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
Jul 15, 2016	2016_219211_0008	011284-16, 023892-15, 013225-16, 000294-16, 015294-16	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

SEVEN OAKS
9 NEILSON ROAD SCARBOROUGH ON M1E 5E1

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

JOELLE TAILLEFER (211)

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): May 3, 4, 5, 6, 9, 10, 11, 12, 13, 16 , 17, 2016

The following logs were inspected: #013225-16, 015294-16, 023892-15, 00294-16, 011284-16 related to alleged abuse.
Summary Statement: Please note the finding of non-compliance O.Reg. 79/10, s. 104. (2) for concurrent inspection Log # 015294-16 to be found in complaint inspection #2016_219211_0009.

During the course of the inspection, the inspector(s) spoke with with residents, Personal Support Workers (PSW), Housekeeping Staff, Registered Practical Nurses (RPN), Registered Nurses (RN), three Nurse Managers (NM), Acting Nurse Manager (ANM), the home's Behavioural Support Outreach Worker (BSO), Senior Administration Clerk, two Staffing Schedulers, Building Services Manager (BSN), physician, the Director of Nursing (DON), Assistant Administrator and the Administrator.

The following Inspection Protocols were used during this inspection:
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.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 are protected from abuse by anyone.

The following finding is related to five Critical Incident Reports (CIS) received within a period of nine months, related to alleged sexual abuse between Resident #022 and Residents #023, #024, #026, #25, and #029.

The following finding is related to Log #023892-15 and Log #015294-16.

Sexual abuse is defined by the LTCH, 2007 as (a) a consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of five Critical Incident Reports indicated that Resident #022 touched in a sexual nature five residents in a period of nine months.

Resident #022 was admitted at the Seven Oaks Long-Term Care Home on a specified date, with cognitive impairment. The resident mobilized independently without mobility aid. The Critical Incident Report on a specified date, indicated the resident's mini-mental status examination (MMSE) had cognitive impairment.

The Central Community Care Access Centre (CCAC) report on a specified date, indicated that there have been some issues around behaviors.

Incident #1: Log #: 023892-15

On an specified date, the licensee sent the above Critical Incident Report indicating that Resident #022 touched Resident #023 in an inappropriate manner.

In reviewing the progress notes, it was noted that on the previous day, Resident #022 touched in a sexual nature Resident #023. The incident occurred three days after Resident #022 was admitted to the home.

Resident #023 was diagnosed with cognitive impairment and other medical issues. The resident has difficulty to communicate.

The progress notes indicated that on the specific date, the identified staff and a PSW saw and found Resident #022 touching in an inappropriate manner Resident #023. The staff stopped Resident #022 from touching in a inappropriate manner Resident #023.

The staff separated both residents. Resident #022 was brought to his/her room.

The police, the physician and the substitute decision-makers (SDMs) were notified. The incident was reported immediately to the Director under the LTCHA and the Critical Incident Report was completed and sent on the next day of the incident.

Interview with the DON revealed that Resident #023 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

The progress notes written on the next day of the incident and interview with RN #120 revealed that Resident #022 was still exhibiting attention seeking behaviour toward resident #023. While resident #023 was placed at the nursing station for "protection", Resident #022 attempted to climb over the desk to reach the above resident. On the second day after the incident, Resident #023 and Resident #022 were transferred to two different floors.

Review of the physician order and interview with RPN #131 indicated that Resident #022 was referred to the Behavioural Support Ontario (BSO) present in the home and the Geriatric Mental Health Outreach Team (GMHOT) on the day of the incident.

Incident #2: Log #: 023892-15

Four days after the incident, the licensee sent the above Critical Incident Report indicating that Resident #022 touched in an inappropriate manner Resident #024.

Three days after the first incident on a different floor, the critical incident report and the progress notes indicated Resident #022 touched in an inappropriate manner another resident #024.

Resident #024 was diagnosed with cognitive impairment and another medical issues. Resident #024 is unable to communicate his/her need in words.

Review of the progress notes indicated on a specified day, Resident #022 was sitting beside Resident #024. The progress notes indicated that Resident #022 was told three times by the PSW not to touch Resident #024. While Resident #022 was repeating the word “no touch” he/she immediately touched Resident #024 in an inappropriate manner. Interview with PSW #124 revealed he/she saw resident #022 going toward resident #024 and started fondling resident #024 in an inappropriate manner. Staff intervened

immediately and separated both residents.

PSW #124 revealed that on specified day, Resident #022 did not have one to one supervision as an intervention. The licensee thought Resident #022's sexual behaviour was triggered by Resident #023's presence on the other floor. Resident #022 would have stopped his/her sexual behaviour when he/she was transferred to a different floor.

The police, the physician and the SDMs were notified on the same day. The incident was reported immediately to the Director under the LTCHA and the Critical Incident Report was completed and sent the next day.

Interview with the DON revealed that Resident #024 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

On the same day of the second incident, review of resident #022's plan of care and interview with RPN #131 indicated that resident's medications were revised, a one to one staff supervision schedule was implemented and the Dementia Observation System (DOS) was initiated.

Incident #3: Log #: 023892-15

One month after the second incident, Resident #022 was accompanied with one to one staff supervision to a specific floor for his/her first scheduled activity for elderly with cognitive impairment.

Interview with RPN #121 revealed that Resident #022 was able to pull away from his/her while he/she was still holding his/her hand and went to touch Resident #026.

Resident #026 was diagnosed with cognitive impairment and other health issues.

Review of the Critical Incident Report, the progress notes and interviews with RPN #121 and RN #120 indicated while two nurses were exchanging information in the nursing station, Resident #026 had approached Resident #022 to tell him/her "Hi" and to hold Resident #022's arm. Immediately, Resident #022 grabbed Resident #026 in an inappropriate sexual manner over resident #026. Both residents were separated immediately and Resident #022 was brought back to his/her respective floor.

The police, the SDMs and the MOHLTC were notified on the same day and the Critical

Incident Report was initiated and submitted two days after the incident.

Interview with the DON revealed that Resident #026 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

Interview with the RPN #131 revealed that the one to one supervision for Resident #022 was decreased in that specified month, to two shifts from 0700 to 2100 hours for seven days a week. On night shift, the resident did not need one to one supervision from 2100 to 0700 hours since he/she was sleeping in his/her bedroom all night.

Incident #4: Log #: 023892-15

Review of the progress notes on an identified date, indicated both Resident #022 and #025 were sitting in an area when Resident #022 got up and started touching Resident #025 in an inappropriate manner. Resident #025 told co-resident #022 to stop but was unable to get the nurses attention. Resident #025 stated he/she was at the mercy of Resident #022.

Resident #025 was diagnosed with cognitive impairment and other health issues. The resident used a wheelchair for mobility.

Interview with the Acting Nurse Manager #122 (ANM) revealed Resident #022 has one to one staff supervision since three months ago due to his inappropriate touching of sexual nature toward other residents. The one to one monitoring started from 0700 hours to 2130 hours.

According to the DON, the resident does not need one to one staff supervision during the night because he/she is staying in his/her room and the room is near to the nursing station. At night, the resident is monitored every 2 hours.

Interview with RPN #121 revealed that PSW #123 left Resident #022 unsupervised on the specified date at a specific time. While sitting behind the nursing station, he/she heard PSW #124 telling resident #022 “What are you doing”?

Interview with PSW #124 revealed he/she was sitting in the nursing station when he/she heard Resident #025 screaming “He/she is touching me” and saw Resident #022 touching Resident #025 in an inappropriate manner.

Interview with PSW #123 revealed that he/she told the staff sitting in the nursing station that he/she was going to the bathroom but did not verify with them that they understood that he/she will be momentarily absent and that they should supervise resident #022. Interview with PSW #123 indicated that he/she was aware of the 1:1 supervision rule and he/she was not allowed to leave the resident #022's unsupervised.

Interview with Resident #025 revealed he/she did not remember that a resident touched him/her in any sexual nature.

Interview with the DON revealed that Resident #025 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

Interview with ANM #122 revealed that resident #022 should not have been left unsupervised by the one to one staff on that specific date.

The police, the physician and the SDMs were notified on the same day.

Interview with PSW #152 and RN #151 revealed Resident #022 is getting out from his/her room during the night and he/she needs to be re-direct into his/her bed.

Incident #5

This following finding is related to Log #015294-16.

Six months after the fourth incident, the licensee sent the above Critical Incident Report indicating that co-Resident #032 reported Resident #022 touched Resident #029 in an inappropriate manner.

Interview with the DON, revealed there was another confirmed incident of alleged sexual abuse when it was reported that Resident #022 touched Resident #029 in an inappropriate manner.

Review of the letter left by the identified staff #145 to ANM on a specified date in the afternoon indicated co-resident #032 reported that resident #022 touched resident #029 in an inappropriate manner. The letter also indicated that resident #022 was caught by the identified staff #145 twice to lift resident #029’s clothes over the knees and to squeeze the resident #029's thighs when there should have been a one to one person present to monitor resident #022.

Interview with this identified staff #145 revealed that co-resident #032 reported the incident on that specific date and the letter was given to the ANM’s office on the same day. The above identified staff revealed he/she did not know the date, or the time of the other two incidents when Resident #022 had lifted Resident #029’s clothes and squeezed his/her thighs.

Review of the home’s investigation and interview with co-resident #032, revealed that resident #022 was observed touching resident #029 in an inappropriate manner over the clothes on a specified date. Co-resident #032 reported that he/she observed resident #029 trying to move resident #022’s hands a few times.

Interview with PSW #123 revealed that he/she informed PSW #146 to monitor resident #022 while he/she was leaving for his/her break at 1000 hours.

Interview with PSW #146 indicated the resident was left sitting in a specific area and he/she was unable to supervise resident #022 constantly while he/she was busy giving care to other residents.

Interview with the DON revealed that resident #029 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

Interview of the ANM #122 revealed he/she received the letter of alleged sexually inappropriate behaviours about resident #022 toward resident #029 at the end of the day on that specific date. On the same day at 16:46 hours an email was sent from the Acting Nurse Manager (ANM) to the Administrator informing he/she will report and notify the MOHLTC of the alleged abuse and will follow up with an investigation.

Interview with the Assistant Administrator revealed he/she was informed by the Acting Nurse Manager (ANM) on that day, related to the sexual inappropriate behaviour about resident #022 toward resident #029 and told the AMN to notify the Director and to start a Critical Incident Report (CIS).

Interview with the Administrator and the DON confirmed that resident #022 was left unsupervised on two occasions and the home has the duty to keep the residents safe from being abused.

In summary, the licensee failed to comply with:

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

The licensee did not completely document the provision of the care set out in the plan of care by completing the Modified Dementia Observation System (DOS). [Refer to WN #2]

2. O. Reg 79/10 s. 98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The licensee did not immediately notify the appropriate police force of the alleged incident of abuse from Resident #022 to Resident #029 on a specified date. [Refer to WN #6]

3. LTCHA, 2007 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.

The licensee did not comply with the written home's policy to promote zero tolerance of abuse. [Refer to WN #3]

4. LTCHA, 2007 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: 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 licensee did not notify immediately of the alleged sexual abuse for two specified dates to the Director under LTCHA. [Refer to WN #4]

5. O. Reg 79/10 s. 54 (b) Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

The licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between Resident #022 to Resident #025 and Resident #029. [Refer to WN #5]

6. O. Reg 79/10 s. 104 (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The licensee did not send the Critical Incident Report within 10 days to the Director under LTCHA related to the alleged sexual abuse from resident #022 toward resident #29. [Refer to WN #2 from Inspection #2016_219211_0009, Log #015294-16]

As a result of reviewing the severity and scope of these incidents and the licensee’s compliance history, the Inspector #211 identified that a compliance order was warranted for this licensee report inspection #2016_2192211_008. There was serious allegation of sexual abuse where many residents were impacted by these incidents. The scope level was identified as a pattern.

When reviewing the home’s compliance history for the past 3 years, the licensee has had previous non-compliance related to immediately reporting alleged abuse to the Director. Two years ago, the home was issued a Written Notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007 s. 24 (failure to immediately report instances of alleged abuse to the Director). The severity of harm in the above incident was determined to be “minimum risk” and the scope was identified as “isolated” as one resident was considered roughly handled and rudely spoken to by a staff and the suspicions or finding was not reported to the Director. [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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the plan of care sit out in the plan of care
3. The effectiveness of the plan of care

Review of the Modified Dementia Observation System (DOS) and interview with the Behavioural Support Outreach Worker (BSO) indicated that resident #022 started to be monitored hourly on the day of the second incident related to the inappropriate sexual behaviours.

Review of the home's policy #RC-0517-07 titled "Behavioural Response-Care Strategies: Modified Dementia Observation System" indicated the Modified Dementia observation System (DOS) is used as a component of the assessment for new or escalating behaviours in order to gain a better insight and understanding of the time, pattern and antecedents leading to behavioural response when the root cause or triggers are difficult to identify.

Review of the DOS and interview with the DON confirmed that the DOS sheets were not completed by the staff to have a better assessment and understanding of resident #022's responce to new treatments and interventions for 188 days within a period of nine months. [s. 6. (9)]

WN #3: 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 there is in place a written policy to promote zero tolerance of abuse of residents, and shall ensure that the policy is complied with.

Review of five Critical Incident Report indicated resident #022 have touched in a sexual nature five different residents in the home within a period of nine months.

Review of the home's policy titled "Zero Tolerance for abuse and neglect" indicated the following:

All staff to inform the RN/RPN immediately on becoming aware of any and every alleged, suspected or witnessed incident of abuse or neglect in order to commence an immediate investigation and reporting.

Notify the MOHLTC immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway.

Immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of resident that may constitute a criminal offence.

Initiate critical incident with 10 days of becoming aware of the alleged, suspected or witnessed incident.

Interview with the DON confirmed the home's policy for the subsequent items were not followed:
1. MOHLTC was not notified immediately on two specified dates.
2. The police was not notified immediately on one specified date.
3. The Critical Incident Report was not provided to the Director within ten days of becoming aware of the alleged, suspected or witnessed of abuse of a resident by anyone that resulted in harm or a risk of harm to the resident on a specified date. [s. 20. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following finding is related to Log #00294-16.

Review of the progress notes from a specified date in the afternoon indicated resident #021’s family member said his/her relative living in the home was hurt by a nurse. The family member stated there is a bruise on his/her relative’s body and wants to know why the bruise is there. The family member was told that the relative’s activities can bring about bruising. The bruise is old. The family member wanted to speak with the nurse manager and promised to come back in three days.

Review of the progress notes from that specific date during the evening and interview with RN #112 indicated the resident’s bruise area measured 2.5 cm x 3 cm with bluish and reddish color. The resident stated that he/she was hurt by a worker. RN #112 revealed the resident was banging the specific area on the medication room door on the previous day of the complaint.

Review of the home’s Resident Incident Report on the specific date of the complaint

indicated the resident #021's family member stated his/her relative had a bruise on a specific area of the body. The bruise is about 2.5 x 3.0 centimetres (cm) with bluish and some reddish color. The resident #021 stated "He/she was beaten by a worker". The documentation of the previous day of the complaint, indicated the resident was banging the specific area of the body on the nursing medication room and had a fall on the previous month.

Interview with RN #112 revealed he/she did not notify the Director because the family member reported the alleged abuse to the RPN working during the days. The RPN stayed after his/her day shift to complete the report and the progress notes. The RPN who received the concern from the resident's family member is not an employee in the home anymore. The RPN should have called the Director under LTCHA immediately when the family member revealed alleged abuse toward his/her relative from a staff.

Review of the home's policy #RC-0305-00 titled "Zero Tolerance of Abuse and Neglect" Section 03-Resident's Rights dated October 1, 2014, indicated the following:
-The RN/RPN must inform the Nurse Manager/RN-in-Charge immediately once an allegation, suspicious or witnessed of abuse and/or neglect has been made (this includes informing the on-call manager)
-All Managers to notify the MOHLTC immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway.

Review of the progress notes indicated the resident's family member was contacted by the Nurse Manager (NM) on the next day of the complaint. The family member stated he/she has a witness stating one of the staff grabbed his/her relative body area and that the NM should look into it. On that day after talking with the complainant, a phone call to MOHLTC after hours was made.

Review of the MOHLTC Incident on that specified date, indicated the incident happened the previous day.

Review of the record of the MOHLTC incident indicated that the Director was informed on the next day of the incident.

Interview with the interim Director of Care confirmed the Director should have been notified immediately when the family member reported the alleged abuse. [s. 24. (1) 2.]

2. The following finding is related to Log #023892-15.

Review of the written plan of care since the past nine months, indicated resident #022 was identified with sexually inappropriate behaviours.

Review of the progress notes on an specified date, indicated both Resident #022 and #025 were sitting in a specific area when Resident #022 got up and started touching Resident #025 in an inappropriate manner. Resident #025 told co-resident #022 to stop but was unable to get the nurses attention.

Interview with RPN #121 revealed that PSW #123 left Resident #022 unsupervised on that specific date for a certain time. While sitting behind the nursing station, he/she heard PSW #124 telling resident #022 "What are you doing"?

Interview with PSW #124 revealed he/she was sitting in the nursing station when he/she heard Resident #025 screaming "He/she is touching me" and saw Resident #022 touching Resident #025 in an inappropriate manner.

Interview with PSW #123 revealed that he/she told the staff sitting in the nursing station that he/she was going to the bathroom but did not verify with them that they understood that he/she will be momentarily absent and that they should supervise resident #022.

Interview with ANM #122 revealed he/she did not remember why the Director under LTCHA was not notified immediately.

Interview with the nurse manager #100 confirmed the Director was not immediately notified on that specific date, when the licensee suspected resident #022 had inappropriately shown sexual behaviour toward resident #025.

Another incident of alleged sexual abuse for Resident #029 from Resident #022 was not reported immediately to the Director under LTCHA on another date.

Interview of the ANM #122 revealed he/she received the letter of alleged sexually inappropriate behaviours about resident #022 toward resident #029 at the end of the day on that specific date at 16:46 hours. An email was sent from the ANM to the Administrator informing he/she will report and notify the MOH of the alleged abuse and will follow up with an investigation.

Interview with the Assistant Administrator revealed he/she was informed by AMN on that specific day, related to sexually inappropriate behaviour about resident #022 toward resident #029 and told the AMN to notify the Director and to start the Critical Incident Report (CIS).

Interview with the Administrator and the DON confirmed the alleged sexually inappropriate behaviours should have been immediately reported to the Director on that specific date. [s. 24. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, by identifying and implanting interventions.

The following findings are related to Log #023892-14 and #015294-16

Review of the written plan of care within a period of nine months, indicated resident #022 was identified with sexually inappropriate behaviours toward five different residents.

Review of the progress notes of the fourth incident on a specific date, indicated both resident #022 and #025 were sitting in the an area when resident #022 got up and started touching resident #025 in an inappropriate manner. Resident #025 told co-

resident #022 to stop but was unable to get the nurses attention.

Interview with RPN #121 revealed that PSW #123 left Resident #022 unsupervised on that specific date during a certain time.

Interview with PSW #124 revealed he/she was sitting in the nursing station when he/she heard Resident #025 screaming “He/she is touching me” and saw resident #022 touching resident #025 in an inappropriate sexual manner over the clothes.

Interview with PSW #123 revealed that he/she told the staff sitting in the nursing station that he/she was going to the bathroom but did not verify with them that they understood that he/she will be momentarily absent and that they should supervise resident #022.

Interview with PSW #123 indicated that he/she was aware of the 1:1 supervision rule and he/she was not allowed to leave the resident #022's unsupervised.

Interview with the DON, revealed there was a fifth confirmed incident of alleged sexual abuse to resident #029 from resident #022 that occurred on a specific date.

Review of the home's investigation for that fifth incident on a specific date, indicated co-resident #032 observed resident #022 touching resident #029 in an inappropriate sexual nature over the resident's clothes on a specific date.

Interview with the identified staff #145 revealed that co-Resident #032 reported the incident on that specified date in the morning.

Interview with PSW #123 revealed that he/she informed PSW #146 to monitor resident #022 while he/she was leaving for his/her break at 1000 hours.

Interview with PSW #146 indicated resident #022 was left sitting in the specific room and he/she was unable to supervise the resident constantly while he/she was busy giving care to others residents.

Interview with the DON confirmed that steps were not taken to minimize the risk of potentially harmful interactions from resident #022 toward resident #025 and resident #029 when the staff did not follow the intervention that Resident #022 needed 1:1 constant supervision. s. 54. (b) [s. 54. (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The following finding is related to Log #015294-16.

Review of the written plan of care within the past nine months, indicated resident #022 was identified with sexually inappropriate behaviours.
Interview with the DON, revealed there was a fifth confirmed incident of alleged sexual abuse and it was reported that resident #022 touched resident #029 on a specific date.

Review of the letter left by an identified staff #145 to ANM on a specific date in the afternoon indicated co-resident #032 reported that resident #022 touched resident #029 in an inappropriate manner.

Review of the home's investigation and interview with co-resident #032, revealed that resident #022 was observed touching resident #029 in an inappropriate sexual nature over the clothes on an specific date. Co-resident #032 reported that he/she observed resident #029 trying to move resident #022's hands a few times.
Interview with PSW #123 revealed that he/she informed PSW #146 to monitor resident #022 while he/she was leaving for his/her break at 1000 hours.

Interview with PSW #146 indicated resident was left sitting in the specific room and he/she was unable to supervise resident #022 constantly while he/she was busy giving care to other residents.

Interview with the identified staff #145 revealed resident #032 reported the incident in the morning on a specific date that resident #022 demonstrated sexual inappropriate behaviour toward resident #029 and the letter was given in the ANM's office on the same day.

Interview with Administrator, DON and NM #100 confirmed that the incident happened on that specific date and the police force should have been notified immediately on that day when the ANM #122 was informed of an alleged inappropriate sexual behaviour by resident #022 toward resident #029 that may have constituted a criminal offence. [s. 98.]

Issued on this 18th day of July, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOELLE TAILLEFER (211)
Inspection No. / No de l'inspection :	2016_219211_0008
Log No. / Registre no:	011284-16, 023892-15, 013225-16, 000294-16, 015294-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 15, 2016
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	SEVEN OAKS 9 NEILSON ROAD, SCARBOROUGH, ON, M1E-5E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GAYLE CAMPBELL

To City of Toronto, 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) (b)

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:

Take immediate or appropriate actions to ensure that effective measures are in place to protect all residents from abuse by resident #022.

Notify the MOHLTC immediately when an alleged, suspected or witnessed incident of abuse or neglect has become known.

Complete a critical incident report within ten days of becoming aware of the alleged, suspected or witnessed incident to the Director under the LTCH.

Immediately notify the police of alleged, suspected, or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

Ensure that all staff comply with the abuse's policy titled "Zero Tolerance for Abuse and Neglect".

Ensure all direct care staff are provided with clear directions related to their role and responsibility when monitoring residents with responsive behaviors.

Grounds / Motifs :

1. Grounds / Motifs :

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

The following finding is related to five Critical Incident Reports (CIS) received

within nine months, related to alleged sexual abuse between Resident #022 and Residents #023, #024, #026, #25, and #029.

The following finding is related to Log #023892-15 and Log #015294-16.

Sexual abuse is defined by the LTCH, 2007 as (a) a consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of five Critical Incident Reports indicated that Resident #022 touched in a sexual nature five residents in a period of nine months.

Resident #022 was admitted at the Seven Oaks Long-Term Care Home on an specified date, with cognitive impairment. The resident mobilized independently without mobility aid. The Critical Incident Report on a specified date, indicated the resident's mini-mental status examination (MMSE) had cognitive impairment.

The Central Community Care Access Centre (CCAC) report before his/her admission, indicated that there have been some issues around inappropriate behaviors.

Incident #1: Log #: 023892-15

On an specified date, the licensee sent the above Critical Incident Report indicating that Resident #022 touched Resident #023 in an inappropriate sexual manner.

In reviewing the progress notes, it was noted on a specified date, Resident #022 touched in a sexual nature Resident #023. The incident occurred three days after Resident #022 was admitted to the home.

Resident #023 was diagnosed with cognitive impairment and other medical issues. The resident is unable to communicate.

The progress notes indicated that on specified date, the identified staff and a PSW saw and found Resident #022 touching Resident #023 in an inappropriate

sexual manner. On the above date, the PSW reported that Resident #022 touched Resident #023 in a specific area. The staff stopped Resident #022 from touching Resident #023. The staff separated both residents. Resident #022 was brought to his/her room.

The police, the physician and the substitute decision-makers (SDMs) were notified. The incident was reported immediately to the Director under the LTCHA and the Critical Incident Report was completed and sent the next day of the incident.

Interview with the DON revealed that Resident #023 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

The progress notes written on the specific date and interview with RN #120 revealed that Resident #022 was still exhibiting attention seeking behaviour toward resident #023 the following day. While resident #023 was placed at the nursing station for "protection", Resident #022 attempted to climb over the desk to reach the above resident. On the second day after the incident, Resident #023 and Resident #022 were transferred to two different floors.

Review of the physician order and interview with RPN #131 indicated that Resident #022 was referred to the Behavioural Support Ontario (BSO) present in the home and the Geriatric Mental Health Outreach Team (GMHOT) the next day after this incident.

Incident #2: Log #: 023892-15

Four days after the incident, the licensee sent the above Critical Incident Report indicating that Resident #022's touched in an inappropriate manner Resident #024.

Three days after the first incident on a different floor, the critical incident report and the progress notes indicated Resident #022 touched in an inappropriate manner another resident #024.

Resident #024 was diagnosed with cognitive impairment and another medical issue. Resident #024 is unable to communicate his/her need in words.

Review of the progress notes indicated that on a specified day, Resident #022

was sitting beside Resident #024. The progress notes indicated that Resident #022 was told three times by the PSW not to touch Resident #024. While Resident #022 was repeating the word “no touch” he/she immediately touched Resident #024 in an inappropriate manner. Interview with PSW #124 revealed he/she saw resident #022 going toward resident #024 and started fondling the resident #024 in an inappropriate manner. Staff intervened immediately and separated both residents.

PSW #124 revealed that on the specified day, Resident #022 did not have one to one supervision as an intervention. The licensee thought Resident #022's sexual behaviour was triggered by Resident #023's presence on the other floor. Resident #022 would have stopped the sexual behaviour when he/she was transferred to a different floor.

The police, the physician and the SDMs were notified on the same day. The incident was reported immediately to the Director under the LTCHA and Critical Incident Report was completed and sent the next day.

Interview with the DON revealed that Resident #024 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

On the same day of the second incident, review of resident #022's plan of care and interview with RPN #131 indicated that resident's medications were revised, a one to one staff supervision schedule was implemented and the Dementia Observation System (DOS) was initiated.

Incident #3: Log #: 023892-15

One month after the second incident, Resident #022 was accompanied with one to one staff supervision to a specific floor for his/her first scheduled activity for elderly with cognitive impairment.

Interview with RPN #121 revealed that Resident #022 was able to pull away from him/her while he/she was still holding his/her hand and went to touch Resident #026.

Resident #026 was diagnosed with cognitive impairment and other health issues.

Review of the Critical Incident Report, the progress notes and interviews with RPN #121 and RN #120 indicated while two nurses were exchanging information in the nursing station, Resident #026 had approached Resident #022 to tell him/her “Hi” and to hold Resident #022’s arm. Immediately, Resident #022 grabbed Resident #026 in an inappropriate sexual manner over resident #026's clothes. Both residents were separated immediately and Resident #022 was brought back to his/her respective floor.

The police, the SDMs and the MOHLTC were notified on the same day and the Critical Incident Report was initiated and submitted two days after the incident.

Interview with the DON revealed that Resident #026 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

Interview with the RPN #131 revealed that the one to one supervision for Resident #022 was decreased in that specified month, to two shifts from 0700 to 2100 hours for seven days a week. On the night shift, the resident did not need one to one supervision from 2100 to 0700 hours since he/she was sleeping in his/her bedroom all night.

Incident #4: Log #: 023892-15

Review of the progress notes on an identified date, indicated both Resident #022 and #025 were sitting in an area when Resident #022 got up and started touching Resident #025 in an inappropriate manner. Resident #025 told co-resident #022 to stop but was unable to get the nurses attention. Resident #025 stated he/she was at the mercy of Resident #022.

Resident #025 was diagnosed with cognitive impairment and other health issues. The resident used a wheelchair for mobility.

Interview with the Acting Nurse Manager #122 (ANM) revealed Resident #022 has one to one staff supervision three months ago due to his/her inappropriate touching of a sexual nature toward other residents. The one to one monitoring started from 0700 hours to 2130 hours.
According to the DON, the resident does not need one to one staff supervision during the night because he/she is staying in his/her room and the room is near to the nursing station. At night, the resident is monitored every 2 hours.

Interview with RPN #121 revealed that PSW #123 left Resident #022 unsupervised on that specified date at a specific time. While sitting behind the nursing station, he/she heard PSW #124 telling resident #022 “What are you doing”?

An Interview with PSW #124 revealed he/she was sitting in the nursing station when he/she heard Resident #025 screaming “He/she is touching me” and saw Resident #022 touching Resident #025 in an inappropriate manner over the clothes.

Interview with PSW #123 revealed that he/she told the staff sitting in the nursing station that he/she was going to the bathroom but did not verify with them that they understood that he/she will be momentarily absent and that they should supervise resident #022. Interview with PSW #123 indicated that he/she was aware of the 1:1 supervision rule and he/she was not allowed to leave the resident #022's unsupervised.

Interview with Resident #025 revealed he/she did not remember that a resident touched him/her in any sexual nature.

Interview with the DON revealed that Resident #025 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

Interview with ANM #122 revealed that resident #022 should not have been left unsupervised by the one to one staff on that specific date.

The police, the physician and the SDMs were notified on the same day.

Interview with PSW #152 and RN #151 revealed Resident #022 is getting out from his/her room during the night and he/she needs to be re-direct into his/her bed.

Incident #5

This following finding is related to Log #015294-16 .

Six months after the fourth incident, the licensee sent the above Critical Incident Report indicating that co-Resident #032 reported Resident #022 touched Resident #029 in an inappropriate manner.

Interview with the DON revealed there was another confirmed incident of alleged sexual abuse when it was reported that Resident #022 touched in an inappropriate manner Resident #029 on a specific date.

Review of the letter left by the identified staff #145 to ANM on a specified date in the afternoon indicated co-resident #032 reported that Resident #022 touched resident #029 in an inappropriate manner. The letter also indicated that resident #022 was caught by identified staff twice to lift resident #029's clothes over the knees and to squeeze the thighs when there should have been a one to one person present to monitor Resident #022

Interview with the identified staff #145 revealed that co-resident #032 reported the incident on that specified date in the morning and the letter was given to the ANM's office on the same day. The above identified staff #145 revealed he/she did not know the date, or the time of the other two incidents when resident #022 had lifted Resident #029's clothes and squeezed his/her thighs.

Review of the home's investigation and interview with co-resident #032, revealed that resident #022 was observed touching resident #029 in an inappropriate manner over the clothes on the specified date. Co-resident #032 reported that he/she observed resident #029 trying to move resident #022's hands a few times.

Interview with PSW #123 revealed that he/she informed PSW #146 to monitor resident #022 while he/she was leaving for his/her break at 1000 hours.

Interview with PSW #146 indicated the resident was left sitting in a specific area and he/she was unable to supervise resident #022 constantly while he/she was busy giving care to other residents.

Interview with the DON revealed that resident #029 does not have the capacity to understand nor to provide consent to resident #022 to touch him/her.

Interview of the ANM #122 revealed he/she received the letter of alleged sexually inappropriate behaviours about resident #022 toward resident #029 at the end of the day on that specific date. On the same day at 16:46 hours an email was sent from the Acting Nurse Manager (ANM) to the Administrator informing he/she will report and notify the MOHLTC of the alleged abuse and will

follow up with an investigation.

Interview with the Assistant Administrator revealed he/she was informed by the Acting Nurse Manager (ANM) on that day, related to the sexual inappropriate behaviour about resident #022 toward resident #029 and told the AMN to notify the Director and to start a Critical Incident Report (CIS).

Interview with the Administrator and the DON confirmed that resident #022 was left unsupervised on two occasions and the home has the duty to keep the residents safe from being abused.

In summary, the licensee failed to comply with:

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

The licensee did not completely document the provision of the care set out in the plan of care by completing the Modified Dementia Observation System (DOS). [Refer to WN #2]

2. O. Reg 79/10 s. 98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The licensee did not immediately notify the appropriate police force of the alleged incident of abuse from Resident #022 to Resident #029 on an specified date. [Refer to WN #6]

3. LTCHA 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.

The licensee did not comply with the written home's policy to promote zero tolerance of abuse. [Refer to WN #3]

4. LTCHA 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: 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 licensee did not notify immediately of the alleged sexual abuse for two specified dates to the Director under LTCHA. [Refer to WN #4]

5. O. Reg 79/10 s. 54 (b) Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

The licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between Resident #022 to Resident #025 and Resident #029. [Refer to WN #5]

6. O. Reg 79/10 s. 104 (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The licensee did not send the Critical Incident Report within 10 days to the Director under LTCHA related to the alleged sexual abuse from resident #022 toward resident #29. [Refer to WN #2 of Inspection #2016_219211_0009, Log #015294-16]

As a result of reviewing the severity and scope of these incidents and the licensee's compliance history, the Inspector #211 identified that a compliance order was warranted for this licensee report inspection #2016_2192211_008. There was serious allegation of sexual abuse where many residents were impacted by these incidents. The scope level was identified as a pattern. When reviewing the home's compliance history for the past 3 years, the licensee has had previous non-compliance related to immediately reporting alleged abuse to the Director. Two years ago, the home was issued a Written Notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007 s. 24 (failure to immediately report instances of alleged abuse to the Director). The severity of harm in the above incident was

determined to be “minimum risk” and the scope was identified as “isolated” as one resident was considered roughly handled and rudely spoken to by a staff and the suspicions or finding was not reported to the Director.
(211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 29, 2016

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 15th day of July, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Joelle Taillefer

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