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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2018	2018_505103_0007	026741-17, 028650-17, 029629-17, 000232-18, 002810-18, 003187-18, 003237-18, 004065-18	Critical Incident System

Licensee/Titulaire de permis

County of Prince Edward
603 Highway 49 R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

H.J. McFarland Memorial Home
603 Highway 49, R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 14, 15, 16, 19, 20, 21, 22, 2018.

Log #026741-17- (CIS #M559-000028-17),
Log #029629-17- (CIS #M556-000034-17),
Log #002810-18- (CIS #M556-000003-18),
Log #003187-18- (CIS #M556-000004-18),
Log #004065-18- (CIS #M556-000008-18)- resident falls that resulted in an injury.

Log #028650-17- (CIS #M556-000033-17),
Log #000232-18- (CIS #M556-000002-18),
Log #003237-18- (CIS #M556-000006-18)- alleged incidents of staff to resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Acting lead for recreational department, a volunteer, the Director of Care and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the critical incidents submitted by the home, the home's investigation notes into the incidents of alleged abuse/neglect, the home's abuse policy, the home's fall prevention policy, education records for abuse training completed in 2017, and made resident observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

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. 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 :

1. The person who had reasonable grounds to suspect an incident of resident abuse or neglect had occurred, failed to immediately report the suspicion and the information upon which it was based immediately to the Director (MOHLTC).

Resident #004 had diagnoses that included cognitive impairment. On a specified date on or about 0430 hour, RN #109 was asked by PSW #102 to come and assess an injury on resident #004. RN #109 was interviewed and stated the resident had been found by PSW #102 to be wandering in their room and when the PSW attempted to redirect the resident to bed, resident #004 became angry. PSW #102 had reported to the RN that they had noted an injury on resident #004 at that time. The RN spoke with the resident and when asked what had happened, the resident had replied someone had hit them.

RN #109 sent an email to the Director of Care (DOC) on the specified date at 0730 hour to report the allegation of physical abuse. RN #109 was interviewed and stated they had asked the resident on three occasions how the injury had occurred and each time the resident gave the same answer. The RN stated they were hesitant to report the incident to the MOHLTC because of resident #004's cognitive impairment.

The DOC was interviewed and indicated they received the email from RN #109 on the specified date at approximately 0830 hour to report the allegation of abuse. The home immediately began to investigate the alleged incident and reported the allegation to the

MOHLTC at that time. The DOC stated registered staff are in charge of the home at all times when the DOC and Administrator are not on site and are to immediately report all alleged, suspected or witnessed incidents of resident abuse or neglect to the MOHLTC.

RN #109 failed to immediately report an incident of alleged staff to resident abuse. [s. 24. (1)]

2. Resident #006 had diagnoses that included a specified condition. On a specified date, the home submitted a critical incident (CIS), #M556-000033-17 to report an alleged incident of staff to resident neglect involving resident #006. The CIS outlined the resident returned from a leave of absence on a specified date on or about 1330 hour and reported to RPN #115 they were feeling unwell. The RPN assessed the resident and reported the information to RN #116, however the RN did not assess the resident. RPN #115 remained concerned about the resident and reported to RN #113 when they reported to work on the evening shift. RN #113 assessed resident #006 and the resident was sent to hospital and diagnosed with a specified condition.

The DOC was interviewed in regards to the incident and indicated RN #113 emailed an update to the DOC in regards to the resident's status. The DOC indicated upon receipt of the email, they investigated the reason RN #116 had not assessed the resident. The DOC stated it was at that time they suspected it was an incident of staff to resident neglect and immediately began an investigation into the incident. They indicated the MOHLTC was notified of the alleged staff to resident neglect for the first time by means of the critical incident which was submitted fourteen days later. The DOC stated it was an oversight that the notification to the MOHLTC was not immediate.

The DOC failed to immediately report a suspected incident of staff to resident neglect to the Director. [s. 24. (1)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the abuse policy, "Prevention of Abuse and Neglect of a Resident" VII-G-10.00, was complied with.

Resident #005 had diagnoses that included a cognitive impairment. On a specified date on or about 1815 hour, resident #005 was observed on the first floor to be agitated and staff were having difficulty redirecting the resident. Activity aide #107 was interviewed and stated they observed a staff member encouraging the resident to sit down in the wheelchair for their safety, but resident #005 was agitated and uncooperative. Activity aide #107 stated they attempted to assist the staff with resident #005 and asked Volunteer #108 to retrieve a registered staff member.

Volunteer #108 was interviewed and stated they found RPN #114 in the second floor nursing station. Volunteer #108 stated they had told the RPN resident #005 was agitated and asked if they would come to assist. Volunteer #108 stated the RPN became angry and commented they were sick of dealing with this. Volunteer #108 stated when RPN #114 approached resident #005, the RPN grabbed the resident by the arm and pushed the resident with force into the wheelchair. Volunteer #108 stated the RPN was visibly angry and rough with resident #005 throughout the interaction.

Activity aide #107 was interviewed and also stated they observed RPN #114 using a harsh tone with resident #005 and being forceful when pushing the resident into the wheelchair. Activity aide #107 and Volunteer #108 both told the inspector they knew this had to be reported. Activity aide #107 stated they were planning on telling their immediate supervisor when they returned to work two days later. Volunteer #108 stated they sent an email to the DOC when they got home later that evening.

The DOC was interviewed and stated the email from Volunteer #108 was received when they returned to work two days later. The home began the investigation into the alleged incident of staff to resident abuse upon the receipt of the email.

The alleged incident of staff to resident abuse was not immediately reported to the MOHLTC by Activity Aide #107 and Volunteer #108 who had reasonable grounds to suspect an incident of physical abuse involving resident #005 had occurred. [s. 20. (1)]

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 all suspected, witnessed or alleged incidents of resident abuse are immediately reported in accordance with the home's abuse policy, to be implemented voluntarily.

WN #3: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of the resident abuse/neglect investigations were reported to the Director.

On a specified date, the home submitted critical incident (CIS) #M556-000006-18 to report the alleged staff to resident abuse. The following day, the DOC amended the CIS and indicated at that time the home's investigation was ongoing. [s. 23. (2)]

2. On a specified date, the home submitted CIS #M556-000033-17 to report an alleged incident of staff to resident neglect. The CIS was amended four days later and indicated the home's investigation was ongoing. [s. 23. (2)]

3. On a specified date, the home submitted critical incident (CIS) #M556-000002-18 to report an alleged staff to resident abuse. Eight days later, the DOC amended the CIS and indicated the home's investigation was ongoing.

The DOC was interviewed in regards to the three CIS's outlined above and indicated additional amendments had not been made to reflect the results of the home's investigation into the alleged abuse. [s. 23. (2)]

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 the results of every investigation undertaken and every action taken for alleged, suspected or witnessed incidents of resident abuse or neglect are reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 77. Orientation for volunteers
Every licensee of a long-term care home shall develop an orientation for volunteers that includes information on,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protections afforded by section 26. 2007, c. 8, s. 77.

Findings/Faits saillants :

1. The licensee has failed to ensure there was an orientation for volunteers that included the information on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

As outlined in WN #2, Volunteer #108 stated during an interview that they had been volunteering in the home since 2016. Volunteer #108 stated they had never received education related to the home's zero tolerance of abuse and neglect policy or education related to mandatory reporting of abuse or neglect.

The acting lead for the recreation department #107 was interviewed and stated the home had not provided education to the volunteers in these areas, but planning had been started to ensure this was completed. [s. 77.]

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 volunteers receive orientation that includes all legislated requirements, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure RN #109 received retraining annually on the long term care home's policy to promote zero tolerance of abuse and the duty under section 24 to make mandatory reports.

As outlined in WN #1, RN #109 failed to immediately report an alleged staff to resident abuse. The Administrator was interviewed in regards to the annual abuse education for all staff. The Administrator stated the annual abuse training had last been completed in May 2017. The inspector requested to review the list of staff who attended the 2017 abuse training and found RN #109's name was not included. The Administrator stated the RN had been working as a casual RN in May 2017 when the training had been given and confirmed the RN had not received the annual training. [s. 76. (4)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #005's substitute decision maker (SDM) was notified of the results of the alleged abuse immediately upon the completion of the home's investigation.

As outlined in WN #2, the DOC was interviewed and stated the home concluded the investigation related to the alleged incident of staff to resident abuse involving resident #005 on a specified date. To date of this inspection, the SDM of resident #005 had not been notified of the results of the home's alleged abuse investigation. [s. 97. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of resident abuse or neglect that the licensee suspects may constitute a criminal offence.

As outlined in WN #1 and WN #2 , the police were not notified of the alleged incidents of staff to resident physical abuse involving residents #004 and #005. The DOC was interviewed and acknowledged both incidents should have been immediately reported to the local police. [s. 98.]

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

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Issued on this 17th day of April, 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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2018_505103_0007
Log No. / No de registre :	026741-17, 028650-17, 029629-17, 000232-18, 002810-18, 003187-18, 003237-18, 004065-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 16, 2018
Licensee / Titulaire de permis :	County of Prince Edward 603 Highway 49, R.R. #2, Hallowell Township, PICTON, ON, K0K-2T0
LTC Home / Foyer de SLD :	H.J. McFarland Memorial Home 603 Highway 49, R.R. #2, Hallowell Township, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Mauro

To County of Prince Edward, 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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must be compliant with s. 24 of the LTCHA.

a) Specifically, the licensee must ensure all suspected, alleged or witnessed incidents of resident abuse or neglect involving residents #004, #006 and any other resident are immediately reported to the Director (MOHLTC).
b) Ensure RN #109 receives training on the licensee's abuse policy, "Prevention of Abuse and Neglect of a Resident" VII-G-10.00, including mandatory reporting as outlined in s. 24.

Grounds / Motifs :

1. The person who had reasonable grounds to suspect an incident of resident abuse or neglect had occurred, failed to immediately report the suspicion and the information upon which it was based immediately to the Director (MOHLTC).

Resident #004 had diagnoses that included a cognitive impairment. On a specified date on or about 0430 hour, RN #109 was asked by PSW #102 to come and assess an injury on resident #004. RN #109 was interviewed and stated the resident had been found by PSW #102 to be wandering in their room and when the PSW attempted to redirect the resident to bed, resident #004 became angry. PSW #102 had reported to the RN that they had noted an injury

on resident #004 at that time. The RN spoke with the resident and when asked what had happened, the resident had replied someone had hit them.

RN #109 sent an email to the Director of Care (DOC) on the specified date at 0730 hour to report the allegation of physical abuse. RN #109 was interviewed and stated they had asked the resident on three occasions how the injury had occurred and each time the resident gave the same answer. The RN stated they were hesitant to report the incident to the MOHLTC because of resident #004's cognitive impairment.

The DOC was interviewed and indicated they received the email from RN #109 on the specified date at approximately 0830 hour to report the allegation of abuse. The home immediately began to investigate the alleged incident at that time. The DOC stated registered staff are in charge of the home at all times when the DOC and Administrator are not on site and are to immediately report all alleged, suspected or witnessed incidents of resident abuse or neglect to the MOHLTC.

RN #109 failed to immediately report an incident of alleged staff to resident abuse.

(103)

2. Resident #006 had diagnoses that included a specified condition. On a specified date, the home submitted a critical incident (CIS), #M556-000033-17 to report an alleged incident of staff to resident neglect involving resident #006. The CIS outlined the resident returned from a leave of absence on a specified date on or about 1330 hour and reported to RPN #115 they were feeling unwell. The RPN assessed the resident and reported the information to RN #116, however the RN did not assess the resident. RPN #115 remained concerned about the resident and reported to RN #113 when they reported to work on the evening shift. RN #113 assessed resident #006 and the resident was sent to hospital and diagnosed with a specified condition.

The DOC was interviewed in regards to the incident and indicated RN #113 emailed an update to the DOC in regards to the resident's status. The DOC indicated upon receipt of the email they investigated the reason RN #116 had not assessed the resident. The DOC stated it was at that time they suspected it was an incident of staff to resident neglect and immediately began an

investigation into the incident. They indicated the MOHLTC was notified of the alleged staff to resident neglect for the first time by means of the critical incident which was submitted fourteen days later. The DOC stated it was an oversight that the notification to the MOHLTC was not immediate.

The DOC failed to immediately report a suspected incident of staff to resident neglect to the Director.

The decision to issue this as a compliance order was based on the following: The severity in each of the two incidents reviewed by the inspector were determined as a level 2 as there was minimal harm or potential for actual harm. The scope was determined as a level 3 as two out of the two incidents reviewed were late reported to the MOHLTC. The home had a level 4 history of ongoing non compliance with this section of the Act that included:
-Written Notification (WN) and Voluntary Plan of correction (VPC) issued September 29, 2015 (2015_396103_0053), March 21, 2016 (2016_236622_0010), July 7, 2016 (2016_280541_0016), and March 6, 2017 (2017_505103_0007). (103)

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 14, 2018

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

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 16th day of April, 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 : DARLENE MURPHY

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