licence
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 Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. 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. 1.

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.

Compliance Order #001 was issued to the licensee on November 25, 2019, under inspection #2019_702197_0025, with a compliance due date of December 13, 2019.

On November 25, 2019, Compliance Order (CO) #001 from inspection #2019_702197_0025, was made under LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) and stated:

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 6. (1)

The licensee was ordered to:
Ensure that the plan of care for all residents assessed at risk for falls (including residents #002 and #006 if applicable), in relation to falls prevention, sets out clear directions to staff and others who provide direct care to the resident by ensuring:
1) Consistent information throughout the plan of care that is understood and followed by

direct care staff.
2) Revisions are based on a documented reassessment of a resident's condition/behavior and all changes are clearly documented and communicated to direct care staff.
3) When new fall prevention interventions are implemented, there is documentation to
support the effectiveness and ongoing use or discontinuation of the interventions.

The licensee failed to comply with step 1 whereby the licensee failed to ensure resident #003, at high risk for falls, had a plan of care that set out clear directions to staff and others who provided direct care to the resident and that the information throughout the plan of care that was understood and followed by direct care staff.

The licensee did not comply with the order made under this Act. [s. 101. (3)] [s. 101. (3)]

Issued on this 24th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DIANE BROWN (110) - (A1)
Inspection No. / No de l'inspection :	2019_595110_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022477-19, 022480-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 24, 2020(A1)
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

Ontario

Ministry of Long-Term Care

Ministère 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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_702197_0025, CO #001;

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 shall be compliant with LTCHA, 2007, c.8, s. 6. (1).

The licensee shall ensure that the plan of care for all residents assessed at risk for falls (including resident #003 if applicable), in relation to falls prevention, sets out clear directions to staff and others who provide direct care to the resident by ensuring consistent information throughout the plan of care that is understood and followed by direct care staff.

Grounds / Motifs :

1. Compliance Order #001 was issued to the licensee on November 25, 2019, under inspection #2019_702197_0025, with a compliance due date of December 13, 2019.

The compliance order was issued to LTCHA, 2007, c.8, s. 6. (1) and asked that the licensee do the following:

Specifically, the licensee shall ensure that the plan of care for all residents assessed at risk for falls (including residents #002 and 006 if applicable), in relation to falls prevention, sets out clear directions to staff and others who provide direct care to the resident by

ensuring:
1) Consistent information throughout the plan of care that is understood and followed by direct care staff.
2) Revisions are based on a documented reassessment of a resident's condition/behavior and all changes are clearly documented and communicated to direct care staff.
3) When new fall prevention interventions are implemented, there is documentation to support the effectiveness and ongoing use or discontinuation of the interventions.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #003.

A record review of the 'Assessment History Report' provided by the DOC identified residents at high risk for falls. Resident #003 was selected from the list. The report identified the resident was assessed utilizing the Scott Fall Risk Screen. The resident's score was identified with a note 'high risk for falls and unsafe ambulation'.

An interview with physiotherapist (PT) #111 shared that the Scott Fall Risk Scale was a standardized scale used by Extendicare to evaluate a resident's risk of falling. The PT confirmed that resident #003's score and stated their score was in the highest risk category for falls.

A review of the resident's current written plan of care included a fall focus.
The interventions were identified in the written plan of care and kardex as follows:
1. Use of a fall prevention device in two locations.
2. Individualized routines geared to fall prevention with "e.g." examples identified.
3. Monitor daily for change in mental status and ability to remember and follow instructions.
4. Coordinate with appropriate staff to ensure a safe environment with i.e. examples identified.
5. Identify root causes of falls and work with resident, family and team to develop strategies to address.

Intervention #1
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An interview with full time days PSW #106 shared their understanding of the application of the resident's fall prevention device.

An interview with full time nights PSW #109 shared another interpretation of the application of the device and stated the resident's plan of care was not clear as at the start of their shift they identified the previous shift had applied the safety device in the opposite manner to their understanding and approach.

An interview with RPN #105 shared their understanding of the application of the resident's fall prevention device.

An interview with Clinical Coordinator shared that they had run short of the safety devices and that in the interim the application was similar to how PSW #106 was applying it.

A final interview with PT #111 shared that resident #003 was at high risk for falls and their recommendations included the use of the fall prevention device and explained the intended application. The PT stated that the safely device was not intended to be used in the manner that PSW #106 or the clinical coordinator had stated and in reading the resident's plan of care stated direction was not clear to staff.

The DOC confirmed the resident's plan of care for the use of a fall prevention device was not clear.

Intervention #2
- Individualized routines geared to fall prevention with "e.g." examples identified.
In separate interviews PSW #106, RN #116 and PT #111 all shared that they were unclear of the direction related to intervention #2 in preventing resident #003 from falls.
An interview with the DOC confirmed that the direction in the plan of care related to 'e.g examples and falls prevention was not clear.

Intervention #4
- Coordinate with appropriate staff to ensure a safe environment with "i.e." examples identified.

An interview with PSW #106 shared they used one of the fall prevention interventions identified in the "i.e" examples in the resident's plan of care.
An interview with full time night PSW #110 also confirmed that they used the same fall prevention intervention but was unclear as to why explaining reasons not to use the intervention for resident #003. The PSW shared the care plan was not clear.
An interview with RN #116 shared that staff were not to use the fall prevention intervention listed under the "i.e" examples in the resident's plan of care, explaining a rationale that would make it unsafe for the resident.
An interview with PT #111 shared the same response as RN #116 that the intervention used as described by PSW #106 and #110 should not be used for resident #003 as it was unsafe to do so. The PT stated that the 'i.e' in the resident's written plan of care did not provide clear direction to staff.
In separate interviews RN #116, PSW #110 and PSW #106, all shared that they were unclear of the direction and role related to providing another "i.e" intervention for fall prevention.

The DOC confirmed that the plan of care does not set out clear directions to staff and others who provide direct care to the resident by ensuring consistent information throughout the plan of care that is understood and followed by direct care staff. [s. 6. (1) (c)]

The severity of this issue was determined to be a level 3 as there was actual risk to resident #003. The scope of the non compliance was 1 for isolated.

The home had a level 4 compliance history to the same section as follows:
- Inspection #2019_702197_0025-Compliance Order (CO) issued November 22, 2019.
- Inspection #2019_717531_0015 - VPC issued July 8, 2019.
- Inspection #2018_594624_0009 - WN issued Sept 7, 2018.

(110)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 31, 2020(A1)

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère 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 24th day of February, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DIANE BROWN (110) - (A1)

Ontario

Ministry of Long-Term Care

Ministère 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

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