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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016	2016_290551_0008	009523-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

MEGAN MACPHAIL (551)

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): April 6, 7, 8, 11, 12, 20, 21 and 22, 2016.

Log #009523-16 (an allegation of staff to resident abuse) was inspected.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), the Physiotherapist Assistant (PTA), a Registered Nurse (RN), Registered Practical Nurses (RPNs), a Recreation Staff Member, the Staff Scheduler, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s): reviewed the home's investigation file, reviewed health care records, reviewed a personnel file, reviewed the Resident Abuse-Staff to Resident policy and reviewed registered nursing staff job descriptions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone.

A Critical Incident Report for staff to resident abuse was submitted to the Director on a specified date.

According to O. Reg 79/10, s. 2:
the definition of physical abuse is "the use of physical force by anyone other than a resident that causes physical injury or pain"
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

Resident #001 was admitted to the home in 2014 with specific diagnoses.

The Physiotherapist Assistant (PTA) #101 was interviewed and indicated that resident #001 liked to walk in the hallways. The PTA stated that the resident had good balance, was independent with ambulation and was not considered to be a fall risk. According to the PTA, resident #001 participated in group exercise classes and could follow instructions.

During an interview with RPN #104 she reported that on a specified day, she was at her medication cart that was parked at the end of the wall, across from the elevator, when she heard PSW #115 saying to resident #001 "get out, you don't belong here". The RPN described PSW #115's tone of voice as aggressive. RPN #104 stated that she then saw resident #001 stagger out of a resident's room backwards, then walk forward, trying to go back into the room, at which time the door to the room was closed with a loud bang, and RPN #104 saw resident #001 fall. RPN #104 stated that resident #001 was found sitting with his/her back against the wall, and stated that he/she had been pushed.

The resident was assessed by RPN #104, RN #105 and a physician. During an interview with RN #105, she reported that resident #001 complained of pain and was sent to the hospital.

According to the home's investigation file, after resident #001's fall on a specified day, PSW #115 was sent to see the Director of Care (DOC), and the PSW reported to the DOC that she was trying to get away from resident #001 who was chasing her and wanted to throw juice on her. PSW #115 is reported as saying that she ran from the resident because she did not want to get wet.

According to a review of the resident's health care record, resident #001 received a

specified diagnosis at the hospital. Resident #001 returned to the home on a specified day and was assessed by the Physiotherapist (PT).

According to a progress note entry, at a specified time on a specified day, the resident was toileted with no issues. In a progress note entry several hours later, it indicated that resident #001 received a medication for pain, and that when the resident's vitals were being assessed, he/she became unresponsive. Resident #001 was sent to the hospital. The resident passed away on a specified date.

The home's investigation into the incident of staff to resident physical abuse on a specified date, involving PSW #115 and resident #001, revealed that there was a prior incident of staff to resident emotional abuse involving PSW #115 and resident #001 that was witnessed and that was not reported to either of the RNs who were working in the building on that day, the manager or the Director.

According to the home's investigation file, on a specified date, the Administrator met with RPN #104 with regards to the incident when the resident fell. In RPN #104's statement made to the Administrator, the following is indicated "[RPN #104] at this meeting also mentioned that staff had mentioned another incident with [PSW #115] a few days ago where the PSW's reported that [resident #001] sat in the wrong seat in the dining room and that [PSW #115] had come in with the resident who was to sit there and she was very abrupt with [resident #001] instructing him/her to get out of the chair. [RPN #104] said she was told that [PSW #115] grabbed him/her roughly by the arm and pulled him/her out of the chair. [RPN 104] did not witness this she said she reported it to the RN that she had been told that and did not know if it had been reported to DOC".

In an interview, RPN #104 told the inspector that prior to resident #001's fall, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms. RPN #104 told the inspector that she reported the incident to the charge nurse, RN #105 on the same day. It was later clarified that RPN #104 did not make a report to RN #105.

In an email between the Administrator and the inspector, the Administrator indicated that she spoke with RPN #104 again on a specified date, and the RPN indicated that she did not report the incident in the dining room on a specified date to RN #105, as she recalled that the RN was not working on that day. The home's staffing scheduler told the

inspector that on the specified day, RN #105, who was the full-time day RN on the floor, had called in sick, and that she was not replaced as there were two other RNs working in the building on the day shift.

The DOC stated that in the absence of an RN on the specified floor on the day shift, the two RPNs are responsible for the residents on their wing (east and west), and if assistance is required, an RN is called. The DOC stated that on a specified date, RPN #104 received responsibility pay which is additional pay for additional responsibilities and was in charge of the specified floor.

In an interview, RPN #103 stated that with regards to the incident in the dining room on a specified date, she was in a resident's room and heard from that room that resident #001 was sitting in a co-resident's chair in the dining room, had been asked to move and was agitated. The RPN stated that as she entered the dining room she saw that resident #001 had gotten up from the chair and was trying to go back to the chair. RPN #103 stated that she took resident #001 to his/her room and calmed the resident down. The RPN stated that she did not witness and was not told that anything inappropriate had happened between PSW #115 and resident #001 prior to her arrival to the dining room. In RPN #103's written statement to the Administrator, she wrote "At the time that I entered the dining room [resident #001] was already up. I then stated to the other RPN on the shift [RPN #103] that I will be talking to the staff regarding thier approach with [resident #001]. No other issue was brought to my attention from staff ".

In an interview, Recreation Worker #113 told the inspector that on a specified date she witnessed an incident of suspected abuse when PSW #115 was trying to get resident #001 to move from a chair in the dining room. The staff member described that resident #001 was waving his/her arms at PSW #115, who went behind the chair that the resident was sitting in and dragged the resident in the chair quickly from behind towards the kitchen. The staff member did not report the incident until she was approached by the home's Administrator who asked her if she had witnessed resident #001 being treated inappropriately in the dining room.

In an interview with resident #001's primary care PSW, she stated that on a specified day, prior to the incident when resident #001's fell, she was in the hallway and heard a commotion which drew her to the dining room. PSW #114 stated that when she entered the dining room, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

The home's administrator stated that the incident in the dining room involving PSW #115 and resident #001 was inappropriate and should have been reported by any staff to the management who would have investigated. The CIR that was amended on a specified date indicated that if staff had reported the incident in the dining room, the employee would have been taken off the schedule.

A review of PSW #115 file's showed several performance issues that resulted in disciplinary action.

The home's policy titled "Resident Abuse – Staff to Resident", version September 2015 states that all staff who have reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (ON) or the governing provincial regulatory body. The policy further instructs staff to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or their designate, and states that all staff is responsible to ensure that they understand and comply fully with the Resident Abuse - Staff to Resident policy and procedures.

The licensee has failed to comply with:
1. LTCHA s. 20 (1) Every licensee shall ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with. Refer to WN #3.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

PSW #114 indicated that on a specified date, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

On a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

Recreation Staff Member #113 stated that on a specified date, she saw PSW #115 go behind the chair that resident #001 was sitting in and drag the resident in the chair quickly from behind towards the kitchen.

On a specified date, none of the staff members immediately reported the suspicion of abuse and the information upon which it is based to the Director (ON) or the governing provincial regulatory body, and none of the staff members immediately reported any

suspected or witnessed abuse to the Administrator, Director of Care or their designate, as required by the home's policy titled "Resident Abuse - Staff to Resident", version September 2015.

The licensee has failed to comply with:
2. LTCHA s. 24 (1) A person who has reasonable grounds to suspect that 2. Abuse of a resident by anyone, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. Refer to WN #5.

According to O. Reg 79/10, s. 2:
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

As cited in the evidence above, on a specified date, resident #001 was physically abused by PSW #115, and resident #001 fell and sustained an injury.

In an interview, RPN #104 told the inspector that prior to resident #001's fall on a specified date, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

PSW #114 indicated that on a specified date, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

As cited in the evidence above, on a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

Recreation Staff Member #113 stated that on a specified date, she saw PSW #115 go behind the chair that resident #001 was sitting in and dragged the resident in the chair quickly from behind towards the kitchen.

As cited in the evidence above, RPN #104 was in charge of the specified floor on a specified date. The incident of emotional abuse that occurred on a specified date was

not reported to the Director immediately; it was not reported until fourteen days later when the CIR was amended.

The licensee has failed to comply with:
3. LTCHA s. 23 (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed of (i) abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. Refer to WN #4.

According to O. Reg 79/10, s. 2:
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

As cited in the evidence above, on a specified date, resident #001 was physically abused by PSW #115, and resident #001 fell and sustained an injury. The incident was witnessed by RPN #104 who immediately began investigating the situation and alerted the RN.

In an interview, RPN #104 told the inspector that prior to resident #001's fall on a specified date, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

As cited in the evidence above, on a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

As cited in the evidence above, RPN #104 was in charge of the specified floor on a specified date. The incident of emotional abuse that occurred on a specified date was not investigated immediately; it was not investigated until six days later. Furthermore, because of this delay, no action was taken to further mitigate the risk of abuse by PSW #115 when she continued to provide care and services to residents without additional supervision.

The licensee has failed to comply with:
4. O. Reg 79/10 s. 97 (1) (b) Every licensee of a long-term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. Refer to WN #6.

A Critical Incident Report for staff to resident physical abuse, involving PSW #115 and resident #001 was submitted to the Director on a specified date. A progress note entry on a specified date indicated that the resident's SDM had been notified.

As cited in the evidence above, prior to the staff to resident physical abuse on a specified date, there was an incident of staff to resident emotional abuse involving PSW #115 and resident #001 on a specified date.

On a specified date, the Administrator stated to the inspector that resident #001's SDM had not been notified of the incident of emotional abuse that occurred in the dining room. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan on specified dates.

Resident #001 was admitted to the home in 2014 with specific diagnoses.

Resident #001's care plan states that the resident "can become verbally responsive if

other resident or staff approach him/her in a abrupt manor. Must remain calm at all times. If upset guide him/her to his/her room and let him/her vent".

PSW #102 was interviewed and stated that resident #001 walked up and down the hallway. PSW #102 stated that resident #001 collected items and that staff removed the items when he/she was not present, otherwise the resident would follow the staff. The PSW stated that the resident required a peaceful approach and that if he/she was resistive, staff were to leave him/her and re-approach at a later time

RPN #103 was interviewed and stated that the resident would sit in random chairs in the dining room, and that if you wanted him/her to move, telling him/her to do so would not be effective. The RPN stated that the resident would forget about the request to move and when re-approached in a calm manner, he/she would comply. RPN #103 stated that when the resident was in another resident's room, if he/she was shown the name outside of the door, he/she would understand that it was not his/her room.

PSW #111 stated that when resident #001 was approached calmly, he/she would respond in a nice way, and RN #105 stated that the resident liked to walk and was easily redirected.

In an interview, Recreation Worker #113 told the inspector that on a specified date, she witnessed an incident of suspected abuse when PSW #115 was trying to get resident #001 to move from a chair in the dining room. The staff member described that resident #001 was waving his/her arms at PSW #115, who went behind the chair that the resident was sitting in and dragged the resident in the chair quickly from behind towards the kitchen.

During an interview with RPN #104 she reported that on a specified day, she was at her medication cart that was parked at the end of the wall, across from the elevator, when she heard PSW #115 saying to resident #001 "get out, you don't belong here". The RPN described PSW #115's tone of voice as aggressive. RPN #104 stated that she then saw resident #001 stagger out of a resident's room backwards, then walk forward, trying to go back into the room, at which time the door to the room was closed with a loud bang, and RPN #104 saw resident #001 fall. RPN #104 stated that resident #001 was found sitting with his/her back against the wall, and stated that he/she had been pushed. The resident was sent to hospital and diagnosed with an injury.

According to the home's investigation file, after resident #001's fall on a specified date,

PSW #115 was sent to see the Director of Care (DOC), and the PSW reported to the DOC that she was trying to get away from resident #001 who was chasing her and wanted to throw juice on her. PSW #115 is reported as saying that she ran from him/her because she did not want to get wet and stated well what was I supposed to do. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse was complied with.

The home's policy titled "Resident Abuse – Staff to Resident", version September 2015 states that all staff who have reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (ON) or the governing provincial regulatory body. The policy further instructs staff to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or their designate.

On a specified date, the home began an investigation into an incident of staff to resident physical abuse involving PSW #115 and resident #001 that occurred on the same day.

According to the home's investigation file, on a specified date, the Administrator met with RPN #104, and during this meeting, RPN #104 told the Administrator about an incident that occurred on a specified date between PSW #115 and resident #001. RPN #104 indicated that she was told that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of the chair. In an interview, RPN #104 told the inspector that she reported the incident to the charge nurse, RN #105 on the same day. It was later clarified

that RPN #104 did not make a report to RN #105.

In an email between the Administrator and the inspector, the Administrator indicated that she spoke with RPN #104 again on a specified date and the RPN indicated that she did not report the incident in the dining room on a specified date to RN #105, as she recalled that the RN was not working on that day. The home's staffing scheduler told the inspector that on the specified day, RN #105, who was the full-time day RN on the floor, had called in sick, and that she was not replaced as there were two other RNs working in the building on the day shift.

The DOC stated that in the absence of an RN on the specified floor on the day shift, the two RPNs are responsible for the residents on their wing (east and west), and if assistance is required, an RN is called. The DOC stated that on a specified date, RPN #104 received responsibility pay which is additional pay for additional responsibilities and was in charge of the specified floor.

In an interview, RPN #103 stated that with regards to the incident in the dining room on a specified date, she was in a resident's room and heard from that room that resident #001 was sitting in a co-resident's chair in the dining room, had been asked to move and was agitated. The RPN stated that as she entered the dining room she saw that resident #001 had gotten up from the chair and was trying to go back to the chair. RPN #103 stated that she took resident #001 to his/her room and calmed the resident down. The RPN stated that she did not witness and was not told that anything inappropriate had happened between PSW #115 and resident #001 prior to her arrival to the dining room. In RPN #103's written statement to the Administrator, she wrote "At the time that I entered the dining room [resident #001] was already up. I then stated to the other RPN on the shift [RPN #103] that I will be talking to the staff regarding thier approach with [resident #001]. No other issue was brought to my attention from staff ".

In an interview, Recreation Worker #113 told the inspector that on a specified date, she witnessed an incident of suspected abuse when PSW #115 was trying to get resident #001 to move from a chair in the dining room. The staff member described that resident #001 was waving his/her arms at PSW #115, who went behind the chair that the resident was sitting in and dragged the resident in the chair quickly from behind towards the kitchen. The staff member did not report the incident until she was approached by the home's Administrator who asked her if she had witnessed resident #001 being treated inappropriately in the dining room.

In an interview with resident #001's primary care PSW, she stated that on a specified day, prior to the incident when resident #001's fell, she was in the hallway and heard a commotion which drew her to the dining room. PSW #114 stated that when she entered the dining room, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

As cited in the evidence above:

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

PSW #114 indicated that on a specified date, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

On a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

Recreation Staff Member #113 stated that on a specified date, she saw PSW #115 go behind the chair that resident #001 was sitting in and drag the resident in the chair quickly from behind towards the kitchen.

On a specified date, none of the staff members immediately reported the suspicion of abuse and the information upon which it is based to the Director (ON) or the governing provincial regulatory body, and none of the staff members immediately reported any suspected or witnessed abuse to the Administrator, Director of Care or their designate, as required by the home's policy titled "Resident Abuse - Staff to Resident", version September 2015 . [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 :

1. The licensee has failed to ensure that every witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

According to O. Reg 79/10, s. 2:
Emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident".

As cited in evidence above, on a specified date, resident #001 was physically abused by PSW #115, and resident #001 fell and sustained an injury. The incident was witnessed by RPN #104 who immediately began investigating the situation and alerted the RN.

In an interview, RPN #104 told the inspector that a few days prior to resident #001's fall on a specified date, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms. In an interview, RPN #104 told the inspector that she reported the incident to the charge nurse, RN #105 on the same day. It was later clarified that RPN #104 did not make a report to RN #105.

In an email between the Administrator and the inspector, the Administrator indicated that she spoke with RPN #104 again on a specified date, and the RPN indicated that she did

not report the incident in the dining room on a specified date to RN #105, as she recalled that the RN was not working on that day. The home's staffing scheduler told the inspector that on the specified day, RN #105, who was the full-time day RN on the floor, had called in sick, and that she was not replaced as there were two other RNs working in the building on the day shift.

The DOC stated that in the absence of an RN on the specified floor on the day shift, the two RPNs are responsible for the residents on their wing (east and west), and if assistance is required, an RN is called. The DOC stated that on a specified date, RPN #104 received responsibility pay which is additional pay for additional responsibilities and was in charge of the specified floor.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

On a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

As cited in the evidence above, RPN #104 was in charge of the specified floor on a specified date. The incident of emotional abuse that occurred on a specified date was not investigated immediately; it was not investigated until six days later. Furthermore, because of this delay, no action was taken to further mitigate the risk of abuse by PSW #115 when she continued to provide care and services to residents without additional supervision. [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 :

1. A person who had reasonable grounds to suspect that abuse occurred failed to immediately report the suspicion and the information upon which it was based to the Director.

According to O. Reg 79/10, s. 2:
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

As cited in the evidence above, on a specified date, resident #001 was physically abused by PSW #115, and resident #001 fell and sustained an injury.

In an interview, RPN #104 told the inspector that prior to resident #001's fall on a specified day, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms. RPN #104 told the inspector that she reported the incident to the charge nurse, RN #105 on the same day. It was later clarified that RPN #104 did not make a report to RN #105.

In an email between the Administrator and the inspector, the Administrator indicated that

she spoke with RPN #104 again on a specified date, and the RPN indicated that she did not report the incident in the dining room on a specified date to RN #105, as she recalled that the RN was not working on that day. The home's staffing scheduler told the inspector that on the specified day, RN #105, who was the full-time day RN on the floor, had called in sick, and that she was not replaced as there were two other RNs working in the building on the day shift.

The DOC stated that in the absence of an RN on the specified floor on the day shift, the two RPNs are responsible for the residents on their wing (east and west), and if assistance is required, an RN is called. The DOC stated that on a specified date, RPN #104 received responsibility pay which is additional pay for additional responsibilities and was in charge of the specified floor.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

PSW #114 indicated that on a specified date, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

On a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

Recreation Staff Member #113 stated that on a specified date, she saw PSW #115 go behind the chair that resident #001 was sitting in and dragged the resident in the chair quickly from behind towards the kitchen.

As cited in the evidence above, RPN #104 was in charge of the specified floor on a specified date. The incident of emotional abuse that occurred on a specified date was not reported to the Director immediately; it was not reported until fourteen days later when the CIR was amended. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse.

A Critical Incident Report for staff to resident physical abuse, involving PSW #115 and resident #001 was submitted to the Director on a specified date. A progress note entry on a specified date indicated that the resident's SDM had been notified.

As cited in the evidence above, prior to the staff to resident physical abuse on a specified date, there was an incident of staff to resident emotional abuse involving PSW #115 and resident #001 on a specified date.

On a specified date, the Administrator stated to the inspector that resident #001's SDM had not been notified of the incident of emotional abuse that occurred in the dining room.

Issued on this 30th day of June, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MEGAN MACPHAIL (551)
Inspection No. / No de l'inspection :	2016_290551_0008
Log No. / Registre no:	009523-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 30, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE LAURIER MANOR 1715 MONTREAL ROAD, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cory Nezan

To EXTENDICARE (CANADA) INC., 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

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

The licensee will prepare, submit and implement a plan for achieving compliance to ensure that all staff complete an education session specific to Zero Tolerance of Abuse.

At minimum, this education should include:
- as defined by O. Reg 79/10, section 2 (1) (2) (3), definitions of abuse
- the use of MOHLTC Abuse Decision Tree Algorithms (as a guide)
- as outlined in LTCHA, section 24, mandatory reporting requirements
- as outlined in O. Reg 79/10, section 97 (1) (2) (3), person(s) who are to be notified when there is an alleged, suspected or witnessed incident of abuse or neglect of a resident
- for those in a charge role, how to complete a thorough, timely and appropriate investigation and how to implement interventions to safe guard the resident when there is an alleged, suspected or witnessed incident of abuse or neglect of a resident
- a review of the home's specific policies related to: Prevention of Abuse, Mandatory Reporting, Whistle Blowing Protection and the Residents' Bill of Rights

The licensee will ensure that there is a process for measuring the learning acquired during the education session, and a process to identify the actions to be taken to address learning gaps.

The written plan must be submitted by fax to the attention of Megan MacPhail at 613-569-9670. The licensee will provide the written plan no later than July 15, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone.

A Critical Incident Report (CIR) for staff to resident abuse was submitted to the Director on a specified date.

According to O. Reg 79/10, s. 2:
the definition of physical abuse is "the use of physical force by anyone other than a resident that causes physical injury or pain"
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

Resident #001 was admitted to the home in 2014 with specific diagnoses.

The Physiotherapist Assistant (PTA) #101 was interviewed and indicated that resident #001 liked to walk in the hallways. The PTA stated that the resident had good balance, was independent with ambulation and was not considered to be a fall risk. According to the PTA, resident #001 participated in group exercise classes and could follow instructions.

During an interview with RPN #104 she reported that on a specified day, she was at her medication cart that was parked at the end of the wall, across from the elevator, when she heard PSW #115 saying to resident #001 “get out, you don’t belong here”. The RPN described PSW #115's tone of voice as aggressive. RPN #104 stated that she then saw resident #001 stagger out of a resident's room backwards, then walk forward, trying to go back into the room, at which time the door to the room was closed with a loud bang, and RPN #104 saw resident #001 fall. RPN #104 stated that resident #001 was found sitting with his/her back against the wall, and stated that he/she had been pushed.

The resident was assessed by RPN #104, RN #105 and a physician. During an interview with RN #105, she reported that resident #001 complained of pain and was sent to the hospital.

According to the home's investigation file, after resident #001's fall on a specified day, PSW #115 was sent to see the Director of Care (DOC), and the

PSW reported to the DOC that she was trying to get away from resident #001 who was chasing her and wanted to throw juice on her. PSW #115 is reported as saying that she ran from the resident because she did not want to get wet.

According to a review of the resident's health care record, resident #001 received a specified diagnosis at the hospital. Resident #001 returned to the home on a specified day and was assessed by the Physiotherapist (PT).

According to a progress note entry, at a specified time on a specified day, the resident was toileted with no issues. In a progress note entry several hours later, it indicated that resident #001 received a medication for pain, and that when the resident's vitals were being assessed, he/she became unresponsive. Resident #001 was sent to the hospital. The resident passed away on a specified date.

The home's investigation into the incident of staff to resident physical abuse on a specified date, involving PSW #115 and resident #001, revealed that there was a prior incident of staff to resident emotional abuse involving PSW #115 and resident #001 that was witnessed and that was not reported to either of the RNs who were working in the building on that day, the manager or the Director.

According to the home's investigation file, on a specified date, the Administrator met with RPN #104 with regards to the incident when the resident fell. In RPN #104's statement made to the Administrator, the following is indicated "[RPN #104] at this meeting also mentioned that staff had mentioned another incident with [PSW #115] a few days ago where the PSW's reported that [resident #001] sat in the wrong seat in the dining room and that [PSW #115] had come in with the resident who was to sit there and she was very abrupt with [resident #001] instructing him/her to get out of the chair. [RPN #104] said she was told that [PSW #115] grabbed him/her roughly by the arm and pulled him/her out of the chair. [RPN 104] did not witness this she said she reported it to the RN that she had been told that and did not know if it had been reported to DOC".

In an interview, RPN #104 told the inspector that prior to resident #001's fall, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms. RPN #104 told the inspector that she reported the incident to the charge nurse, RN #105 on the same day. It was

later clarified that RPN #104 did not make a report to RN #105.

In an email between the Administrator and the inspector, the Administrator indicated that she spoke with RPN #104 again on a specified date, and the RPN indicated that she did not report the incident in the dining room on a specified date to RN #105, as she recalled that the RN was not working on that day. The home's staffing scheduler told the inspector that on the specified day, RN #105, who was the full-time day RN on the floor, had called in sick, and that she was not replaced as there were two other RNs working in the building on the day shift.

The DOC stated that in the absence of an RN on the specified floor on the day shift, the two RPNs are responsible for the residents on their wing (east and west), and if assistance is required, an RN is called. The DOC stated that on a specified date, RPN #104 received responsibility pay which is additional pay for additional responsibilities and was in charge of the specified floor.

In an interview, RPN #103 stated that with regards to the incident in the dining room on a specified date, she was in a resident's room and heard from that room that resident #001 was sitting in a co-resident's chair in the dining room, had been asked to move and was agitated. The RPN stated that as she entered the dining room she saw that resident #001 had gotten up from the chair and was trying to go back to the chair. RPN #103 stated that she took resident #001 to his/her room and calmed the resident down. The RPN stated that she did not witness and was not told that anything inappropriate had happened between PSW #115 and resident #001 prior to her arrival to the dining room. In RPN #103's written statement to the Administrator, she wrote "At the time that I entered the dining room [resident #001] was already up. I then stated to the other RPN on the shift [RPN #103] that I will be talking to the staff regarding thier approach with [resident #001]. No other issue was brought to my attention from staff ".

In an interview, Recreation Worker #113 told the inspector that on a specified date she witnessed an incident of suspected abuse when PSW #115 was trying to get resident #001 to move from a chair in the dining room. The staff member described that resident #001 was waving his/her arms at PSW #115, who went behind the chair that the resident was sitting in and dragged the resident in the chair quickly from behind towards the kitchen. The staff member did not report the incident until she was approached by the home's Administrator who asked

her if she had witnessed resident #001 being treated inappropriately in the dining room.

In an interview with resident #001's primary care PSW, she stated that on a specified day, prior to the incident when resident #001's fell, she was in the hallway and heard a commotion which drew her to the dining room. PSW #114 stated that when she entered the dining room, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

The home's administrator stated that the incident in the dining room involving PSW #115 and resident #001 was inappropriate and should have been reported by any staff to the management who would have investigated. The CIR that was amended on a specified date indicated that if staff had reported the incident in the dining room, the employee would have been taken off the schedule.

A review of PSW #115 file's showed several performance issues that resulted in disciplinary action.

The home's policy titled "Resident Abuse – Staff to Resident", version September 2015 states that all staff who have reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (ON) or the governing provincial regulatory body. The policy further instructs staff to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or their designate, and states that all staff is responsible to ensure that they understand and comply fully with the Resident Abuse - Staff to Resident policy and procedures.

The licensee has failed to comply with:
1. LTCHA s. 20 (1) Every licensee shall ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with. Refer to WN #3.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

PSW #114 indicated that on a specified date, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

On a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

Recreation Staff Member #113 stated that on a specified date, she saw PSW #115 go behind the chair that resident #001 was sitting in and drag the resident in the chair quickly from behind towards the kitchen.

On a specified date, none of the staff members immediately reported the suspicion of abuse and the information upon which it is based to the Director (ON) or the governing provincial regulatory body, and none of the staff members immediately reported any suspected or witnessed abuse to the Administrator, Director of Care or their designate, as required by the home's policy titled "Resident Abuse - Staff to Resident", version September 2015.

The licensee has failed to comply with:
2. LTCHA s. 24 (1) A person who has reasonable grounds to suspect that 2. Abuse of a resident by anyone, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. Refer to WN #5.

According to O. Reg 79/10, s. 2:
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

As cited in the evidence above, on a specified date, resident #001 was physically abused by PSW #115, and resident #001 fell and sustained an injury.

In an interview, RPN #104 told the inspector that prior to resident #001's fall on a specified date, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

PSW #114 indicated that on a specified date, she saw PSW #115 pulling a chair away from the table with resident #001 seated in the chair.

As cited in the evidence above, on a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

Recreation Staff Member #113 stated that on a specified date, she saw PSW #115 go behind the chair that resident #001 was sitting in and dragged the resident in the chair quickly from behind towards the kitchen.

As cited in the evidence above, RPN #104 was in charge of the specified floor on a specified date. The incident of emotional abuse that occurred on a specified date was not reported to the Director immediately; it was not reported until fourteen days later when the CIR was amended.

The licensee has failed to comply with:
3. LTCHA s. 23 (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed of (i) abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. Refer to WN #4.

According to O. Reg 79/10, s. 2:
the definition of emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident"

As cited in the evidence above, on a specified date, resident #001 was physically abused by PSW #115, and resident #001 fell and sustained an injury. The incident was witnessed by RPN #104 who immediately began investigating the situation and alerted the RN.

In an interview, RPN #104 told the inspector that prior to resident #001's fall on a specified date, PSW #114 reported to her that PSW #115 had spoken to and interacted with resident #001 abusively in the dining room. RPN #104 stated that it was reported to her that PSW #115 was pulling the chair with resident #001 seated in it and was grabbing the resident's arms.

On a specified date, RPN #104 was told by PSW #114 that PSW #115 grabbed resident #001 roughly by the arm and pulled him/her out of a chair.

As cited in the evidence above, on a specified date, RPN #103 intervened in the dining room and was going to speak with staff regarding their approach with resident #001.

As cited in the evidence above, RPN #104 was in charge of the specified floor on a specified date. The incident of emotional abuse that occurred on a specified date was not investigated immediately; it was not investigated until six days later. Furthermore, because of this delay, no action was taken to further mitigate the risk of abuse by PSW #115 when she continued to provide care and services to residents without additional supervision.

The licensee has failed to comply with:
4. O. Reg 79/10 s. 97 (1) (b) Every licensee of a long-term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. Refer to WN #6.

A Critical Incident Report for staff to resident physical abuse, involving PSW #115 and resident #001 was submitted to the Director on a specified date. A progress note entry on a specified date indicated that the resident's SDM had been notified.

As cited in the evidence above, prior to the staff to resident physical abuse on a specified date, there was an incident of staff to resident emotional abuse involving PSW #115 and resident #001 on a specified date.

On a specified date, the Administrator stated to the inspector that resident #001's SDM had not been notified of the incident of emotional abuse that occurred in the dining room (551)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Megan MacPhail

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