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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
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Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
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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
Jun 19, 2019	2019_643111_0009 (A1) (Appeal\Dir#: DR# 121)	008649-18, 003365-19, 004689-19, 004968-19, 006696-19, 006826-19	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 Boyd Street P.O. Box 670 BOBCAYGEON ON K0M 1A0

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

Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 121)

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*

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on June 18, 2019.
Order(s) CO#001 was/were rescinded to reflect the Director's review DR# 121.

Issued on this 19th day of June, 2019 (A1)(Appeal\Dir#: DR# 121)

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
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Case Manor Care Community
28 Boyd Street P.O. Box 670 BOBCAYGEON ON K0M 1A0

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

Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 121)

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): March 28 and April 1, 2019. Off-site on April 9, 2019.

The following critical incidents were inspected concurrently during this inspection related to resident to resident abuse:

-Log # 004689-19 (CIR), Log #003365-19 (CIR), Log #004968-19 (CIR), Log #008649-18 (CIR), Log #006696-18 (CIR) and Log # 006826-19 (CIR).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Cares (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector reviewed the health care record of residents, reviewed investigations and reviewed the following licensee policies: Prevention of Abuse and Neglect of Resident and Responsive Behaviours -Management.

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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations and by identifying and implementing interventions.

A review of critical incident reports and the progress notes for resident #001,#002, #003 and #004 indicated resident #001 was involved in a number of resident to resident abuse incidents and ongoing altercations with other residents (#002, #003, #004, #005 and #006) as follows:
1. A critical incident report (CIR/ Log #008649-18) was submitted for an alleged, resident to resident abuse incident that occurred on a specified date and time. The CIR indicated resident #001 had been abusive towards resident #002 in a specified area, resident #002 was transferred to hospital and diagnosed with an injury to a specified area. The incident was witnessed by resident #004 and #005. The CIR indicated specified actions were taken to prevent a recurrence.
2. A critical incident report (CIR/ Log #006826-18) was submitted for a witnessed, resident to resident abuse incident that occurred four days later at a specified time. The CIR indicated resident #001 was abusive towards resident #004 in a specified area, with an object, resulting in an injury to a specified area. The incident was witnessed by RN #012 and was unprovoked. The CIR indicated specified actions were taken to prevent a recurrence.
3. A critical incident report (CIR/ Log #003365-19) was submitted for a witnessed, resident to resident abuse incident that occurred, on a specified date and time.

The CIR indicated resident #001 was in a specified area when they were abusive towards resident #003. The incident was witnessed by PSW #101 who immediately intervened and reported the incident to RN #102. There were no injuries to either resident. The CIR indicated specified actions were taken to prevent a recurrence.
4. A critical incident report (CIR/ Log #004689-19) was submitted for a witnessed, resident to resident abuse incident, that occurred approximately two weeks later, at a specified time. The CIR indicated staff found resident #002 engaged in an altercation and abuse with resident #001, in a specified area. There were no injuries noted to either resident. The incident was witnessed by RN #103. The CIR indicated specified actions were taken to prevent a recurrence.
5. A critical incident report (CIR/ Log #006696-19) was submitted for an alleged, resident to resident abuse incident that occurred approximately one week later, at a specified time. The CIR indicated PSW #105 and RPN #106 found resident #002 on the floor, in a specified area. Resident #003 reported that they observed resident #001 being abusive towards resident #002. ADOC #108 assessed resident #002, the resident complained of pain to a specified area and was transferred to hospital for assessment. The resident sustained an injury to a specified area. The CIR indicated no investigation completed as resident #003 was no longer able to recall the incident.

The progress notes for resident #001 indicated the following interventions and additional altercations with other residents:
-On a specified date (a number of days after the first CIR incident), there was a note to staff to provide care with caution, due to unpredictable responsive behaviours and to see care plan for care considerations. The resident was being provided one to one monitoring by staff and a consultation referral was made for responsive behaviours.
-A few days later, the resident was assessed by the physician and indicated significant responsive behaviours, sent to hospital, use of a specified medication precipitated an increase in responsive behaviour so the medication was discontinued. The physician also ordered changes to other specified medications. The resident remained on one to one monitoring and other specified interventions. There were no further altercations or incidents of abuse with other residents until a specified period.
-On a specified date and time, resident #001 was reassessed by the physician, indicated the resident was frequently missing their medications due to sleeping and due to other health concerns they were considering reducing the specified medication. Later the same day (CIR), resident #001 was witnessed by PSW

#109 engaging in an altercation with resident #003, in a specified area. Resident #003 sustained an injury to a specified area as a result. The physician was notified and ordered specified medication changes. There were specified actions taken to prevent a recurrence.
-A number of days later, the BSO RPN indicated resident #001 was still not receiving all of their medications due to sleeping. The physician and pharmacy were contacted to change the route of the medication administration.
-The following day, the BSO RPN indicated an assessment for resident#001's responsive behaviours had been completed for a number of days and no responsive behaviours were noted (despite the CIR being submitted).
-The following day, the physician reassessed resident #001 and indicated the resident had increased responsive behaviours noted, altercations with multiple staff, receiving specified medication inconsistently due to sleeping, trial of the specified route of administration and to reassess.
-The following day at a specified time (CIR), resident #001 had an altercation with resident #003 in a specified area. Resident #001 then sustained a fall. Resident #003 and resident #001 continued to have an altercation when a PSW separated both residents. No injuries were noted to either resident. Resident #001 was given a specified medication with good effect and there was no indication BSO was notified of the incident.
-Approximately one week later, resident #001 was assessed by the physician and ordered specified medication to be discontinued in two weeks.
-A number of days later, BSO RPN indicated an assessment for resident #001's responsive behaviours had been started for a number of days (due to medication changes) and noted the resident was sleeping majority of the time, no altercations were noted during the observation period (despite the CIR submitted) and one to one monitoring remained in place.
-A number of days later at a specified time (CIR), the resident was observed in an unidentified, co-resident engaged in an altercation with resident #001. No injuries were noted to either resident. BSO RPN indicated they were informed of this incident and provided one to one monitoring of resident #001.
-One week later, at a specified time, a PSW reported to RPN #107 that resident #001 was demonstrating responsive behaviours during personal care and was given a specified medication with good effect. There was no documented evidence of the incident that occurred at a specified time (CIR), when a co-resident reported they witnessed resident #001 being abusive towards resident #002, resulting in resident #002 being transferred to hospital for an injury to a specified area and despite the CIR indicating resident #001 being on one to one monitoring. There was also no indication the BSO was notified of the incident.

-The following day, at a specified time, resident #001 was found in resident #002's room, after staff heard resident #002 screaming and staff redirected resident #001 out of resident #002's room. There was no indication resident #001 had been on one to one monitoring at that time. The following day, the physician reassessed resident #001 and indicated that nursing staff reported resident#001's responsive behaviours had improved with the specified route of medication administration.
-Two weeks later, at a specified time (CIR), resident #008 was heard yelling at resident #001 in a specified area, when resident #001 got up and was abusive towards resident #008. No injuries were noted. Both residents were separated and a PRN medication was given to resident #001.
-Two days later, at a specified time (CIR), resident #001 had entered resident #009's room twice and the second time, resident #009 engaged in abusive behaviour towards resident #001, resulting in resident #001 sustaining a fall with no injuries. Resident #001 was found on the floor by a PSW and remained on increased monitoring.
-Two days later, resident #001 was reassessed by the physician, indicated they reviewed the suggestions provided by the consultation and ordered further medication changes and suggested a specified medication as responsive behaviours may be related to pain.

Observation of resident #001 on specified dates by the Inspector, indicated the resident was noted to be sleeping for long periods of time. The resident had a specified alarm in place and was activated. The staff were noted to immediately respond to the specified intervention. The resident was noted to be independently mobile when awake.

Observation of resident #002 on specified date by the Inspector, indicated the resident sat in a mobility aid that was directly across from resident #001's room. The resident did not respond appropriately to any questions asked.

Review of the current written plan of care for resident #001 related to responsive behaviours indicated: the resident demonstrated specified responsive behaviours with potential for injury to self and others. The resident at times had unknown triggers and was unpredictable. There were specified interventions identified.

During an interview with PSW #109, the PSW indicated resident #001 had been more settled lately, they had never witnessed the resident engaged in altercations but were aware of the resident's altercations towards staff and residents. The

PSW indicated the resident demonstrated specified responsive behaviours, specified triggers and identified possible interventions. The PSW indicated there were directions previously in place to remind staff to use two staff at all times for care but they were removed. The PSW indicated resident #002 had demonstrated specified responsive behaviours and could engage in altercations towards staff during personal care, but the behaviours had decreased. The PSW confirmed they were working on a specified date and shift when there was an altercation between resident #001 and #002 but they did not witness the incident. The PSW indicated they were notified by PSW #113 to respond to a specified area as resident #002 had sustained a fall. The PSW indicated when they arrived, they witnessed resident #001 in the area where resident #002 was found on the floor. The PSW indicated resident #003 was present and reported they witnessed resident #001 engaged in abuse towards resident #002, which resulted in resident #002 sustaining a fall. The PSW indicated RPN #106 and the ADOC #108 responded to the incident and resident #002 could not recall how they fell. The PSW indicated PSW #105 and #113 were also working when the incident occurred, but PSW #105 was off the unit at the time of incident.

During an interview with PSW #105, the PSW indicated on a specified date and time (CIR), they had left resident #002 in a specified area after the meal because the resident refused to leave the area and then they left the unit for their break. The PSW indicated when they returned from their break, they were informed of the incident between resident #001 and #002 and that resident #002 was transferred to hospital for assessment.

During an interview, the DOC indicated the first resident to resident abuse incident that occurred on a specified date, between resident #001 and #002, was witnessed by two residents (#004 and #005). The DOC indicated resident #001 was placed on increased monitoring following the first incident and remained on increased monitoring until resident #001 was sent to the hospital for assessment five days later, after the second incident. The DOC indicated the resident returned from hospital that same day and the responsive behaviours did not improve, so the resident was placed on one to one monitoring, until the resident was admitted to hospital for an assessment, a short time later. The DOC indicated when the resident returned from the hospital, the resident had not demonstrated any further responsive behaviours until recently, when the resident again, began demonstrating responsive behaviours.

During an interview, the Administrator indicated the current BSO RPN (#112) was

currently on leave and the role was being covered by ADOC #108.

During an interview with ADOC #108, the ADOC indicated they were just recently assigned to BSO in the last few weeks. The ADOC indicated on a specified date and time, they were notified by RPN #106 that they found resident #002 on the floor after an altercation with resident #001. The ADOC indicated that resident #003 reported to the RPN that they witnessed the incident. The ADOC indicated resident #002 was sent to hospital for further assessment. The ADOC indicated PSW #109 and #105 were also working when the incident occurred. The ADOC indicated PSW #109 was on the unit at the time of the incident, but did not witness the incident and PSW #105 was on their break at the time of the incident. The ADOC indicated no staff witnessed the incident. The ADOC indicated later the same day, after resident #002 was sent to hospital, the ADOC and the RPN interviewed resident #003, but the resident could no longer recall the incident. The ADOC indicated PSW #105 reported that they attempted to remove resident #002 from a specified area but the resident refused to leave. The ADOC indicated resident #001 had not been demonstrating responsive behaviours since changing the specified route of a specified medication, the month before. The ADOC indicated when resident #001 demonstrated specified responsive behaviours, staff were to initiate the one to one monitoring. The ADOC indicated the resident recently had an alarming device put in place to alert staff when the resident left their room or when anyone entered the resident's room. The ADOC indicated the resident has remained on increased monitoring. The ADOC indicated the previous BSO (RPN #112) had been on leave for approximately two weeks and they were covering BSO as needed. The ADOC indicated they had not witnessed resident #001 engage in altercations with other residents/staff in the last three to four months, resident #001 was easily redirected (despite above incidents indicating otherwise). The ADOC indicated resident #001 had deteriorated in health but if someone got in their personal space, the resident would not engage in altercations.

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations and by identifying and implementing interventions for resident #001. There were a number of incidents of resident to resident abuse involving resident #001 and ongoing altercations with other residents and the written plan of care did not provide specific strategies to implement.

Additional Required Actions:

(A1)(Appeal/Dir# DR# 121)
The following order(s) have been rescinded: CO# 001

WN #2: 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 the person who had reasonable grounds to suspect that any of the following had occurred, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Log # 008649-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed resident to resident abuse incident. The CIR indicated four days earlier, at a specified time, resident #001 had been abusive to resident #002 resulting in an injury to a specified area for which the resident was transferred to hospital. The incident was witnessed by two residents (#004 and #005). The CIR indicated no after-hours call was received.

Review of the progress notes for resident #001 indicated on a specified date and time, RN #102 and the DOC were standing in a specified area, when they heard a loud bang and found resident #002 lying on the floor, in a specified area. Resident #001 was redirected away from the area. Resident #004 and #005 were also present and reported that resident #001 had been abusive towards resident #002. Resident #002 was transferred to hospital and diagnosed with an injury to a specified area. There was no indication the Director was notified.

Review of the Risk Management report completed by RN #102 for the same incident, had no documented evidence the Director was notified.

During an interview with the DOC by Inspector #111, the DOC indicated the resident to resident abuse incident that occurred on a specified date, between resident #001 and #002, was witnessed by two residents, #004 and #005. The DOC was unable to recall when the incident was first reported to the Director.

During an interview with RN #102 by Inspector #111, the RN confirmed they did not inform the Director because the DOC was also present and they assumed they would have reported the incident.

The licensee has failed to ensure the Director was immediately notified of a suspected resident to resident abuse incident that occurred on a specified date, between resident #001 and #002, as the Director was not informed until four days later.

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 a person who has reasonable grounds to suspect abuse of a resident by anyone, that results in harm or risk of harm, is immediately reported to the Director, to be implemented voluntarily.

Issued on this 19th day of June, 2019 (A1)(Appeal/Dir# DR# 121)

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 Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 121)
Inspection No. / No de l'inspection :	2019_643111_0009 (A1)(Appeal/Dir# DR# 121)
Appeal/Dir# / Appel/Dir#:	DR# 121 (A1)
Log No. / No de registre :	008649-18, 003365-19, 004689-19, 004968-19, 006696-19, 006826-19 (A1)(Appeal/Dir# DR# 121)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2019(A1)(Appeal/Dir# DR# 121)
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Case Manor Care Community 28 Boyd Street, P.O. Box 670, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Monica Cara

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 The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR# 121)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

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
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 June, 2019 (A1)(Appeal/Dir# DR# 121)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Wendy Lewis (Director) - (A1)
(Appeal/Dir# DR# 121)

Service Area Office / Bureau régional de services : Central East Service Area Office