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

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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
Sep 28, 2018	2018_655679_0025	012902-18, 020306-18, 025808-18	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 27- 31, 2018, September 10-14, and 17-18, 2018.

The following intakes were inspected upon during this Complaint inspection:
- Two intakes submitted to the Director regarding resident care concerns.

The following Critical Incident System intake related to the same issue was inspected during this Complaint inspection:
- One intake submitted to the Director regarding alleged staff to resident abuse.

A Critical Incident System inspection #2018_655679_0024 was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Restorative Care Coordinator, Registered Dietitian (RD), Culinary Manager, Staff Educator, Administrative Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeeping staff, Personal Support Workers (PSWs), residents and family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, manufacturer instructions, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **5 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

A complaint was submitted to the Director outlining concerns regarding resident #002's wound care.

Inspector #679 reviewed resident #002's electronic progress notes which identified that on a specified date resident #002 developed an area of altered skin integrity.

Inspector #679 reviewed the electronic progress notes, as well as electronic dietary referrals and was unable to locate a dietary referral for this resident in regards to altered skin integrity.

Inspector #679 reviewed the homes policy titled "Resident Rights, Care and Services- Required Programs- Skin and Wound Care Program" revised February 28, 2018, which identified that any resident exhibiting altered skin integrity including skin breakdown,

pressure ulcers, skin tears or wounds was to be assessed by a dietitian who was a member of the staff of the home.

In an interview with RN #107 they identified that referrals were to be sent to the Registered Dietitian (RD) when a resident developed a new wound. Together, Inspector #679 and RN #107 reviewed the electronic assessments and only noted a RD referral for an alternate area of altered skin integrity.

In an interview with RD #108 they identified that referrals were sent to them for altered skin integrity. Together, Inspector#679 and RD #108 reviewed the referrals on Point Click Care. RD #108 identified that they did not observe a RD assessment for resident #002's specified area of altered skin integrity.

In an interview with the DOC they identified that a referral was to be sent to the RD for every wound. Together, Inspector #679 and the DOC reviewed the electronic wound assessments and did not identify that an assessment had been sent for the specified area of altered skin integrity.

2. The licensee has failed to ensure that every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

A complaint was submitted to the Director outlining concerns regarding resident #002's wound care.

Inspector #679 reviewed resident #002's electronic progress notes and identified that they experienced a specified number of areas of altered skin integrity. Inspector #679 noted a specified number of wound assessments to be missing.

Inspector #679 reviewed the homes policy titled "Resident Rights, Care and Services-Required Programs- Skin and Wound Care Program" revised February 28, 2018, which identified that any resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds was to be reassessed at least weekly by a member of the registered nursing staff.

In separate interviews with RN #107 and RN #113 they identified that skin assessments were to be completed every week for any area of altered skin integrity.

In an interview with the DOC they confirmed that skin assessments were to be completed initially, and then every week for altered skin integrity. Together, Inspector#679 and the DOC reviewed resident #002's electronic medical record and identified the missing wound assessments.

3. Inspector #679 reviewed the electronic progress notes for resident #004 and identified that on a specified date they had an area of altered skin integrity. The next documented skin assessment was dated a specified number of days later.

Together, Inspector #679 and RPN #116 reviewed the electronic assessments. RPN #104 confirmed the specified dates and identified that wound assessments should be completed weekly.

Together, Inspector #679 and the DOC reviewed the electronic skin assessments and did not identify that an assessment had been completed between a specified date range. The DOC identified wound assessments were to be completed weekly.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was documented.

A complaint was submitted to the Director outlining concerns regarding resident #002's wound care.

Inspector #679 reviewed the Treatment Administration Records (TAR) over a specified period. It was identified that a specified number of treatments were to be completed, and that documentation regarding these treatments was missing on a specified number of occasions.

Inspector #679 reviewed the electronic progress notes and did not identify documentation regarding the above stated wound treatments.

In an interview with RPN #106 they identified that resident #002's treatments should have been documented in the electronic treatment record.

Together, Inspector #679 and the DOC reviewed the electronic treatment record. The DOC identified that the expectation was that the documentation was completed.

2. A complaint was submitted to the Director outlining concerns regarding resident #002's pain management.

Inspector #679 reviewed resident #002's TAR and identified a specified intervention which was started on a specified date. Inspector #679 noted documentation to be missing on a specified number of occasions.

Inspector #679 reviewed the electronic progress notes and did not identify any documentation to support that the intervention was completed on the shifts in which no documentation was present on the TAR.

In an interview with RN #107 they identified that registered staff were to document a specified intervention each shift. RN #107 identified it was the expectation that this residents intervention was documented each shift.

In an interview with the DOC they identified that registered staff were to document on resident #002’s intervention, and that it was the expectation that the documentation was complete.

3. A CI report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident’s health status. The CI report identified on a specified date, resident #009 complained of pain to a specified area of their body. Resident #009 was later diagnosed with a specified injury.

A review of the progress notes for resident #009 identified a specified intervention.

Inspector #679 reviewed the electronic treatment record and progress notes over a specified period and noted that there was no documentation to indicate that the intervention was completed on a number of shifts.

In an interview with RPN #116 they identified that resident #009 had a specified intervention in place and that registered staff were to document this on the electronic medical records.

In an interview with the DOC they identified that resident #009 had a specified intervention in place which was to be completed by registered staff. The DOC identified that it was the expectation that this documentation was complete.

4. The licensee has failed to ensure that the plan of care was reviewed and revised at

least every six months and at any other time when the resident's care needs change or care set out in the plan of care was no longer necessary.

Inspector #679 reviewed a complaint submitted to the Director regarding resident #010's care.

Inspector #679 reviewed the electronic progress notes which identified that on a specified date a specified level of care was initiated for resident #010.

A review of the electronic care plan identified a specified statement. The residents care plan, however, contained no further foci or interventions related to the resident's level of care.

In an interview with PSW #122 they identified specified interventions which were to be provided to a resident under a specified level of care. PSW #122 identified that the information regarding a residents care needs would be found in their care plan.

In an interview with RN #110 they identified specified interventions which were to be provided to a resident under a specified level of care. RN #110 identified that the level of care should be reflected in the plan of care.

Together, Inspector #679 and the DOC reviewed resident #010's most recent care plan. The DOC identified they did not see interventions in the care plan regarding this residents specified level of care, and that the resident's care needs should have been identified in the care plan.

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

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #679 reviewed a complaint submitted to the Director regarding the care of resident #002. The complainant identified that they had observed staff providing rough care to a resident.

In an interview with the DOC on September 13, 2018, they identified that they were not aware of the allegation that rough care was provided to resident #002. Inspector #679 reviewed the allegation as outlined in the complaint, and identified the description of the staff member as outlined in the complaint.

In an interview with the DOC on September 18, 2018, they identified that the investigation into the allegation was started September 17, 2018, after more information was obtained. The DOC identified that the investigation into the allegations were usually started on the day the allegation was brought forth, depending on the information brought forth. The DOC identified they did not have information regarding the date, time or staff involved to start their investigation.

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 ensuring that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: 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.

Inspector #679 reviewed a complaint submitted to the Director regarding the care of resident #002. The complainant identified that they had observed staff providing rough care to a resident.

In an interview with the DOC on September 13, 2018, they identified they were not aware of the allegation that rough care was provided to resident #002. Inspector #679 reviewed the allegation as outlined in the complaint.

Inspector #679 reviewed the Ministry of Health and Long Term Care's online reporting portal and identified that a CI report was submitted to the Director on a specified date.

A review of the policy entitled "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect- Zero Tolerance Policy for Resident Abuse and Neglect" last revised June 2, 2017, identified that "any person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Ministry of Health and Long Term Care: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident".

In an interview with the DOC on September 18, 2018, they identified that they did not submit a CI report as they had to investigate the allegation first. The DOC identified that allegations of abuse or neglect were submitted to the Director immediately.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that resident #002's plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A complaint was submitted to the Director regarding resident #002's care. The complainant identified that staff had advised them that the resident was not complying so they could not provide specified care.

Inspector #679 reviewed the electronic progress notes, and electronic treatment record and identified that resident #002 had refused specified care on a number of occasions.

Inspector #679 reviewed the electronic care plan and did not identify any indication of the resident's behaviours, in which they refused care, or interventions to manage the behaviour.

In separate interviews with PSW #120, PSW #121, RPN #112, RPN #106 and RN #106 they identified that resident #002 would refuse care, including a specified type of care. PSW #120 and #121 identified that interventions regarding a resident's behaviours would be located in the plan of care.

In an interview with the DOC they identified that resident #002 refused care. Together, the DOC and Inspector #679 reviewed the electronic care plan. The DOC identified that there was nothing noted in the care plan in regards to refusal of care.

Issued on this 2nd day of October, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE BERARDI (679)
Inspection No. / No de l'inspection :	2018_655679_0025
Log No. / No de registre :	012902-18, 020306-18, 025808-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 28, 2018
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Megan Merz

To Barrie Long Term Care Centre Inc., 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 :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The Licensee must comply with r. 50. (2) (b) (iv) of the Ontario Regulation 79/10.

The licensee shall ensure that resident #004, and all other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee has failed to ensure that every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

Inspector #679 reviewed the electronic progress notes for resident #004 and identified that on a specified date they had an area of altered skin integrity. The next documented skin assessment was dated a specified number of days later.

Inspector #679 reviewed the homes policy titled "Resident Rights, Care and Services- Required Programs- Skin and Wound Care Program" revised February 28, 2018, which identified that any resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds was to be reassessed at least weekly by a member of the registered nursing staff.

Together, Inspector #679 and RPN #116 reviewed the electronic assessments. RPN #104 confirmed the specified dates and identified that wound assessments should be completed weekly.

Together, Inspector #679 and the DOC reviewed the electronic skin assessments and did not identify that an assessment had been completed between a specified date range. The DOC identified wound assessments were to be completed weekly.
(679)

2. A complaint was submitted to the Director outlining concerns regarding resident #002's wound care.

Inspector #679 reviewed resident #002's electronic progress notes and identified that they experienced a specified number of areas of altered skin integrity. Inspector #679 noted a specified number of wound assessments to be missing.

In separate interviews with RN #107 and RN #113 they identified that skin assessments were to be completed every week for any area of altered skin integrity.

In an interview with the DOC they confirmed that skin assessments were to be completed initially, and then every week for altered skin integrity. Together, Inspector #679 and the DOC reviewed resident #002's electronic medical record and identified the missing wound assessments.

The severity of this issue was determined to be a level 2, potential for harm. The scope of this issue was a level 2, a pattern. The home had a level 3 history of non-compliance
with this section of the Regulations that included:
- a Voluntary Plan of Correction (VPC) issued during inspection #2018_565647_0017; and,
- a VPC issued during inspection #2018_378116_0001 (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 17, 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 September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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