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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2015	2015_168202_0021	T-028577-15	Complaint

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET NEWMARKET ON L3Y 2L1

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

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET NEWMARKET ON L3Y 2L1

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

VALERIE JOHNSTON (202)

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): October 16, 22, 2015.

During the course of the inspection, the inspector reviewed clinical records and the home's policies related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), assistant directors of care (ADOCs), staff educator,

registered nursing staff, personal support workers.

Summary of Facts:

The following are summaries of facts that have been obtained through staff interviews and a review of clinical records. Staff interviewed included direct care staff, registered nursing staff, the ED, DOC, and ADOCs.

The information for resident #001 has been obtained from clinical records that would include progress notes and care plan.

1. The following are summaries of events that occurred on an identified date and within an identified time period on an identified home area.

a) At an approximate time on the identified date, PSW #110 and PSW #109 witnessed PSW #106 to be unwell.

b) At an approximate time later, PSW #111 found PSW #106 wandering around the home area and reported the condition of the PSW to RN #100.

c) Approximately one hour later, PSW #104 found PSW #106 sitting on the floor outside resident #001's room. PSW #104 suggested to PSW #106, that he/she should go home, however, PSW #106 insisted on staying as he/she needed to provide care to resident #001. PSW #104 then left PSW #106 by resident #001's room and continued to provide care to another resident.

d) A few minutes later , PSW #104 entered resident #001's room and found PSW #106 acting inappropriately toward resident #001. PSW #104 escorted PSW #106 out of the resident's room stated that he/she had not been appropriate and continued to provide care to other residents. PSW #104 did not report the incident immediately to the charge nurse.

e) During an identified one hour period of time, RN #100 noticed that PSW #106 had been doing weird things. The RN observed PSW #106 remove a medicated item from resident #002. The RN replaced the medicated item and continued with the medication pass. The RN also indicated that PSW #106 had been notably staring at residents in the lounge, causing enough concern that a resident had asked PSW #106 if he/she was okay. RN #100 later found PSW #106 sitting by the dining room

and staring blankly at resident flow sheets that had been spread across the table.

f) A few moments later, PSW #106 borrowed RN #100's phone and called someone.

g) After the phone call, PSW #106 left the flow sheets spread out across the table, along with his/her bag and jacket and then disappeared.

h) RN #100 then observed PSW #106 running down the hallway quickly, holding a zip lock bag and then go into the utility room.

j) After two hours of observing PSW #106 act inappropriately, RN #100 went downstairs to the main floor to retrieve management's assistance.

k) The DOC, ADOC and the ED entered the identified home area and became aware that after speaking to PSW #106, the PSW was not his/her usual self and required medical attention.

l) Emergency services were called and PSW #106 was escorted to the hospital.

m) At an approximate time after PSW #106 was provided medical attention, PSW #104 reported to RN #100 in a passing conversation that he/she had witnessed PSW #106 act inappropriately toward resident #001. The RN immediately reported the incident to the DOC, the ADOC and then resident #001 was assessed by the RN. Resident appeared to be fine and had no apparent changes.

n) The ED, DOC and the ADOC held a meeting to discuss the witnessed incident. It was decided among the managers, that because the incident between PSW #106 and resident #001 had been intentional, the incident was not considered abuse and subsequently not reported to the MOHLTC Director, or police.

2. On the following day, the ADOC initiated an investigation of the above mentioned witnessed incident. After debriefing staff that had worked on the identified home area on the identified date, concluded that the incident that occurred between PSW #106 and resident #001 could not be defined as abuse because the inappropriate act was done unintentionally.

Upon completion of the home's investigation and after the staff had been debriefed; the family of resident #001 was notified.

3. On an identified date, several days after the incident, the family of resident #001, reported to the incident to the police. After receiving the report, the police arrived at the home to investigate. The police interviewed a staff member and the managers of the home and concluded that no charges will be laid.

4. PSW #106 returned to work after receiving physician clearance.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

This finding of non-compliance is supported by the facts set out in the Summary of Facts in the Inspection Summary and the following:

On an identified date and time, PSW #104 witnessed PSW #106 act in appropriately toward resident #001 while in his/her room. PSW #104 escorted PSW #106 out of resident #001's room and then continued to provide care to other residents.

Interviews with RN #100, and PSWs #104, #109, #110 and #111, revealed that on the same identified date, at an earlier identified time witnessed PSW #106 act inappropriately toward residents on an identified home area. Staff indicated that it was not until an identified period of time had passed, that PSW #106 had been assisted off the identified home area by management and provided medical attention.

PSW #104 indicated in an interview that he/she did not report the incident at the time of observation to anyone. PSW #104 indicated that it was not until later that day, that

he/she reported the incident to the charge nurse, but was not sure of the exact time.

RN #100 revealed that PSW #104 reported the incident to him/her sometime later in the day, and immediately reported the information to the DOC and the ADOC.

An interview with PSW #106 revealed no recollection of the events that occurred on the identified date, only that he/she had been sent to hospital.

Interviews with the ED, DOC and the ADOC, confirmed receipt of the above mentioned incident reported to them by RN #100, on the identified date.

The ED, DOC and the ADOC revealed that the above mentioned incident had been discussed among the management team to determine whether the incident was a reportable matter under the legislation. The ED, DOC and the ADOC, indicated that because PSW #106 had not been well and that the incident had been "unintentional", the incident had not been defined as abuse and subsequently not considered a reportable matter under the legislation.

The ED, DOC and ADOC further indicated that upon completion of the home's internal investigation concluded that the witnessed incident between PSW #106 and resident #001 was not a form of abuse and therefore, confirmed that the incident had not been reported to the MOHLTC Director.

The home’s policy, Resident Abuse-Staff to Resident, #OPER-02-02-04 dated September 2015, defines sexual abuse as any touching of a sexual nature that is inappropriate to care provisions or assisting a resident.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines “sexual abuse” as any 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.

The witnessed incident between PSW #106 and resident #001 on the identified date, may have been unintentional, however, an act of this nature whether it be consensual or non-consensual, is to be considered an act of abuse to a resident by a staff.

The witnessed incident that occurred between PSW #106 and resident #001, was an act of abuse and therefore, required immediate reporting to the MOHLTC Director. The licensee failed to recognize that the above mentioned incident had occurred and

subsequently failed to report the incident to the MOHLTC Director.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
On an identified date, PSW #104 witnessed PSW #106 act inappropriately toward resident #001. PSW #104 did not report the incident to RN #100 an identified duration of time on the identified date. The RN reported the incident to both the DOC and the ADOC immediately. No person in the home reported the incident to the MOHLTC Director as the incident had not been identified as "abuse".
A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, s. 24 (1): A voluntary plan of correction (VPC) was previously issued for S. 24 (1) during a Resident Quality Inspection on January 16, 2015, under Inspection #2015_297558_0001. [s. 24. (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. 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 and free from neglect by the licensee or staff in the home.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as any 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.

The home's policy, Resident Abuse-Staff to Resident, #OPER-02-02-04 dated September 2015, defines sexual abuse as any touching of a sexual nature that is

inappropriate to care provisions or assisting a resident.

This finding of non-compliance is supported by the facts set out in the Summary of Facts in the Inspection Summary and the following:

On an identified date and approximate time, PSW #104 witnessed an inappropriate incident between PSW #106 and resident #001. PSW #104 escorted PSW #106 out of resident #001's room and then continued to provide care to other residents.

Interviews with RN #100, and PSW's #104, #109, #110 and #111, revealed that on the identified date and at an earlier approximate time, witnessed PSW #106 act inappropriately toward residents on an identified home area. Staff indicated that it was not until an identified period of time later, that PSW #106 was escorted from the home area by managers of the home and provided medical attention.

PSW #104, indicated in an interview that he/she recognized that the incident between PSW #106 and resident #001, was wrong. RN #100 indicated in an interview that the incident was inappropriate and should have been reported to him/her immediately. The RN further indicated that PSW #106 should not have been allowed to remain on the home area past his/her completed shift, especially exhibiting bizarre and inappropriate behaviours. RN #100 indicated that if he/she had known of the incident between PSW #106 and resident #001, he/she would have reacted to the situation sooner.

Interviews with the ED, DOC and the ADOC revealed that PSW #106 had been identified as not well on the above mentioned identified day. The managers indicated that although resident #001 had been the recipient of an inappropriate interaction, the act had not been intentional and therefore had not been defined as an act of abuse. The managers further indicated that PSW #106 should have been provided medical attention sooner and closer to the time of the reported incident, to ensure that the other residents on the home area had not been subjected to such inappropriate behaviours.

A review of the home's above mentioned policy and review of the definition of "sexual abuse" under the Long-Term Care Homes Act, 2007, and Regulations, there is no mention of "intent", within the definition of "sexual abuse". Therefore, the interaction between PSW #106 and resident #001, whether intentional or not, is to be defined as "sexual abuse". [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone.

This finding of non-compliance is supported by the facts set out in the Summary of Facts in the Inspection Summary and the following:

On an identified date and approximate time, PSW #104 witnessed PSW #106 act inappropriately toward resident #001. PSW #104 escorted PSW #106 out of resident #001's room and then continued to provide care to other residents.

Interviews with RN #100, and PSWs #104, #109, #110 and #111, revealed that on the identified date, at a time before the witnessed incident, witnessed PSW #106 act inappropriately toward residents on an identified home area. Staff indicated that it was not until an identified period of time had passed, that PSW #106 was escorted from the identified home area by the managers and provided medical attention.

Later on the same day, PSW #104 reported to RN #100, that he/she witnessed PSW #106 act inappropriately toward resident #001 earlier. RN #100 reported the information to the DOC and the ADOC immediately.

An interview with the ADOC revealed that it was not until the following day, that the home initiated an investigation. The ADOC indicated that because PSW #106 had not been well at the time of the incident, the witnessed incident would not have been intentional and therefore, not abuse. The ADOC indicated that because the witnessed incident had not been defined as abuse, the incident had not been immediately reported and investigated.

The ADOC confirmed that it was not until one day after the incident that a decision had been made to investigate the incident and notify resident #001's family.[s. 23. (1) (a)]

Additional Required Actions:

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

Issued on this 25th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2015_168202_0021
Log No. / Registre no:	T-028577-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 20, 2015
Licensee / Titulaire de permis :	SOUTHLAKE RESIDENTIAL CARE VILLAGE 640 GRACE STREET, NEWMARKET, ON, L3Y-2L1
LTC Home / Foyer de SLD :	SOUTHLAKE RESIDENTIAL CARE VILLAGE 640 GRACE STREET, NEWMARKET, ON, L3Y-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra-McNamara

To SOUTHLAKE RESIDENTIAL CARE VILLAGE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall upon receipt of this order:

1. Review the home's policy, titled, Resident Abuse-Staff to Resident, #OPER-02-02-04, dated September 2015, with all staff in the home.

2. The policy review shall include, mandatory reporting of abuse under section 24 (1) of the Act and all areas of abuse, including corresponding definitions as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

3. At the end of the review, staff shall be able to recognize and define all forms of abuse under the legislation, and the immediate reporting of such.

4. Provide education to staff on how to assist, report and manage a colleague who may exhibiting inappropriate behaviours that may pose a risk to themselves or residents in the home.

5. The licensee shall develop, implement and submit a plan, that includes all above four requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to valerie.johnston@ontario.ca by December 18, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

This finding of non-compliance is supported by the facts set out in the Summary of Facts in the Inspection Summary and the following:

On an identified date and time, PSW #104 witnessed PSW #106 act in appropriately toward resident #001 while in his/her room. PSW #104 escorted PSW #106 out of resident #001's room and then continued to provide care to other residents.

Interviews with RN #100, and PSWs #104, #109, #110 and #111, revealed that on the same identified date, at an earlier identified time witnessed PSW #106

act inappropriately toward residents on an identified home area. Staff indicated that it was not until an identified period of time had passed, that PSW #106 had been assisted off the identified home area by management and provided medical attention.

PSW #104 indicated in an interview that he/she did not report the incident at the time of observation to anyone. PSW #104 indicated that it was not until later that day, that he/she reported the incident to the charge nurse, but was not sure of the exact time.

RN #100 revealed that PSW #104 reported the incident to him/her sometime later in the day, and immediately reported the information to the DOC and the ADOC.

An interview with PSW #106 revealed no recollection of the events that occurred on the identified date, only that he/she had been sent to hospital.

Interviews with the ED, DOC and the ADOC, confirmed receipt of the above mentioned incident reported to them by RN #100, on the identified date.

The ED, DOC and the ADOC revealed that the above mentioned incident had been discussed among the management team to determine whether the incident was a reportable matter under the legislation. The ED, DOC and the ADOC, indicated that because PSW #106 had not been well and that the incident had been "unintentional", the incident had not been defined as abuse and subsequently not considered a reportable matter under the legislation.

The ED, DOC and ADOC further indicated that upon completion of the home's internal investigation concluded that the witnessed incident between PSW #106 and resident #001 was not a form of abuse and therefore, confirmed that the incident had not been reported to the MOHLTC Director.

The home's policy, Resident Abuse-Staff to Resident, #OPER-02-02-04 dated September 2015, defines sexual abuse as any touching of a sexual nature that is inappropriate to care provisions or assisting a resident.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as any 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.

The witnessed incident between PSW #106 and resident #001 on the identified date, may have been unintentional, however, an act of this nature whether it be consensual or non-consensual, is to be considered an act of abuse to a resident by a staff.

The witnessed incident that occurred between PSW #106 and resident #001, was an act of abuse and therefore, required immediate reporting to the MOHLTC Director. The licensee failed to recognize that the above mentioned incident had occurred and subsequently failed to report the incident to the MOHLTC Director.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
On an identified date, PSW #104 witnessed PSW #106 act inappropriately toward resident #001. PSW #104 did not report the incident to RN #100 for an identified duration of time on the identified date. The RN reported the incident to both the DOC and the ADOC immediately. No person in the home reported the incident to the MOHLTC Director as the incident had not been identified as "abuse".
A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, s. 24 (1): A voluntary plan of correction (VPC) was previously issued for S. 24 (1) during a Resident Quality Inspection on January 16, 2015, under Inspection #2015_297558_0001. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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
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 20th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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