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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Dec 28, 2017	2017_657681_0013	016558-17, 017520-17, 017599-17, 017856-17, 018268-17, 018394-17, 019282-17, 019551-17, 019960-17, 020058-17, 020378-17, 020618-17, 021106-17, 021801-17, 021934-17, 021952-17, 022528-17, 022801-17, 023424-17, 024904-17	Critical Incident System

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

STEPHANIE DONI (681), SHELLEY MURPHY (684), TIFFANY BOUCHER (543)

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): November 14-17, 2017, and November 20-24, 2017.

The following intakes were completed during this Critical Incident System (CIS) inspection:

- Five intakes related to staff to resident neglect.

- Five intakes related to staff to resident abuse.

- Two intakes related to resident to resident abuse.

- Three intakes related to resident falls that resulted in injury and transfer to hospital.

- Two intakes related to missing or unaccounted for controlled substances.

A Complaint inspection #2017_657681_0014 and a Follow Up inspection #2017_657681_0015 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Coordinator of Education and Special Services, Program Coordinators, Resident-Assessment-Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Nutritional Aides (NAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

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

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

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 care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that on a specific day, residents #013, #014 and #017 were found wearing the previous day's clothing and that two of these residents were found saturated with urine and wearing the incorrect type of incontinence product.

The CIS report indicated that on a specific day, HCA #122 received resident #013 on top of their bed, fully clothed and saturated in urine, with two specific devices still on the resident that were to be removed. The resident was wearing a specified type of incontinence product. Resident #014 was received in the same clothing that HCA #122 had dressed them in the previous day. Resident #017 was received sleeping on top of their blankets wearing the same clothes that HCA #122 had dressed them in the previous day. Resident #017's bedding and clothing were saturated with urine.

Inspector #543 reviewed the care plans for resident #013, #014 and #017 which indicated the following:

- Resident #013 required assistance with care and was to have their incontinence product changed at a specified time during the night. Staff were also to minimize exposure to moisture when possible. Resident #013's care plan indicated that resident #013 required assistance with dressing and that staff were to ensure that clothing was clean and appropriate.

- Resident #014's care plan indicated that they preferred to wear a specific type of clothing at bedtime. The care plan identified that resident #014 required assistance with

dressing and that staff were to ensure that clothing was clean and appropriate.

- Resident #017's care plan indicated that staff would minimize exposure to moisture and would provide care each time resident #017's incontinence product was changed and after toileting. The care plan identified that staff would provide resident #017 assistance with dressing and would ensure that clothing was clean and appropriate.

The Inspector interviewed HCA #122 who stated that the following had occurred on a particular day:

- Resident #013 was received fully dressed in the clothing they were wearing the previous day. HCA #122 indicated the resident was saturated in urine, including their bed linens. They identified that the resident was wearing the incorrect type of incontinence product and that two specific devices, which should have been removed, were still in place.

- Resident #014 was received in the same clothing HCA #122 had helped dress them in the previous day. HCA #122 indicated that this resident preferred to wear a specific type of clothing to bed.

- Resident #017 was received fully clothed in the clothing they wore the previous day. HCA #122 stated the resident #017 was saturated in urine. They indicated that the resident preferred to wear a specific type of clothing to bed.

Inspector #543 reviewed progress notes related to the incident. A progress note identified that resident #014's family was very upset related to the care their loved one was receiving. The progress note indicated that the family was not content when agency staff cared for the resident, as they do not provide appropriate care. The note identified that the family felt there was no consistency with staff in the home.

Inspector #543 interviewed Program Coordinator #123 who indicated that HCA #143 did not change the residents' clothing, toilet the residents, or change their incontinence products. Program Coordinator #123 verified that HCA #143 did not provide the care to residents #013, #014 and #017, as specified in their plans of care. [s. 6. (7)]

2. A CIS report was submitted to the Director related to the improper transfer of a resident. The CIS report indicated that resident #001 was improperly transferred to the toilet by HCA #113, which resulted in resident #001 falling and sustaining an injury.

Inspector #681 reviewed resident #001's electronic medical record. A progress note indicated that RPN #116 was called to resident #001's bathroom by HCA #113. Resident #001 was on the bathroom floor with their back up against the wall beside the toilet. HCA #113 advised RPN #116 that they were attempting to transfer resident #001 to the toilet.

Inspector #681 reviewed resident #001's electronic plan of care that was in place at the time of the incident. Resident #001's care plan indicated that they required assistance from two staff members for all transfers. The toileting focus of resident #001's care plan also indicated that they were not to be toileted.

During an interview with Inspector #681, RPN #116 stated that they were called to resident #001's room by HCA #113 and found resident #001 on bathroom floor slouched over with their back up against the toilet and the wall. HCA #113 said to RPN #116 that they were trying to toilet resident #001 and that they could not hold resident #001 up. RPN #116 stated that resident #001 was a two person transfer and that resident #001 was not to be toileted. RPN #116 stated that resident #001 sustained an injury when they fell.

During an interview with Inspector #681 on November 21, 2017, the Coordinator of Education and Special Services stated that HCA #113 had not followed resident's #001's plan of care, which resulted in resident #001 falling. [s. 6. (7)]

3. A CIS report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that resident #020 was being assisted from bed to the washroom by HCA #141, but a specific aspect of resident #020's assistive device was missing. As a result, resident #020 experienced a fall and sustained an injury.

Inspector #681 reviewed resident #020's electronic plan of care that was in place at the time the incident occurred. Resident #020's care plan indicated that a specific attachment must be applied to the resident's assistive device as a fall intervention.

Inspector #681 reviewed the home's investigation notes related to the incident, which indicated that during a meeting with management, HCA #141 stated that they reviewed resident #020's care plan at the beginning of their shift. However, HCA #141 stated that the specific attachment was not applied to resident #020's assistive device when they assisted resident #020 from their bed to the bathroom.

During an interview with Inspector #681 on November 24, 2017, Program Coordinator #123 stated that HCA #141 did not follow the care set out in resident #020's plan of care and that this resulted in resident #020 falling from their wheelchair. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director, related to staff to resident neglect. The CIS report indicated that HCA #127 was transferring resident #002 by themselves using a specific device.

The CIS report indicated that resident #002 was found with their knees on the floor. As a result of the incident, resident #002 sustained an injury.

During separate interviews with Inspector #681, HCA #128 and RPN #129 each stated that they witnessed resident #002 during the transfer in an unsafe position. HCA #128 and RPN #129 stated that they were not immediately able to assist the resident because of a feature on the device.

HCA #128 and RPN #129 also stated to Inspector #681 that this particular device was to be utilized with two staff members present; however, when this incident occurred, HCA #127 was the only staff member with resident #002.

Inspector #681 reviewed the home's policy titled "Minimal Lift Program", which indicated that two caregivers must always be in attendance when using a specific device.

During an interview with Inspector #681, Program Coordinator #107 stated that HCA #127 did not follow the home's minimal lift policy by operating the device independently and that HCA #127 was disciplined. [s. 36.]

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 staff use safe transferring technique when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medication was stored in an area that was used exclusively for drugs and drug related supplies.

Two CIS reports were submitted to the Director related to missing/unaccounted for controlled substances.

A) Inspector #684 interviewed RPN #114, who informed the Inspector that narcotics are kept in a locked box, which was located in a locked drawer. RPN #114 proceeded to show Inspector #684 the narcotics in the locked box, which was in a locked drawer. The locked drawer was not in a specified medication room.

B) Inspector #684 interviewed RPN #117 who stated that all narcotics are kept in a specific drawer in a specific area and that it was double locked. RPN #117 then showed Inspector #684 the narcotics, which were in a locked box in a locked drawer in the specified area. The Inspector noted that the specified area was not in a specified medication room. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A) Inspector #684 observed that, in a specific home area, some narcotics were kept in a

single locked cupboard in the medication room and other narcotics were kept in a single locked box in a refrigerator.

B) Inspector #684 interviewed RPN #114 who informed the Inspector that narcotics were kept in a locked box, which was located in a locked drawer. RPN #114 proceeded to show Inspector #684 the narcotics in the locked box, which was in a locked drawer.

C) Inspector #684 viewed the medication room in another home area with RPN #115, specifically related to narcotic storage. Narcotics were stored in a cupboard next to the refrigerator in the medication room. The Inspector noted that there were multiple narcotics in the cupboard, which were only single locked.

Inspector #684 interviewed the Manager of Resident Care regarding the Director Referral Action Plan in relation to r. 129 (1) which said; Manager of Physical Services to arrange to have an extra sliding door placed in front of the medication stations in two particular home areas that will be locked to the wall. This will provide the third lock on the narcotics. Target date November 15, 2017.

The Manager of Resident Care confirmed that this has not yet been completed and that the target completion date was November 15, 2017. [s. 129. (1) (b)]

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 medication is stored in an area that is used exclusively for drugs and drug related supplies and that controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

Issued on this 8th day of January, 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) :	STEPHANIE DONI (681), SHELLEY MURPHY (684), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2017_657681_0013
Log No. / No de registre :	016558-17, 017520-17, 017599-17, 017856-17, 018268-17, 018394-17, 019282-17, 019551-17, 019960-17, 020058-17, 020378-17, 020618-17, 021106-17, 021801-17, 021934-17, 021952-17, 022528-17, 022801-17, 023424-17, 024904-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 28, 2017
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
	Aaron Archibald

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 Administrator /
Nom de l'administratrice ou de l'administrateur :

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. (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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically but not limited to,

a) develop and implement a process to ensure that agency HCAs have familiarized themselves with a resident's care plan prior to providing direct care so that care is provided as per the plan of care.

Grounds / Motifs :

1. 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.

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that on a specific day, residents #013, #014 and #017 were found wearing the previous day's clothing and that two of these residents were found saturated with urine and wearing the incorrect type of incontinence product.

The CIS report indicated that on a specific day, HCA #122 received resident #013 on top of their bed, fully clothed and saturated in urine, with two specific devices still on the resident that were to be removed. The resident was wearing a specified type of incontinence product. Resident #014 was received in the same clothing that HCA #122 had dressed them in the previous day. Resident #017 was received sleeping on top of their blankets wearing the same clothes that HCA #122 had dressed them in the previous day. Resident #017's bedding and clothing were saturated with urine.

Inspector #543 reviewed the care plans for resident #013, #014 and #017 which

indicated the following:

- Resident #013 required assistance with care and was to have their incontinence product changed at a specified time during the night. Staff were also to minimize exposure to moisture when possible. Resident #013's care plan indicated that resident #013 required assistance with dressing and that staff were to ensure that clothing was clean and appropriate.

- Resident #014's care plan indicated that they preferred to wear a specific type of clothing at bedtime. The care plan identified that resident #014 required assistance with dressing and that staff were to ensure that clothing was clean and appropriate.

- Resident #017's care plan indicated that staff would minimize exposure to moisture and would provide care each time resident #017's incontinence product was changed and after toileting. The care plan identified that staff would provide resident #017 assistance with dressing and would ensure that clothing was clean and appropriate.

The Inspector interviewed HCA #122 who stated that the following had occurred on a particular day:

- Resident #013 was received fully dressed in the clothing they were wearing the previous day. HCA #122 indicated the resident was saturated in urine, including their bed linens. They identified that the resident was wearing the incorrect type of incontinence product and that two specific devices, which should have been removed, were still in place.

- Resident #014 was received in the same clothing HCA #122 had helped dress them in the previous day. HCA #122 indicated that this resident preferred to wear a specific type of clothing to bed.

- Resident #017 was received fully clothed in the clothing they wore the previous day. HCA #122 stated the resident #017 was saturated in urine. They indicated that the resident preferred to wear a specific type of clothing to bed.

Inspector #543 reviewed progress notes related to the incident. A progress note identified that resident #014's family was very upset related to the care their loved one was receiving. The progress note indicated that the family was not

content when agency staff cared for the resident, as they do not provide appropriate care. The note identified that the family felt there was no consistency with staff in the home.

Inspector #543 interviewed Program Coordinator #123 who indicated that HCA #143 did not change the residents' clothing, toilet the residents, or change their incontinence products. Program Coordinator #123 verified that HCA #143 did not provide the care to residents #013, #014 and #017, as specified in their plans of care. [s. 6. (7)]

2. A CIS report was submitted to the Director related to the improper transfer of a resident. The CIS report indicated that resident #001 was improperly transferred to the toilet by HCA #113, which resulted in resident #001 falling and sustaining an injury.

Inspector #681 reviewed resident #001's electronic medical record. A progress note indicated that RPN #116 was called to resident #001's bathroom by HCA #113. Resident #001 was on the bathroom floor with their back up against the wall beside the toilet. HCA #113 advised RPN #116 that they were attempting to transfer resident #001 to the toilet.

Inspector #681 reviewed resident #001's electronic plan of care that was in place at the time of the incident. Resident #001's care plan indicated that they required assistance from two staff members for all transfers. The toileting focus of resident #001's care plan also indicated that they were not to be toileted.

During an interview with Inspector #681, RPN #116 stated that they were called to resident #001's room by HCA #113 and found resident #001 on bathroom floor slouched over with their back up against the toilet and the wall. HCA #113 said to RPN #116 that they were trying to toilet resident #001 and that they could not hold resident #001 up. RPN #116 stated that resident #001 was a two person transfer and that resident #001 was not to be toileted. RPN #116 stated that resident #001 sustained an injury when they fell.

During an interview with Inspector #681 on November 21, 2017, the Coordinator of Education and Special Services stated that HCA #113 had not followed resident's #001's plan of care, which resulted in resident #001 falling. [s. 6. (7)]

3. A CIS report was submitted to the Director related to an allegation of staff to

resident neglect. The CIS report indicated that resident #020 was being assisted from bed to the washroom by HCA #141, but a specific aspect of resident #020's assistive device was missing. As a result, resident #020 experienced a fall and sustained an injury.

Inspector #681 reviewed resident #020's electronic plan of care that was in place at the time the incident occurred. Resident #020's care plan indicated that a specific attachment must be applied to the resident's assistive device as a fall intervention.

Inspector #681 reviewed the home's investigation notes related to the incident, which indicated that during a meeting with management, HCA #141 stated that they reviewed resident #020's care plan at the beginning of their shift. However, HCA #141 stated that the specific attachment was not applied to resident #020's assistive device when they assisted resident #020 from their bed to the bathroom.

During an interview with Inspector #681 on November 24, 2017, Program Coordinator #123 stated that HCA #141 did not follow the care set out in resident #020's plan of care and that this resulted in resident #020 falling from their wheelchair. [s. 6. (7)]

During previous inspections (#2016_336620_0004, #2016_320612_0010, #2016_269627_0011, and #2015_391603_0029) Written Notifications (WN) were issued to the home on February 11, 2016 and May 3, 2016, a Voluntary Plan of of Correction (VPC) was issued on September 27, 2016, and a compliance order was issued to the home on January 8, 2016. The decision to issue a compliance order was based on the severity, which indicated actual harm/risk to the residents of the home, and scope, which identified a pattern throughout the home. Furthermore, the home's compliance history identified ongoing noncompliance related to this section.
(681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 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 28th day of December, 2017

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 : Stephanie Doni

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