Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Amended Public Copy/Copie modifiée du 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 16, 2019	2019_684604_0022 (A2)	017237-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor
TORONTO ON M4W 3L4

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

Bendale Acres
2920 Lawrence Avenue East SCARBOROUGH ON M1P 2T8

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

Amended by SHIHANA RUMZI (604) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001, issued by Inspector #604 and served on the Licensee on October 16, 2019, is altered with the following compliance order under section 153 (1)(a).

Issued on this 16th day of December, 2019 (A2)

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

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 16, 2019	2019_684604_0022 (A2)	017237-19	Critical Incident System

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Bendale Acres
2920 Lawrence Avenue East SCARBOROUGH ON M1P 2T8

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

Amended by SHIHANA RUMZI (604) - (A2)

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): September 4, 5, and 6, 2019.

During this inspection intake log #017237-19, linked to Critical Incident System (CIS) report related to resident to resident alleged abuse was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Behavior Support Services Lead (BSSL) .

During the course of the inspection, the inspectors conducted observations of staff and resident interactions, provision of care, reviewed home's surveillance footage, conducted reviews of health records, and critical incident log, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **1 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure the resident was protected from abuse by anyone.

The definition of "abuse" in subsection 2 (1) of the Regulation "physical abuse" means, subject to section (2), (c) the use of physical force by a resident that

causes physical injury to another resident. O. Reg 79/10 s. 2 (c).

On an identified date the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting abuse had occurred between resident #001 and #002, in an identified location of the home. On an identified date, the home submitted a Critical Incident System (CIS) report to the MLTC Director which indicated resident #002 was presenting with an identified behaviour when resident #001 approached resident #002 whereby an altercation took place. The CIS report further stated resident #002 sustained identified injuries and was transferred to hospital for further assessment.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect", #RC-0305-00, indicates one of the purposes for the policy is to build awareness on prevention strategies for abuse and neglect. The policy includes pushing as an example of physical abuse. With respect to education and building awareness, the policy states that staff will be trained annually on abuse including how to recognize the signs of abuse and neglect as well as situations that may lead to abuse and neglect and how to avoid such situations (pages 1-10).

A review of resident #001's Minimum Data Set (MDS) assessment for an identified date, indicated the resident has moderate cognitive loss. A review of the resident's plan of care for an identified date consisted of an identified focus related to the residents identified behaviour.

A review of resident #002's MDS assessment for an identified date, indicated the resident has severe cognitive loss. A review of the resident's plan of care for an identified date consisted of identified focuses related identified behaviours. A review of resident#002's plan of care did not show evidence of a focus or interventions identifying behaviours presented on an identified date of the above incident.

In separate interviews Registered Practical Nurse (RPN) #101, Personal Support Worker (PSW) #104 and #100, Registered Nurse (RN) #102, RPN #111, and Behaviour Support Services Lead (BSSL) #108, stated the staff would refer to a resident's plan of care to gather information related to the resident including identified behaviours. The staff indicated they knew resident #002 and stated the resident presented with an identified behaviour.

In further interviews PSW #100 and RPN #101, indicated they worked on an

identified shift, date, and an identified location of the home. The staff stated they were in an identified location of the unit when they heard sound coming from an identified area of the home and observed resident #001 and #002 standing close together. The staff stated resident #001 raised their voice to resident #002 when an identified incident occurred. The RN and RPN stated they called an ambulance as resident #002 sustained identified injuries and was transferred to hospital for further assessment. The staff stated resident #001 had not presented with the identified behaviour in the past and was surprised of this incident.

Inspector #604 was provided with the home's video surveillance by the home's Senior Security Coordinator (SSC) #114. The NM #105 verified resident #001and #002, the PSW and RPN observed in the video surveillance footage. The Inspector made observation of the interactions which occurred between resident #001 and #002 on an identified date, time, and location of the home up to resident #002 being transferred to the hospital.

A review of the hospital consultation notes for an identified date identified various injuries sustained by resident #002 related to the identified incident.

An interview was carried out with Nurse Manager (NM) #105, who stated that they are in-charge of identified home areas. The NM indicated staff in the home would refer to a resident's plan of care to gather information related to Activities of Daily Living (ADL) which would also include behaviours of residents. The NM reviewed the above plan of care and acknowledged the home did not have strategies developed and implemented to respond to resident #002 who demonstrated an identified behaviour. The NM stated they had reviewed the home's video surveillance and the events leading up to the interaction between resident #001 and #002 and resident #002 being transferred to hospital. The NM stated resident #002 sustained injuries from the incident and did not consider this incident to be abuse but an accident as resident #001 had never presented with an identified behaviour.

A compliance order is warranted as the licensee failed to protect resident #002 from abuse. Resident #002 had a known history of an identified behaviour which might provoke other residents. Staff were within close proximity and acknowledged that they heard the verbal exchange between the residents when resident #002 presented with their identified behaviour. There were no interventions in place to keep resident #002 safe from abuse from residents who were reactive to there identified behaviour.

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee had failed to ensure that strategies where developed and implemented to respond to the resident demonstrating responsive behaviours.

On an identified date the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting abuse had occurred between resident #001 and #002, in an identified location of the home. On an identified date, the home submitted a Critical Incident System (CIS) report to the MLTC Director which

indicated resident #002 was presenting with an identified behaviour when resident #001 approached resident #002 whereby an altercation took place. The CIS report further stated resident #002 sustained identified injuries and was transferred to hospital for further assessment.

A review of resident #001's Minimum Data Set (MDS) assessment for an identified date, indicated the resident has moderate cognitive loss. A review of the resident's plan of care for an identified date consisted of an identified focus related to the residents identified behaviour.

A review of resident #002's MDS assessment for an identified date, indicated the resident has severe cognitive loss. A review of the resident's plan of care for an identified date consisted of identified focuses related identified behaviours. A review of resident#002's plan of care did not show evidence of a focus or interventions identifying an identified behaviour presented in the identified date of the above incident.

In separate interviews Registered Practical Nurse (RPN) #101, Personal Support Worker (PSW) #104 and #100, Registered Nurse (RN) #102, RPN #111, and Behaviour Support Services Lead (BSSL) #108, stated the staff would refer to a resident's plan of care to gather information related to the resident including identified behaviours. The staff indicated they knew resident #002 and stated the resident presented with an identified behaviour.

In further interviews PSW #100 and RPN #101, indicated they worked on an identified shift, date, and an identified location of the home. The staff stated they were in an identified location of the unit when they heard an identified sound coming form an identified area of the home and observed resident #001 and #002 standing close together. The staff stated resident #001 raised their voice to resident #002 when an identified incident occurred. The RN and RPN stated they called an ambulance as resident #002 sustained identified injuries and was transferred to hospital for further assessment. The staff stated resident #001 had not presented with the identified behaviour in the past and was surprised of this incident.

A review of the above plan of care did not include a focus or interventions identifying resident #002 to present with an identified behaviour which had occurred in an identified location of the home.

An interview was carried out with Nurse Manager (NM) #105, who stated they are in-charge of identified home areas. The NM indicated staff in the home would refer to a resident's plan of care to gather information related to Activities of Daily Living (ADL) which would also include behaviours of residents. The NM reviewed the above plan of care and acknowledged the home did not have strategies developed and implemented to respond to resident #002 who demonstrated an identified behaviour.

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 strategies where developed and implemented to respond to the resident demonstrating responsive behaviours, to be implemented voluntarily.

Issued on this 16th day of December, 2019 (A2)

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 SHIHANA RUMZI (604) - (A2)
Inspection No. / No de l'inspection :	2019_684604_0022 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017237-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 16, 2019(A2)
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Bendale Acres 2920 Lawrence Avenue East, SCARBOROUGH, ON, M1P-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Filice

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 Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

(A2)
The Licensee must be compliant with s. 19(1) of the LTCHA.

Specifically, the Licensee shall ensure that all residents are protected from physical abuse.
Upon receipt of this Order, the Licensee shall:

(a) Undertake an analysis and evaluation of the home's process in documenting and addressing residents' responsive behaviours and identify what changes and improvements are required to prevent further incidents of resident-to-resident abuse occurring that involve residents with a pattern of escalated behaviours and aggressiveness; and

(b) Develop, implement and/or review policies and procedures to address residents with responsive behaviours taking into consideration the changes and improvements identified through the evaluation outlined in (a) above. These policies and procedures should include all aspects of the responsive behaviours such as listing new behaviours, documenting interventions, access to supports – both internal and external (ex. description of the role of internal and external BSO teams, timing and triggers for external specialist consults, access to High Intensity Needs Fund (HINF) for 1:1 staffing and preferred accommodation support), and mitigation strategies in the management of residents with escalated responsive behaviours.

(c) Ensure that all staff are aware of what constitutes physical abuse.

(d) Ensure that all staff are aware and mitigate any situations which may lead to physical abuse.

A documented record must be kept for (a) and (b) the above.

Grounds / Motifs :

1. The licensee has failed to ensure the resident was protected from abuse by anyone.

The definition of "abuse" in subsection 2 (1) of the Regulation "physical abuse" means, subject to section (2), (c) the use of physical force by a resident that causes

physical injury to another resident. O. Reg 79/10 s. 2 (c).

On an identified date the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting abuse had occurred between resident #001 and #002, in an identified location of the home. On an identified date, the home submitted a Critical Incident System (CIS) report to the MLTC Director which indicated resident #002 was presenting with an identified behaviour when resident #001 approached resident #002 whereby an altercation took place. The CIS report further stated resident #002 sustained identified injuries and was transferred to hospital for further assessment.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect", #RC-0305-00, indicates one of the purposes for the policy is to build awareness on prevention strategies for abuse and neglect. The policy includes pushing as an example of physical abuse. With respect to education and building awareness, the policy states that staff will be trained annually on abuse including how to recognize the signs of abuse and neglect as well as situations that may lead to abuse and neglect and how to avoid such situations (pages 1-10).

A review of resident #001's Minimum Data Set (MDS) assessment for an identified date, indicated the resident has moderate cognitive loss. A review of the resident's plan of care for an identified date consisted of an identified focus related to the residents identified behaviour.

A review of resident #002's MDS assessment for an identified date, indicated the resident has severe cognitive loss. A review of the resident's plan of care for an identified date consisted of identified focuses related identified behaviours. A review of resident#002's plan of care did not show evidence of a focus or interventions identifying behaviours presented on an identified date of the above incident.

In separate interviews Registered Practical Nurse (RPN) #101, Personal Support Worker (PSW) #104 and #100, Registered Nurse (RN) #102, RPN #111, and Behaviour Support Services Lead (BSSL) #108, stated the staff would refer to a resident's plan of care to gather information related to the resident including identified behaviours. The staff indicated they knew resident #002 and stated the resident presented with an identified behaviour.

In further interviews PSW #100 and RPN #101, indicated they worked on an identified shift, date, and an identified location of the home. The staff stated they were in an identified location of the unit when they heard sound coming from an identified area of the home and observed resident #001 and #002 standing close together. The staff stated resident #001 raised their voice to resident #002 when an identified incident occurred. The RN and RPN stated they called an ambulance as resident #002 sustained identified injuries and was transferred to hospital for further assessment. The staff stated resident #001 had not presented with the identified behaviour in the past and was surprised of this incident.

Inspector #604 was provided with the home's video surveillance by the home's Senior Security Coordinator (SSC) #114. The NM #105 verified resident #001and #002, the PSW and RPN observed in the video surveillance footage. The Inspector made observation of the interactions which occurred between resident #001 and #002 on an identified date, time, and location of the home up to resident #002 being transferred to the hospital.

A review of the hospital consultation notes for an identified date identified various injuries sustained by resident #002 related to the identified incident.

An interview was carried out with Nurse Manager (NM) #105, who stated that they are in-charge of identified home areas. The NM indicated staff in the home would refer to a resident's plan of care to gather information related to Activities of Daily Living (ADL) which would also include behaviours of residents. The NM reviewed the above plan of care and acknowledged the home did not have strategies developed and implemented to respond to resident #002 who demonstrated an identified behaviour. The NM stated they had reviewed the home's video surveillance and the events leading up to the interaction between resident #001 and #002 and resident #002 being transferred to hospital. The NM stated resident #002 sustained injuries from the incident and did not consider this incident to be abuse but an accident as resident #001 had never presented with an identified behaviour.

A compliance order is warranted as the licensee failed to protect resident #002 from abuse. Resident #002 had a known history of an identified behaviour which might provoke other residents. Staff were within close proximity and acknowledged that they heard the verbal exchange between the residents when resident #002 presented with their identified behaviour. There were no interventions in place to

keep resident #002 safe from abuse from residents who were reactive to there identified behaviour.

The severity of this issue was determined to be a level four as there was serious harm to resident #002. The scope of the issue was a level one as it related to one resident reviewed. The home had a level three as the home had previous history of on-going non-compliance with this subsection of the Act which included:
-Voluntary Plan of Correction (VPC) issued on September 13, 2017, within report #2017_420643_0013
-Compliance Order (CO) issued on November 30, 2016, within report #2016_302600_0015 (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2020(A1)

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

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 16th day of December, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHIHANA RUMZI (604) - (A2)

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 : Central East Service Area Office