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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 29, 2014	2014_380593_0005	S-000319-14	Complaint

Licensee/Titulaire de permis

THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET, P.O. BOX 4000, COCHRANE, ON, P0L-1C0

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

VILLA MINTO
241 EIGHTH STREET, P.O. BOX 280, COCHRANE, ON, P0L-1C0

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 29th - 30th, 2014

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Nursing Staff, Personal Support Worker's (PSW), Food Service Worker's (FSW), Residents and Resident's family members.

During the course of the inspection, the inspector(s) observed the provision of care and services to Residents, observed Staff to Resident Interactions, observed Resident to Resident Interactions, reviewed Resident health care records, reviewed staff training records and reviewed home policies on the protection of Residents from abuse and neglect.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching,

behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

This non-compliance is supported by the following findings:

Family member #003 submitted a complaint to the Ministry of Health and Long-Term Care action line regarding sexual abuse toward Resident #001 by a resident in the home. During an Interview with Inspector #593, family member #003 advised that there had been numerous incident's of abuse by Resident #002 for which family does not believe the home has taken appropriate action.

Resident #001 was unable to be interviewed at the time of this inspection. There have been numerous incidents of sexual abuse toward other Residents by Resident #002. Documented interventions include that Resident #002 is not to be left alone with other confused Residents and is to be monitored if sitting near another female Resident.

During an interview with Inspector #593 July 30th, 2014 at 14:55 staff member #101 advised that they witnessed Resident #002 sexually abuse Resident #001. Furthermore, staff member #002 advised that evening staff were on higher alert to Resident #002’s known inappropriate sexual behaviors as during handover to evening shift, staff were reminded to keep Resident #002 away from other female Residents.

Prior to this, a review of Resident #002’s progress notes revealed that Resident #002 was discovered with their hand on another female Residents leg. This was confirmed during an interview with Inspector #593 July 30th 2014 at 13:16 by staff member #103. Staff member #103 advised that staff are to supervise Resident #002 after dinner when they are in the common living area of the home. Staff member #103 advised that this action was put into place after the previous incident where they were found touching a female Residents leg without consent. Staff member #103 advised that there is a history with Resident #002 being sexually inappropriate with other female Residents. A Staff member spoke with Resident #002 after this incident and reported that Resident #002 showed no indication that they understood their actions were inappropriate.

During an interview with Inspector #593 July 30th, 2014 at 11:56 staff member #102 advised that Resident #002 had a history of sexually expressive behaviours and that it was in their care plan to not seat Resident #002 near other female Residents. Staff member #102 further advised that there was a prior incident.

During an interview with staff member #101 who witnessed the reported incident that occurred between Resident #001 and Resident #002, staff member #101 advised that after the incident they completed an internal incident report and verbally reported the incident to their ADOC staff member #100. Staff member #101 did not report this incident to the Director. ADOC staff member who was informed about this incident the day that it occurred did not report this critical incident to the Director until six days after the incident occurred. In addition, the incident reported during interviews by staff and documented in Resident #002’s progress notes was also not reported to the Director. A review of the home's "Zero Tolerance of Abuse and Neglect policy" dated December 5th, 2012 found that the policy includes that any person who has reasonable grounds to suspect that abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the director. On both occasions, the licensee has failed to comply with their written policy in immediately reporting matters to the director and with reporting requirements as provided for in the regulations.

A review of the home’s "Zero Tolerance of Abuse and Neglect Policy" dated December 5th, 2012 found that the policy states to provide annual and ongoing education on this policy as well as what steps to take when abuse is alleged, suspected or witnessed. This training requirement outlined in the policy was confirmed by ADOC staff member #100 during an interview with Inspector #593. A review of training records by Inspector #593 found that two thirds of nursing staff and all dietary and housekeeping staff had not attended education on prevention of abuse and neglect during their employment in the home or since 2012. The licensee has failed to comply with their written policy for requirements for staff training in the home as well as to provide retraining on the home's policy to promote zero tolerance of abuse and neglect of residents at intervals provided for in the regulations.

As evidenced by documented progress notes, documented plans of care, and staff interviews; Resident #002 was known to display sexually inappropriate behavior towards female Residents in the home including prior documented non-consensual touching of female Residents. Furthermore on the evening that Resident #001 sexually abused Resident #002, evening staff were reminded of Resident #002's sexual behaviour and their plan of care which states to never leave Resident #002 alone with confused Residents and to monitor Resident #002 when seated near other female Residents. The home have failed to follow Resident #002's plan of care and as such, the licensee has failed to protect Resident #001 from sexual abuse by a Resident with known sexually inappropriate behaviors towards other female

Residents.

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

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A review of Resident #002's care plan in place at the time of the critical incident between Resident #001 and Resident #002 found that Resident #002 has displayed sexually abusive behavioral symptoms towards other Residents and that they have inappropriately touched other female Residents and that Resident #002 is not to be left alone with other confused Residents and is to be monitored if sitting near another female Resident.

This was confirmed during an interview with Inspector #593 July 30th at 11:56, staff member #102 advised that Resident #002 had a history of sexually expressive behaviors and that it was care planned to not seat Resident #002 near other female Residents.

During an interview with Inspector #593 July 30th 2014 at 14:55, staff member #101 advised that they witnessed Resident #002 sexually abuse Resident #001. Staff member was returning from their break and observed both Resident #001 and Resident #002 sitting next to each other in the common living area of the home when the incident occurred.

As such, the licensee has failed to provide the care to Resident #002 as specified in their plan of care. [s. 6. (7)]

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. This non-compliance is supported by the following findings:

A review of the home's "Zero Tolerance of Abuse and Neglect policy" dated December 5th, 2012 found that the policy includes that any person who has reasonable grounds to suspect that abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the director. During an interview with staff member #101 who witnessed the reported incident that occurred between Resident #001 and Resident #002, staff member #101 confirmed that they did not report this incident to the Director. ADOC staff member who was informed about this incident the day that it occurred did not report this critical incident to the Director until six days after the incident occurred. In addition, the previous incident reported during interviews by staff and documented in Resident #002's progress notes was also not reported to the Director.

A review of the home's "Zero Tolerance of Abuse and Neglect Policy" dated December 5th, 2012 found that the policy states to provide annual and ongoing education on this policy as well as what steps to take when abuse is alleged, suspected or witnessed. This training requirement outlined in the policy was confirmed by ADOC staff member #100 during an interview with Inspector #593. A review of training records by Inspector #593 found that two thirds of nursing staff and all dietary and housekeeping staff had not attended education on prevention of abuse and neglect during their employment in the home or since 2012.

On two occasions, the licensee has failed to comply with their written policy in immediately reporting matters to the director as well as comply with their written policy for requirements for staff training and re-training in the home. [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. This non-compliance is supported by the following findings:

Staff member #101 witnessed the reported incident that occurred between Resident #001 and Resident #002. During an interview with Inspector #593 on July 30th 2014, staff member #101 advised that after the incident they completed an internal incident report and reported the incident verbally to their ADOC staff member #100. staff member #101 did not report this incident to the Director.

During an interview with Inspector #593 on July 30th 2014, ADOC staff member #100 advised that it was their error in the delay in reporting to the Director as they did not remember to do this until six days after the critical incident had occurred. ADOC staff member #100 also advised that they were aware that incidents involving abuse or the suspected abuse of a resident by anyone was required to be reported to the Director.

The licensee of Villa Minto submitted a critical incident report for this critical incident involving sexual abuse by Resident #002 towards Resident #001. This critical incident was reported six days after the incident occurred.

A review of the home's "Zero Tolerance of Abuse and Neglect policy" dated December 5th, 2012 found that the policy includes the following under duty to report: a person who has reasonable grounds to suspect that abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the director. On this occasion, the home has failed to comply with their written policy in immediately reporting matters to the director.

Furthermore, non-compliance was previously identified under LTCHA, 2007 S.O. 2007, c.8, s.24. during an inspection completed on September 13th, 17th and 18th 2012 under inspection #2012_099188_0036 in relation of the reporting of allegations of verbal abuse to the director.

As such, the licensee has failed to immediately report the abuse of a resident to the Director. [s. 24. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

The home's "Zero Tolerance of Abuse and Neglect Policy", LTC-630 under "measures and strategies to prevent abuse and neglect" states A. Provide annual and ongoing education on: Review of the policy "Zero Tolerance of Abuse and Neglect", how to recognize the signs of abuse and what steps to take when abuse is alleged, suspected or witnessed.

A review of training records by Inspector #593 found that of 24 nursing staff, 16 staff had not attended education on prevention of abuse and neglect since 2012 or the duration of their employment at the home. In addition records are not available for housekeeping or dietary staff for prevention of abuse and neglect education.

During an interview with Inspector #593 July 29th 2014 at 15:30, ADOC staff member #100 advised that the homes policy for training on prevention of abuse and neglect is that training occurs for staff upon orientation and then annually thereafter. Training on the homes abuse policy is included in the orientation package for new staff however as confirmed by ADOC staff member #100 records of this training were not available for majority of housekeeping and dietary staff.

During an interview with Inspector #593 July 30th 2014 at 14:55, staff member #101 confirmed that they had not received education on prevention of abuse and neglect since completing orientation more than one year prior. This is confirmed by review of the home’s training records.

During an interview with Inspector #593 July 29th 2014 at 16:14, staff member #105 confirmed that they had not received education on prevention of abuse and neglect since commencing employment in the home seven years prior. This is confirmed by review of the home’s training records.

As such, the licensee has failed to provide retraining on the homes policy to promote zero tolerance of abuse and neglect of residents at intervals provided for in the regulations. [s. 76. (4)]

Issued on this 3rd day of October, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2014_380593_0005
Log No. / Registre no:	S-000319-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 29, 2014
Licensee / Titulaire de permis :	THE LADY MINTO HOSPITAL AT COCHRANE 241 EIGHTH STREET, P.O. BOX 4000, COCHRANE, ON, P0L-1C0
LTC Home / Foyer de SLD :	VILLA MINTO 241 EIGHTH STREET, P.O. BOX 280, COCHRANE, ON, P0L-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Fern Morrissette

To THE LADY MINTO HOSPITAL AT COCHRANE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.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 is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. Strategies taken in preventing Resident #002 being alone with female Residents, seated near female Residents or in any situation where Resident #002 could behave sexually inappropriately towards another Resident.

2. Strategies taken to minimize inappropriate sexual behaviors displayed by Resident #002 including psychological, pharmaceutical, behavioral and physical intervention.

3. Identification of the sexual behavioral triggers for Resident #002. How these triggers are minimized and the response taken by each staff discipline when triggers are present.

4. Responsibilities of each staff discipline in preventing further occurrence of sexual abuse from Resident #002 towards another Resident.

5. Continuous monitoring of the above steps to ensure that the plan is relevant if/when contributing factors change.

6. A process to ensure that certain matters as detailed in LTCHA, 2007, S.O. 2007, c.24, s.1 are immediately reported to the director.

7. A training plan to ensure that all staff receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, and re-training annually thereafter.

The Plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Gillian.chamberlin@ontario.ca by September 14th, 2014.

Grounds / Motifs :

1. 1. Under O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

This non-compliance is supported by the following findings:

Family member #003 submitted a complaint to the Ministry of Health and Long-Term Care action line regarding sexual abuse toward Resident #001 by a resident in the home. During an Interview with Inspector #593, family member #003 advised that there had been numerous incident's of abuse by Resident #002 for which family does not believe the home has taken appropriate action.

Resident #001 was unable to be interviewed at the time of this inspection. There have been numerous incidents of sexual abuse toward other Residents by Resident #002. Documented interventions include that Resident #002 is not to be left alone with other confused Residents and is to be monitored if sitting near another female Resident.

During an interview with Inspector #593 July 30th, 2014 at 14:55 staff member #101 advised that they witnessed Resident #002 sexually abuse Resident #001. Furthermore, staff member #002 advised that evening staff were on higher alert to Resident #002's known inappropriate sexual behaviors as during handover to evening shift, staff were reminded to keep Resident #002 away from other female Residents.

Prior to this, a review of Resident #002's progress notes revealed that Resident #002 was discovered with their hand on another female Residents leg. This was confirmed during an interview with Inspector #593 July 30th 2014 at 13:16 by staff member #103. Staff member #103 advised that staff are to supervise Resident #002 after dinner when they are in the common living area of the home. Staff member #103 advised that this action was put into place after the previous incident where they were found touching a female Residents leg without consent. Staff member #103 advised that there is a history with Resident #002 being sexually inappropriate with other female Residents. A Staff member spoke with Resident #002 after this incident and reported that Resident #002 showed no indication that they understood their actions were inappropriate.

During an interview with Inspector #593 July 30th, 2014 at 11:56 staff member #102 advised that Resident #002 had a history of sexually expressive behaviours and that it was in their care plan to not seat Resident #002 near other female Residents. Staff member #102 further advised that there was a prior incident.

During an interview with staff member #101 who witnessed the reported incident that occurred between Resident #001 and Resident #002, staff member #101

advised that after the incident they completed an internal incident report and verbally reported the incident to their ADOC staff member #100. Staff member #101 did not report this incident to the Director. ADOC staff member who was informed about this incident the day that it occurred did not report this critical incident to the Director until six days after the incident occurred. In addition, the incident reported during interviews by staff and documented in Resident #002's progress notes was also not reported to the Director. A review of the home's "Zero Tolerance of Abuse and Neglect policy" dated December 5th, 2012 found that the policy includes that any person who has reasonable grounds to suspect that abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the director. On both occasions, the licensee has failed to comply with their written policy in immediately reporting matters to the director and with reporting requirements as provided for in the regulations.

A review of the home's "Zero Tolerance of Abuse and Neglect Policy" dated December 5th, 2012 found that the policy states to provide annual and ongoing education on this policy as well as what steps to take when abuse is alleged, suspected or witnessed. This training requirement outlined in the policy was confirmed by ADOC staff member #100 during an interview with Inspector #593. A review of training records by Inspector #593 found that two thirds of nursing staff and all dietary and housekeeping staff had not attended education on prevention of abuse and neglect during their employment in the home or since 2012. The licensee has failed to comply with their written policy for requirements for staff training in the home as well as to provide retraining on the home's policy to promote zero tolerance of abuse and neglect of residents at intervals provided for in the regulations.

As evidenced by documented progress notes, documented plans of care, and staff interviews; Resident #002 was known to display sexually inappropriate behavior towards female Residents in the home including prior documented non-consensual touching of female Residents. Furthermore on the evening that Resident #001 sexually abused Resident #002, evening staff were reminded of Resident #002's sexual behaviour and their plan of care which states to never leave Resident #002 alone with confused Residents and to monitor Resident #002 when seated near other female Residents. The home have failed to follow Resident #002's plan of care and as such, the licensee has failed to protect Resident #001 from sexual abuse by a Resident with known sexually inappropriate behaviors towards other female Residents. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 29th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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