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
Feb 16, 2017	2016_565612_0027	028561-16	Resident Quality Inspection

Licensee/Titulaire de permis

NORTH CENTENNIAL MANOR INC.
2 Kimberly Drive KAPUSKASING ON P5N 1L5

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

NORTH CENTENNIAL MANOR
2 KIMBERLY DRIVE KAPUSKASING ON P5N 1L5

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

SARAH CHARETTE (612), ALAIN PLANTE (620)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 23, 24, 30, and December 1, 2016.

The following was inspected during the course of this inspection; four Critical Incidents (CIs) related to resident abuse, one CI related to the improper transfer of a resident, one follow up to compliance order #001 related to food quality, and one complaint related to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC #101), Interim Director of Care (DOC #107), Food Services Manager, Administrative Assistant, Resident Assessment Instrument (RAI) Coordinator, Activities Coordinator, Cook, Dietary Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, investigation notes, policies, procedures, programs, and staff personnel files.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Food Quality
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **8 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 72. (2)	CO #001	2016_283544_0001	612

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.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The Long Term Care Homes Act (LTCHA), 2007, defines sexual abuse as, “any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member."

The LTCHA, 2007, defines verbal abuse as, "any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences."

The LTCHA 2007, defines physical abuse as, "the use of physical force by a resident that causes physical injury to another resident."

On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Resident #012 notified Inspector #620 that resident #010 had been physically, verbally, and sexually abusive toward staff and residents and that the abuse had escalated and was disruptive to the residents of the home. Resident #012 stated that they were concerned for the well being of the staff and residents because of resident #010’s behaviour.

Inspector #620 reviewed the health care record for resident #010 which documented a history of abusive behaviours towards residents and staff. The Inspector identified a progress note documented by RPN #116 which indicated that resident #010 had been “sexually inappropriate” with resident #011 on an identified date. The note identified that PSW #117 had witnessed resident #010 display the “sexually inappropriate" behaviour. The note also described that resident #011 was upset after the incident. The progress note indicated that the PSW intervened and that the resident was “sexually inappropriate” with them too. RPN #116 described that they told resident #010 that the behaviour was inappropriate and that they needed to stop; RPN #116 noted that the resident got upset.

a) Upon further review of resident #010’s health care record, Inspector #620 noted a significant number of progress notes related to resident #010’s abusive behaviours since the resident was admitted to the home. Analysis of the adverse behavioural notations revealed a number of incidents when the resident was verbally, physically and sexually abusive with staff and verbally abusive with other residents.

A review of resident #010’s care plan (current at the time of the inspection) identified four interventions to protect staff from the resident’s verbal, physical and sexual behaviours.

Inspector #620 conducted a review of the resident's clinical file and identified that there were referrals to external resources that identified the escalating verbal, physical and sexual behaviours; however, no specific outcomes of those assessment.

During an interview on December 1, 2016, with the Administrator and DOC #107, they confirmed that the interventions in residents #010's care plan had not been effective at managing resident #010's escalating physical, verbal and sexual behaviours and since the incident of sexual abuse, no new interventions had been included in the resident #010's plan of care to manage the new and escalating sexually responsive behaviours.

According to the LTCHA, 2007, s. 6 (10) (c), the licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective. Please refer to WN #3.

b) Inspector #620 and #612 reviewed closed circuit video surveillance of the alleged incident of abuse that occurred on an identified date. Resident #010 was "sexually inappropriate" towards resident #011. Following the incident, resident #011 was observed to be upset with resident #010. PSW #117 was seen talking to the residents during the incident; PSW #107's verbal interaction with both residents lasted less than four seconds. PSW #117 discontinued their observation of both residents less than ten seconds following the incident. As PSW #117 walked in the opposite direction, resident #011 was seen leaving the surveillance area down a hallway with resident #010 following.

In an interview with the Administrator on December 1, 2016, they stated that PSW #117 did not stay with resident #011, but rather continued to complete their task of assisting other residents to the dining room.

During an interview with DOC #107, they stated that they were the charge nurse who had worked the shift when the incident had occurred. They did not report the incident to DOC #101 or the Ministry of Health and Long-Term Care (MOHLTC). An investigation was not initiated until nine days after the incident was reported to them.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. Under the subsection of "Clinical Staff Responsible for Care of the Resident(s) harmed by the abuse or neglect" the policy advised staff to, ensure the

resident or residents are reassured and supported immediately in the appropriate manner to ensure their safety and security, provide intervention for the resident who has been allegedly abused or neglected and ensure that the resident was not left with the person alleged to have caused the abuse or neglect. The policy also stated that staff must immediately report the alleged or witnessed incident of abuse or neglect to a manager/designate so they can report immediately to the MOHLTC and investigate immediately all reports by staff and board members under this policy in accordance with LTCHA, s. 23.

According to the LTCHA, 2007, s. 20 (1), the 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. Please refer to WN #2.

c) Inspector #620 reviewed the home's submissions to the Director related to critical incident (CI) reports and was unable to identify any CI report related to the alleged incident of abuse that was documented to have occurred on the identified date.

During an interview with DOC #107 and the Administrator, they confirmed that DOC #107 had not immediately reported the incident to the Director, but rather, reported the incident following an interview with Inspector #620 and #612.

According to the LTCHA, 2007, s. 24, 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: 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. Please refer to WN #5.

d) Following an interview with Inspector #620, nine days after they became aware of the incident of alleged abuse, DOC #107 contacted the Substitute Decision Maker (SDM) of resident #011.

According to O. Reg 79/10, s. 97 (1), the licensee shall ensure that the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident, 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. Please refer to WN #7. [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.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Please refer to WN #1 for specific details.

a) Inspector #620 interviewed RPN #116 who stated that they first became aware of the alleged incident of sexual abuse when PSW #117 described the incident to them the day it had occurred. RPN #116 stated that they advised DOC #107 (acting as charge nurse that day) of the incident the same day. RPN #116 stated that they were not questioned about the incident after notifying DOC #107.

Inspector #620 reviewed the home's submissions to the Director related to critical incident (CI) reports and was unable to identify any CI report related to the alleged incident of abuse that was documented to have occurred between resident #010 and #011.

Following an interview with Inspector #620, nine days after they became aware of the incident of sexual abuse, DOC #107 (covering for DOC #101) submitted a CI report to the Director, began an investigation, notified the physician, contacted the Substitute Decision Maker (SDM) of resident #011, and added interventions to resident #010's care plan.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. Under the subsection of "Investigating and Responding to Alleged, Suspected or Witnessed Abuse and Neglect of Residents" The policy advised staff to, "Fully investigate the incident and, complete the documentation of all known details of the reported incident..." The policy instructed staff that, "When a manager/designate or other receives a report from an employee on a suspected, or actual incident of abuse or neglect, they will immediately report to the MOHLTC..." Furthermore, the policy advised that, "Staff must notify the SDM, if any, or any other person specified by the resident immediately if the resident is harmed and within 12 hours of becoming aware of the alleged, suspected or witnessed incident of abuse of a resident..."

b) Inspector #620 and #612 reviewed closed circuit video surveillance of the alleged incident of abuse that occurred on an identified date. Resident #010 was "sexually inappropriate" towards resident #011. Following the incident, resident #011 was observed to be upset with resident #010. PSW #117 was seen talking to the residents during the incident; PSW #107's verbal interaction with both residents lasted less than four seconds. PSW #117 discontinued their observation of both residents less than ten seconds following the incident. As PSW #117 walked in the opposite direction, resident #011 was seen leaving the surveillance area down a hallway with resident #010 following.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. Under the subsection of "Clinical Staff Responsible for Care of the Resident(s) harmed by the abuse or neglect" the policy advised staff to, ensure the resident or residents are reassured and supported immediately in the appropriate manner to ensure their safety and security, provide intervention for the resident who has been allegedly abused or neglected and ensure that the resident was not left with the person alleged to have caused the abuse or neglect.

In an interview with the Administrator on December 1, 2016, they stated that PSW #117 did not stay with resident #011, but rather, continued to complete their task of assisting other residents to the dining room. [s. 20. (1)]

2. Inspector #612 reviewed a CI report submitted to the Director, in regards to an incident that occurred in the home. The CI report indicated that resident #008 and a staff member were in a common area of the home and the staff member made an infantile remark to

resident #008. This was observed by another staff member.

The Inspector reviewed the home's investigation notes. A staff member had heard the infantile remark made by the PSW #102 towards resident #008. The staff member notified the family of the alleged incident. The family member then called RN #104 to report the incident. RN #104 left a note explaining the incident for DOC #101. DOC #101 reviewed the note the day after the incident, and began their investigation at 0800 hours the same day. The home did not report the incident to the Director until 1506 hours the day after the incident. In the interview with PSW #102, they confirmed that they had made the statement while feeding resident #008. Discipline was issued as a result of the verbal abuse by PSW #102 towards resident #008.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last reviewed October 2016, which stated that all residents had the right to live in a home environment that treats them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. The home was committed to zero tolerance of abuse or neglect of its residents. The policy also stated for the home to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC, staff were to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

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

Findings/Faits saillants :

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

Inspector #612 reviewed a CI report, submitted by the home to the Director. The CI report described an incident where PSW #102 was providing care to resident #001. The PSW temporarily left resident #001 to assist another resident and did not implement specific interventions. When PSW #102 turned around to walk back to resident #001's bedside, the PSW noted that the resident was sitting on the floor beside their bed. Resident #001 sustained an injury.

The Inspector reviewed the resident #001's care plan which was in place at the time of the incident which identified specific interventions.

The Inspector interviewed the DOC #101 who confirmed that the care was not provided as per the resident #001's plan of care, as PSW #102 left the resident's bedside without implementing the specific interventions. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan had not been effective.

On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Please refer to WN #1 for specific details.

A review of resident #010's care plan (current at the time of inspection) identified four interventions to protect staff from the resident's verbal, physical and sexually abusive behaviours.

Inspector #620 conducted a review of the resident's clinical file and identified that there were referrals to external resources that identified the escalating verbal, physical and sexually responsive behaviours; however, no specific outcomes of those assessment.

During an interview on December 1, 2016, DOC #107 and the Administrator stated that they were not aware of the outcome of the assessments related to resident #010's verbally and sexually inappropriate behaviours.

On November 30, 2016, Inspector #620 observed a meal service on a specific unit. Resident #010 was present at the meal service. During the meal service resident #010 directed sexually inappropriate comments toward RPN #116; the statements being made by resident #010 could be heard throughout the dining room. RPN #116 did not ask resident #116 to stop the inappropriate behaviour.

On November 30, 2016, Inspector #620 observed resident #010's interaction with a staff member during a snack service. Resident #010 was observed to be verbally and physically sexually inappropriate with the staff member. In response to resident #010's behaviour the staff member placed a cart between them and the resident.

Inspector #620 interviewed RPN #116 who stated that there were some staff who did not want to work on the unit because of resident #010's inappropriate behaviour. RPN #116 described that they and other staff felt resident #010's behaviour was out of control.

Inspector #620 interviewed DOC #107 and the home's Administrator. Both agreed that the provisions in the residents care plan had been ineffective at managing resident #010's escalating behaviours. DOC #117 confirmed that since the incident of sexual abuse towards resident #011, no new interventions had been included in the resident #010's plan of care to manage the new and escalating sexually responsive behaviours. DOC #107 advised that they intended to alter resident #010's plan of care to include specific interventions to address the behaviours. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported to the licensee, was 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.

The Director received a complaint alleging that a staff member in the home had abused residents within the home.

a) During an interview with the complainant, they reported to Inspector #612 that they

had a meeting with the Administrator and DOC #101, where they brought forward six residents' (#002, 013, 014, 015, 016, 017) names and stated that those residents had reported being abused by a staff member. The complainant stated that there had been no follow up or investigation by the home.

The Inspector reviewed the home's documentation related to the meeting. There was a letter indicating that DOC #101 had interviewed resident #016; however, there was no information regarding the other five residents.

During an interview with Inspector #612 and #620, the Administrator and DOC #101 stated that they had not conducted any investigation related to resident #002, 013, 014, 015 or 017 and there was no information in the report from the complainant, only the names of the residents were provided, therefore DOC #101 did not feel that there were any grounds to investigate further.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last reviewed October 2016, which stated that the management staff must investigate immediately all reports of abuse or neglect, in accordance with the investigation procedures set out in the policy and the LTCHA, 2007. They will need to consider whether the circumstances of the alleged, suspected or witnessed abuse or neglect met the definitions within the LTCHA, 2007, s. 2 (1). It also stated that management staff must fully investigate the incident, and complete the documentation of all known details of the reported incident.

The Inspector reviewed a Memorandum sent to all Licensees, Administrators and DOC of LTC Homes on August 4, 2010, titled, Clarification of Mandatory and Critical Incident Reporting Requirements. This memo stated that the licensee was required to investigate alleged, suspected or witnessed incidents of abuse of a resident by anyone.

b) During an interview with the complainant, they reported that resident #015 had reported that a specific staff member had treated them roughly that they had reported the incident to the DOC who did not do anything about it.

Inspector #620 interviewed resident #015. They confirmed that a specific staff member had treated them roughly and that they no longer accepted care from that staff member. The resident stated to the Inspector that they had not reported this information to anyone.

On November 24, 2016, Inspector #612 and #620 interviewed the DOC #101. DOC #101 stated that resident #015 had approached them and reported that a specific staff member was rough with them. Resident #015 was unable to provide specific information. DOC #101 stated that they were unable to see any evidence. DOC #101 further stated that their first step was to investigate; however, in this case, they did not see any reason to further investigate as there was no evidence. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #5: 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 :

1. The licensee has failed to ensure that a person who had reasonable grounds to

suspect that any of the following had occurred or may have occurred should have immediately reported the suspicion and the information upon which it was based to the Director:
a) 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.

The Long Term Care Health Act, 2007, describes sexual abuse as, "… any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member […]"

On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Please refer to WN #1 for specific details.

Inspector #620 reviewed the home's submissions to the Director related to critical incident reports. Inspector #620 was unable to identify any CI report related to the alleged incident of abuse that was documented to have occurred between resident #010 and #011.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. The policy advised staff that, "When a manager/designate or other receives a report from an employee on a suspected, or actual incident of abuse or neglect, they will immediately report to the MOHLTC..."

Inspector #620 interviewed RPN #116 who stated that they first became aware of the alleged incident of sexual abuse when PSW #117 described the incident to them on the day it had occurred. RPN #116 stated that they advised DOC #107 of the incident.

Inspector #620 interviewed DOC #107 (DOC #107 served as the interim DOC in DOC #101's absence). DOC #107 stated that they were made aware of the alleged incident of sexual abuse on the day it had occurred; however, they were unsure if DOC #101 was notified. At the time of the interview DOC #107 did not know if a submission to the Director had occurred. In a subsequent interview, DOC #107 stated that they should have made a report to the Director, and should have notified DOC #101 of the incident but they did not do so.

Following their interview with Inspector #620, DOC #107 submitted a CI report to the Director, nine days after they became aware of the incident of sexual abuse. [s. 24. (1)]

2. Inspector #612 reviewed a CI report, submitted to the Director, in regards to an incident that occurred in the home on a specific date. Please refer to WN #2, section two, for additional details.

The Inspector reviewed the investigation notes provided by the home. RN #104 had been notified by a family member the day of the incident and left a note explaining the incident for the DOC #101. DOC #101 was notified the next day and began their investigation at 0800 hours. The Director was not notified until the CI report was completed at 1506 hours the day after the incident.

The Inspector interviewed DOC #101 and the Administrator who stated that any incident of suspected or alleged abuse should be reported to either of them immediately so that they could coordinate submitting the report to the Director.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. The policy stated, that fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC, staff were to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect. When a manger/designate or other receives an internal report from an employee on a suspected or alleged, or actual incident of abuse or neglect, they will immediately report to the Ministry of Health and Long-Term Care (MOHLTC). A designate of the home was responsible for completing reports using Critical Incident System (CIS) to the MOHLTC. This designate may make the MOHLTC report together with the person who witnessed the incident of abuse or neglect. [s. 24. (1)]

3. The Director received a complaint alleging that a staff member in the home had abused residents within the home. Please refer to WN #4 for additional details.

On November 24, 2016, Inspector #612 and #620 interviewed DOC #101 and the Administrator. They confirmed that they had a meeting with staff members, and that six resident's names were brought forward. DOC #101 stated that they had approached resident #016; however they did not further investigate the other five resident's stating that the staff members had not brought forward specific incidents or information to investigate. DOC #101 stated that they did not report the alleged abuse to the Director.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last reviewed October 2016, which stated that all staff, volunteers, contractors and

affiliated personnel are required to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the Ministry of Health and Long-Term Care (MOHLTC) and immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect. When a manager/designate or other receives an internal report from an employee on a suspected or alleged, or actual incident of abuse or neglect, they will immediately report to the MOHLTC. The immediate report may be completed together with the individual who alerted them of the incident or alleged incident of abuse or neglect. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that 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, had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Inspector #620 reviewed a CI report submitted by the home to the Director, which indicated that PSW #108 transferred resident #006 without the assistance of another staff member. The CI report also indicated that PSW #108 was aware that resident #006's plan of care indicated that the resident was required to be transferred utilizing the assistance of a second staff member and a mechanical lift.

A review of the home's investigation notes revealed that PSW #108 received discipline as a result of the improper transfer. The investigation notes contained a statement drafted by PSW #108 which indicated that they were aware that resident #006 was required to utilize a mechanical lift and two staff members to complete a transfer; however, PSW #108 transferred the resident on their own.

A review of resident #006's plan of care in place at the time of the incident revealed that resident #006 required to be transferred by two staff members via a specific mechanical lift.

Inspector #620 reviewed the home's policy titled, "Lift & Transfer Zero Lift Policy" last revised August 2013. The policy stated that, "All employees must adhere to the designated lift/transfer status as identified on each resident care plan and according to the logo at each bedside. Failure to follow this standard will result in disciplinary action."

Inspector #620 interviewed the home's Administrator who confirmed that PSW #108 performed an improper transfer and that it posed a risk to resident #006's safety. The Administrator stated that PSW #108 did not adhere to the homes policy on resident transfers and was disciplined as a result of the improper transfer. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: 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 substitute decision-maker (SDM), if any, and any other person specified by the resident, was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could have been potentially detrimental to the resident's health or well-being.

On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Please refer to WN #1 for specific details.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" with a review date of October 2016. The policy advised staff that, "Staff must notify the SDM, if any, or any other person specified by the resident immediately if the resident is harmed and within 12 hours of becoming aware of the alleged, suspected or witnessed incident of abuse of a resident..."

Inspector #620 interviewed RPN #116 who stated that they first became aware of the alleged incident of sexual abuse the same day it occurred. RPN #116 stated that they advised DOC #107 of the incident. RPN #116 stated that they were unsure of whether the incident had been reported to the SDM.

Inspector #620 interviewed DOC #107. DOC #107 stated that they had been aware of the alleged incident of sexual abuse the same day if occurred. In a subsequent interview, DOC #107 stated that resident #011's SDM had not been notified immediately following the incident. They stated that they had notified the resident #011's SDM nine days following the incident. The SDM advised DOC #107 that they were unaware that an incident had occurred, and they were upset that they were not immediately made aware. [s. 97. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or the staff that led to the report included 2. A description of the individuals involved in the incident, including, ii. names of any staff members or others persons who were present at or discovered the incident.

Inspector #612 reviewed a CI report, submitted to the Director, in regards to an incident that occurred in the home on a specific date. Please refer to WN #2, section two, for additional details. The CI report did not indicate the name of the staff member who was involved in the incident.

The Inspector interviewed the DOC who stated that the staff member was PSW #102 and that should have been included in the report.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last reviewed October 2016, under Appendix B: reports to the Director, which stated that the report to the Director shall include 2. A description of the individuals involved in the incident, including, ii. Names of any staff members or other persons who were present at or discovered the incident. [s. 104. (1) 2.]

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

Issued on this 22nd day of February, 2017

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) :	SARAH CHARETTE (612), ALAIN PLANTE (620)
Inspection No. / No de l'inspection :	2016_565612_0027
Log No. / Registre no:	028561-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 16, 2017
Licensee / Titulaire de permis :	NORTH CENTENNIAL MANOR INC. 2 Kimberly Drive, KAPUSKASING, ON, P5N-1L5
LTC Home / Foyer de SLD :	NORTH CENTENNIAL MANOR 2 KIMBERLY DRIVE, KAPUSKASING, ON, P5N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Claude Tremblay

To NORTH CENTENNIAL MANOR INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents are protected from abuse from anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The Long Term Care Homes Act (LTCHA),2007, defines sexual abuse as, "any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member."

The LTCHA, 2007, defines verbal abuse as, "any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences."

The LTCHA 2007, defines physical abuse as, "the use of physical force by a resident that causes physical injury to another resident."

On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Resident #012 notified Inspector #620 that resident #010 had been physically, verbally, and sexually abusive toward staff and residents and that the abuse had escalated and was disruptive to the residents of the home. Resident #012 stated that they were concerned for the well being of the staff and residents because of resident #010's behaviour.

Inspector #620 reviewed the health care record for resident #010 which documented a history of abusive behaviours towards residents and staff. The Inspector identified a progress note documented by RPN #116 which indicated that resident #010 had been "sexually inappropriate" with resident #011 on an identified date. The note identified that PSW #117 had witnessed resident #010 display the "sexually inappropriate" behaviour. The note also described that resident #011 was upset after the incident. The progress note indicated that the PSW intervened and that the resident was "sexually inappropriate" with them too. RPN #116 described that they told resident #010 that the behaviour was inappropriate and that they needed to stop; RPN #116 noted that the resident got upset.

a) Upon further review of resident #010's health care record, Inspector #620 noted a significant number of progress notes related to resident #010's abusive behaviours since the resident was admitted to the home. Analysis of the adverse behavioural notations revealed a number of incidents when the resident was verbally, physically and sexually abusive with staff and verbally abusive with other residents.

A review of resident #010's care plan (current at the time of the inspection) identified four interventions to protect staff from the resident's verbal, physical and sexual behaviours.

Inspector #620 conducted a review of the resident's clinical file and identified that there were referrals to external resources that identified the escalating verbal, physical and sexual behaviours; however, no specific outcomes of those assessment.

During an interview on December 1, 2016, with the Administrator and DOC #107, they confirmed that the interventions in residents #010's care plan had not been effective at managing resident #010's escalating physical, verbal and sexual behaviours and since the incident of sexual abuse, no new interventions had been included in the resident #010's plan of care to manage the new and escalating sexually responsive behaviours.

According to the LTCHA, 2007, s. 6 (10) (c), the licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective. Please refer to WN #3.

b) Inspector #620 and #612 reviewed closed circuit video surveillance of the alleged incident of abuse that occurred on an identified date. Resident #010 was "sexually inappropriate" towards resident #011. Following the incident, resident #011 was observed to be upset with resident #010. PSW #117 was seen talking to the residents during the incident; PSW #107's verbal interaction with both residents lasted less than four seconds. PSW #117 discontinued their observation of both residents less than ten seconds following the incident. As PSW #117 walked in the opposite direction, resident #011 was seen leaving the surveillance area down a hallway with resident #010 following.

In an interview with the Administrator on December 1, 2016, they stated that PSW #117 did not stay with resident #011, but rather continued to complete their task of assisting other residents to the dining room.

During an interview with DOC #107, they stated that they were the charge nurse who had worked the shift when the incident had occurred. They did not report the incident to DOC #101 or the Ministry of Health and Long-Term Care (MOHLTC). An investigation was not initiated until nine days after the incident was reported to them.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. Under the subsection of "Clinical Staff Responsible for Care of the Resident(s) harmed by the abuse or neglect" the policy advised staff to, ensure the resident or residents are reassured and supported immediately in the appropriate manner to ensure their safety and security, provide intervention for the resident who has been allegedly abused or neglected and ensure that the resident was not left with the person alleged to have caused the abuse or neglect. The policy also stated that staff must immediately report the alleged or witnessed incident of abuse or neglect to a manager/designate so they can report immediately to the MOHLTC and investigate immediately all reports by staff and board members under this policy in accordance with LTCHA, s. 23.

According to the LTCHA, 2007, s. 20 (1), the 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. Please refer to WN #2.

c) Inspector #620 reviewed the home's submissions to the Director related to critical incident (CI) reports and was unable to identify any CI report related to the alleged incident of abuse that was documented to have occurred on the identified date.

During an interview with DOC #107 and the Administrator, they confirmed that DOC #107 had not immediately reported the incident to the Director, but rather, reported the incident following an interview with Inspector #620 and #612.

According to the LTCHA, 2007, s. 24, 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: 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. Please refer to WN #5.

d) Following an interview with Inspector #620, nine days after they became aware of the incident of alleged abuse, DOC #107 contacted the Substitute Decision Maker (SDM) of resident #011.

According to O. Reg 79/10, s. 97 (1), the licensee shall ensure that the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident, 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. Please refer to WN #7.

The decision to issue this compliance order was based on the severity which was determined to be actual harm towards other residents by resident #010 and although the scope was isolated, there is a compliance history previously issued in this area of the legislation as a WN issued during Critical Incident System (CIS) inspection #2014_339579_0007. (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the home's policy titled, "Zero Tolerance of Abuse and Neglect" is complied with, specifically, but not limited to the following:

i) Zero Tolerance of abuse,
ii) the requirements for immediate reporting,
iii) the requirements for immediate investigation, and
iv) notification of the Substitute Decision Maker (SDM), if any, or any other person specified by the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #612 reviewed a CI report submitted to the Director, in regards to an incident that occurred in the home. The CI report indicated that resident #008 and a staff member were in a common area of the home and the staff member made an infantile remark to resident #008. This was observed by another staff member.

The Inspector reviewed the home's investigation notes. A staff member had heard the infantile remark made by the PSW #102 towards resident #008. The staff member notified the family of the alleged incident. The family member then called RN #104 to report the incident. RN #104 left a note explaining the incident for DOC #101. DOC #101 reviewed the note the day after the incident, and began their investigation at 0800 hours the same day. The home did not report

the incident to the Director until 1506 hours the day after the incident. In the interview with PSW #102, they confirmed that they had made the statement while feeding resident #008. Discipline was issued as a result of the verbal abuse by PSW #102 towards resident #008.

The Inspector reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect", last reviewed October 2016, which stated that all residents had the right to live in a home environment that treats them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. The home was committed to zero tolerance of abuse or neglect of its residents. The policy also stated for the home to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC, staff were to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect. (612)

2. On November 30, 2016, resident #012 approached Inspector #620 to address a concern. Please refer to WN #1 for specific details.

a) Inspector #620 interviewed RPN #116 who stated that they first became aware of the alleged incident of sexual abuse when PSW #117 described the incident to them the day it had occurred. RPN #116 stated that they advised DOC #107 (acting as charge nurse that day) of the incident the same day. RPN #116 stated that they were not questioned about the incident after notifying DOC #107.

Inspector #620 reviewed the home's submissions to the Director related to critical incident (CI) reports and was unable to identify any CI report related to the alleged incident of abuse that was documented to have occurred between resident #010 and #011.

Following an interview with Inspector #620, nine days after they became aware of the incident of sexual abuse, DOC #107 (covering for DOC #101) submitted a CI report to the Director, began an investigation, notified the physician, contacted the Substitute Decision Maker (SDM) of resident #011, and added interventions to resident #010's care plan.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. Under the subsection of "Investigating and

Responding to Alleged, Suspected or Witnessed Abuse and Neglect of Residents" The policy advised staff to, "Fully investigate the incident and, complete the documentation of all known details of the reported incident..." The policy instructed staff that, "When a manager/designate or other receives a report from an employee on a suspected, or actual incident of abuse or neglect, they will immediately report to the MOHLTC..." Furthermore, the policy advised that, "Staff must notify the SDM, if any, or any other person specified by the resident immediately if the resident is harmed and within 12 hours of becoming aware of the alleged, suspected or witnessed incident of abuse of a resident..."

b) Inspector #620 and #612 reviewed closed circuit video surveillance of the alleged incident of abuse that occurred on an identified date. Resident #010 was "sexually inappropriate" towards resident #011. Following the incident, resident #011 was observed to be upset with resident #010. PSW #117 was seen talking to the residents during the incident; PSW #107's verbal interaction with both residents lasted less than four seconds. PSW #117 discontinued their observation of both residents less than ten seconds following the incident. As PSW #117 walked in the opposite direction, resident #011 was seen leaving the surveillance area down a hallway with resident #010 following.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last reviewed October 2016. Under the subsection of "Clinical Staff Responsible for Care of the Resident(s) harmed by the abuse or neglect" the policy advised staff to, ensure the resident or residents are reassured and supported immediately in the appropriate manner to ensure their safety and security, provide intervention for the resident who has been allegedly abused or neglected and ensure that the resident was not left with the person alleged to have caused the abuse or neglect.

In an interview with the Administrator on December 1, 2016, they stated that PSW #117 did not stay with resident #011, but rather, continued to complete their task of assisting other residents to the dining room.

The decision to issue this compliance order was based on the scope, which was identified as a pattern and while there has been previous unrelated non-compliance, the severity was identified as a potential for actual harm. (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2017

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
Ontario, 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
Ontario, 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 16th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Charette

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