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 prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2018	2018_669642_0030 (A1)	007053-18, 007464-18, 008709-18, 010001-18, 010636-18, 010747-18, 010882-18, 012387-18, 013389-18, 014902-18, 017605-18, 021286-18, 023706-18, 025716-18, 026951-18, 031334-18	Critical Incident System

Licensee/Titulaire de permis

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

Amended by AMY GEAUVREAU (642) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

To correct the date in WN #3 of a CI report that was submitted to the Director.

Issued on this 19th day of December, 2018 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2018	2018_669642_0030 (A1)	007053-18, 007464-18, 008709-18, 010001-18, 010636-18, 010747-18, 010882-18, 012387-18, 013389-18, 014902-18, 017605-18, 021286-18, 023706-18, 025716-18, 026951-18, 031334-18	Critical Incident System

Licensee/Titulaire de permis

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

Amended by AMY GEAUVREAU (642) - (A1)

Amended 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 19-23, 26-30, 2018.

The following Critical Incidence reports (CIS) were inspected upon:

One Critical Incident report (CIS), submitted to the Director related to the plan of care;

One CIS, submitted to the Director related to medication destruction;

Four CISs, submitted to the Director related to alleged staff to resident abuse;

Eight CISs, submitted to the Director related to falls;

Two CISs, submitted to the Director related to responsive behaviours, resulting in resident to resident altercations;

A Complaint inspection #2018_669642_0029, was conducted concurrently with this Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director, Manager of Resident Care (MORC), Pharmacists, Manager of Therapeutic Services, Program Coordinators, Coordinator of Recreation Therapy & Volunteerism, Intake Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Nutritional Aid (NA), Personal Support Workers (PSWs), a volunteer, 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
Responsive Behaviours

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident set out the planned care for the resident.

A Critical Incident (CI) report was submitted by the home to the Director, which outlined a physical altercation; whereby, resident #012 threw an item at resident #013 on a day in July, 2018.

A review was conducted by Inspector #609 of resident #012's progress notes for the six month period between May, to November, 2018, and found that on a day in September, 2018, the resident made an allegation that items had been taken from their room.

As a result and after discussion between the MORC, resident #012 and RN #122, all agreed that one item would be kept in a locked drawer in the resident's room when not in use.

During interviews with PSW #129 and RPN #123, both verified that resident #012's specific item was to be locked in their drawer when not in use.

Inspector #609 reviewed resident #012's plan of care, and found no mention that the resident's specific item, was to be kept locked in their drawer when not in use.

A review of the home's policy titled, "Documentation Resident Care Plan," last revised September 2, 2018, required the plan of care to give relevant direction to staff providing care to the resident.

During an interview with Program Coordinator (PC) #109, a review of resident #012's progress notes and plan of care were conducted. They verified that the requirement that the resident's specific item be locked in their drawer when not in use, and it should have been set out in their plan of care, however it was not identified in their plan of care. [s. 6. (1) (a)]

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 there is a written plan of care for resident #012, and that the plan clearly sets out the planned care for the resident, and clear directions for staff and others who provide direct care to the resident, to be implemented voluntarily.

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 that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director, which outlined how resident #014 had accepted a specific service, and then resident #014 attempted to not receive the service. Volunteer #113 who had provided the resident with the service then tried to stop the resident in attempts to force the resident to accept the service. PSW #114 and another volunteer intervened and separated Volunteer #113 from the resident. During the incident, resident #014 could be heard stating, "help me, help me".

Inspector #609 interviewed PSW #114, they stated that on a day in June, 2018, they observed Volunteer #113 grab resident #014 and attempt to force the specific service, at which point they intervened to stop the volunteer.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" approved last May 3, 2018, indicated that the home had a policy of not tolerating resident

abuse/neglect.

A review of a letter to Volunteer #113 from the home on a day in June, 2018, outlined how as a result of their actions which constituted physical abuse and caused distress to resident #014, they were no longer able to continue in their role in the home as a volunteer.

During an interview with the Coordinator of Recreation Therapy and Volunteerism, they described how despite discussing their actions, Volunteer #113 refused to acknowledged their actions on a day in June, 2018, as abusive towards resident #014. [s. 20. (1)]

2. A CI report was submitted by the home to the Director, which outlined how on a day in July, 2018, resident #012 was observed saying specific comments and flinging a specific item at resident #014.

Inspector #609 reviewed resident #012's progress notes for the six month period, between May, to November, 2018, and found that on a day in September, 2018, the resident told RPN #123 that they believed their roommate had taken specific items.

During an interview with RPN #123, they verified that on a day in September, 2018, resident #012 made allegations to them that their roommate had taken specific items. The RPN further indicated that they had immediately informed their supervisor, RN #122 of the resident's allegations.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" approved last May 3, 2018, indicated that taking specific items and personal belongings from a resident constituted financial abuse and that all employees who have witnessed or suspect that a resident was being abused must report the allegations immediately to the home area PC or the Administrative Person On Call. Communication with the Administrative Person On Call was to be facilitated by the supervisor RN.

During an interview with the MORC a review of resident #012's progress notes was conducted. They denied being made aware of resident #012's allegations.

During an interview with PC #109 a review of resident #012's progress notes was conducted. They denied being made aware of resident #012's allegations. They

further indicated that RN #122 did not comply with the home's abuse policy when they failed to inform the Administrative Person On Call or the home area PC of the allegations. [s. 20. (1)]

3. a) A CIS was submitted to the Director, where resident #003 was cared for in an improper manner and a report of an alleged emotional abuse was reported.

Inspector #642 reviewed the home's internal investigation file, which included a document titled, "Suspected Resident Abuse/Neglect Report," where RPN #117 had reported PSW's #121 and #127 for alleged emotional abuse towards resident #003.

Further review of the home's investigation file, Inspector #642 reviewed PSW's #121 and #127, letters titled, "Written Warning's." The letters had described what was said during the incident and the actions of the PSW's, which had distressed and upset, the resident, and they were powerless to do it themselves without help.

In an interview with Inspector #642, RPN #117 stated, that they had witnessed the incident, the resident was yelling, upset and crying when the PSW's left the room.

The home's policy titled "Abuse: Resident Abuse/Neglect" last updated May 3, 2018, identified emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In an interview with Inspector #642, the MORC and PC #109 indicated that PSW #121 and #127 actions towards resident #003 were not appropriate and that during this incident the PSW's were not following the home's policy to promote zero tolerance of abuse.

b) A CIS was submitted to the Director, where it was reported resident #003 was cared for in an improper manner and a report of alleged verbal abuse was reported.

Inspector #642 reviewed the home's internal investigation file, which included a letter titled, "Suspected Resident Abuse/Neglect Report," which identified PSW #132 had reported PSW #107 for alleged verbal abuse towards resident #003. PSW #132 stated in the report that both of them were assisting the resident with a

specific device, when the resident stated that they were not sitting right because a specific item was half way on. Then PSW #107 stated in a loud voice, “It’s not the specific item, it's how you were in bed, you know everyone who does you, cry when they go home. I don’t care, I want out of this unit.” The PSW said a few other things, then left crying and the resident was crying.

Inspector #642 reviewed the home’s discipline letter for PSW #107, titled “Three Day Suspension without Pay,' related to a specific incident. The letter identified that after the home’s investigation, while providing care to resident #003, PSW #107, started yelling at the resident, saying, “Whenever anybody does you they leave here crying.” To which the resident responded, “You haven’t been nice to me.” In addition the PSW stated to the resident, “Report me, I want off this floor, the PC is not here today-report me tomorrow.” This interaction left the resident upset and crying.

Inspector #642 had interviewed PSW #107, and they had admitted to saying to resident #003 that, people do not want to work with them and they were difficult, and they were always threatening to get them in trouble, and resident #003 had been upset and angry, and they said they were going to go to management.

The home’s policy titled “Abuse: Resident Abuse/Neglect” last updated May 3, 2018, identified verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In an interview with Inspector #642, the MORC and PC #109 indicated that PSW #107 actions towards resident #003 were not appropriate and that during this incident the PSW was not following the home’s Abuse policy to promote zero tolerance of abuse. [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 that the policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that when a controlled substance was to be destroyed, that it would be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. a physician or a pharmacist.

A Critical Incident (CI) report was submitted by the home to the Director on a day in April, 2018, which outlined allegations of how on the same day RPN #115 had accessed a container from a cart and had removed an item.

The CI report further outlined how a review of the video footage by the home's leadership found that RPN #115 had accessed a container, and took out an unknown object. They then returned the container back to the cart.

a) During an interview with Inspector #609, the Manager of Resident Care (MORC), indicated that it was a used item, that RPN #115 had removed from the container.

During an interview with RPN #102, they described the process of when an item is removed from a resident; two registered staff would sign off in the Electronic Medication Administration Record (EMAR), they would then destroy the item once they folded it and placed it in the container.

During an interview with Pharmacist #104, they described the containers were kept within the locked government stock room until a staff member from a specific company transported them away for incineration.

b) The Act further specifies that a specific item is considered to be destroyed, when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

A review of the home's policy titled, "Medication Administration: Controlled Substances," last revised April 2, 2018, failed to provide specific direction to staff on the destruction of a specific item.

A review of the home's interoffice correspondence on a day in April, 2018, required two nursing staff members to "destroy" a specific item by placing it into a container.

Inspector #609 interviewed Pharmacist #108, they acknowledged that placing the specific item into a container, did not denature the item to the extent that their consumption was rendered impossible.

During an interview with the MORC, they acknowledged that the home's process for destroying a specific item did not denature it to such an extent that their consumption was impossible and that they would be reviewing the process. [s. 136. (3) (a)]

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 when a controlled substance is to be destroyed, the drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

Issued on this 19th day of December, 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMY GEAUVREAU (642) - (A1)
Inspection No. / No de l'inspection :	2018_669642_0030 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007053-18, 007464-18, 008709-18, 010001-18, 010636-18, 010747-18, 010882-18, 012387-18, 013389-18, 014902-18, 017605-18, 021286-18, 023706-18, 025716-18, 026951-18, 031334-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 19, 2018(A1)
Licensee / Titulaire de permis :	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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Aaron Archibald

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To City of Greater Sudbury, you are hereby required to comply with the following order (s) by the date(s) set out below:

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:

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 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)
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 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 19th day of December, 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AMY GEAUVREAU (642) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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