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

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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
Mar 15, 2016	2016_280541_0006	000282-16	Critical Incident System

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

AMBER MOASE (541), WENDY BROWN (602)

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): March 7-10, 2016

This inspection was for critical incident #2982-000001-16, an allegation of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Medical Director, the Police, the Clinical Nurse Manager, Behavioral Support Staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Providers (PCPs), a Physiotherapy Assistant, Laundry staff, Housekeeping staff, and residents.

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.
- **9 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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 failed to protect resident #002, #003 and #004 from abuse by resident #001.

On March 7, 2016 an inspection began for critical incident # 2982-000001-16, an allegation of resident to resident sexual abuse. The critical incident was as follows:

On a specified date resident #001 was witnessed sitting in the television room inappropriately touching resident #002. The critical incident indicates resident #002 was unaware of the situation as both residents are cognitively impaired.

O. Reg 79/10 s. 2(1)b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Upon entering the home, inspector #541 requested the home's investigation into the incident that occurred on a specified date. Inspector was provided with a copy of resident #001's progress notes which reflected multiple incidents of sexual behaviour by resident #001 directed towards 3 residents dating back to a specified date. The incidents were documented in resident #001's progress notes as follows:

On a specified date: Resident #001 observed with hands on waist of resident #004 and kissed resident #004 on the lips.

On a specified date: Resident #001 was found in "sexual act" with resident #004. Inspector interviewed the witnessing RPN staff #114 and it was determined that resident #001 was in bed on top of resident #004. Resident #004 appeared to have difficulty breathing due to the weight of resident #001.

On a specified date: Resident #001 was witnessed kissing resident #004.

On a specified date: Resident #001 was found in bed with resident #004 in a "sexual position." Inspector #541 interviewed witnessing PCP staff #110 and it was determined resident #001 was witnessed trying to have sexual intercourse with resident #004.

On a specified date: Resident #001 lying in bed with resident #004. Resident #001's pants were pulled down and resident #001 was trying to hug resident #004, who remained clothed.

On a specified date: Resident #001 was found with resident #004 in bed. Resident #001's genitals were exposed, resident #004 was clothed.

On a specified date: Critical Incident (CI) #2982-000031-15 was submitted stating resident #001 was found on top of resident #003 kissing the resident and making thrusting motions. The CI submitted by the home stated this was an isolated incident. When Inspector #541 interviewed witnessing RPN #114 and it was determined that resident #001 was found fully naked on top of resident #003 who appeared to be stressed. Resident #001 was angry at RPN #114 for removing resident #003 from the room.

On a specified date: Resident #001 was found trying to touch and kiss resident #003. Both residents were fully clothed.

On a specified date: Resident #001 was found in bed with resident #004. Resident #001's genitals were exposed and resident #004's pants and brief were removed.

On a specified date: Resident #001 found kissing resident #003 in the tv room.

On a specified date: Resident #001 found with resident #004. Resident #004's pants were down but resident #001 fully clothed. A PCP intervened before anything further took place.

On a specified date: Resident #001 found with resident #003 on resident #001's bed. Resident was kissing resident #003's neck and was about to touch resident #003 when staff intervened.

On a specified date: Resident #001 was found at the end of the hallway kissing resident. Progress note indicates the resident is either resident #003 or #002.

On a specified date: Resident #001 witnessed kissing resident #002 in the hallway. Resident #002 stated "no" and resident #001 was being forceful as resident #002 was trying to get away.

On a specified date: Resident #001 and resident #003 found in bed together, both fully clothed and staff intervened before anything further took place.

On a specified date: Resident #001 witnessed rubbing resident #002's leg. When staff intervened, resident #001 was angry and stated that he/she should be able to kiss and touch whoever he/she wants.

On a specified date: Resident #002's progress notes indicate the resident stated to staff "get that person away from me" and was referring to resident #001.

On a specified date: Resident #001 witnessed inappropriately touching resident #002. Critical Incident # 2982-000001-16 submitted.

On a specified date: Resident #001 witnessed in bed with resident #003. Resident #001 had a hand over resident #003's chest holding the resident down on the bed.

On a specified date: Behavior Support Staff (BSO) present with Resident #001 and watched this resident take resident #003 by the hand and lure resident #003 into a room. Resident #003 stated "I want to go; I don't want to be here". Resident #001 held resident #003 around the waist and would not let the resident go. BSO staff member then intervened.

On a specified date: Resident #001's progress notes indicate resident observed as having "stalking" behaviors. When staff were not within sight the resident would move closer to co-residents, when staff approached resident #001, the resident would then turn in the other direction.

On a specified date: Resident #001 indicated being aware staff were watching him/her trying to take a co-resident into a room, resident #001 informed staff that they did not catch him/her.

On a specified date: BSO Staff member reported to RPN that the previous day at 1550 hours and at 1620 hours resident #001 was observed touching a co-resident and trying to hold the co-resident's hand. Progress notes do not specify if this is resident #002 or #003.

On a specified date: Resident #002's progress notes indicate resident was observed weeping when resident #001 approached him/her.

On a specified date: Resident #001 witnessed approaching co-resident #002 or #003 three times trying to hold resident's hand and get a kiss.

On a specified date resident #001 was transferred to another unit in the home.

Inspector #541 was not able to obtain any information from the home to provide evidence that the home established consent in any of the above incidents.

Inspector #541 interviewed RPN staff #114 who witnessed the incidents one of the incidents. RPN #114 stated that he observed resident #001 in bed on top of resident #004. Resident #004 appeared to have difficulty breathing due to the weight of resident #001 on top of him/her. From this information, the incident can be defined as non-consensual.

RPN #114 was interviewed regarding another incident that was witnessed on a specified date. RPN #114 found resident #001 fully naked on top of resident #003 who appeared to be stressed. From this information, the incident can be defined as non-consensual.

Inspector #541 interviewed PCP staff #110 who witnessed an incident with resident #001 on a specified date. PCP indicated to inspector he saw resident #001 trying to have sexual intercourse with resident #004. PCP could not provide information to determine if consent was received from resident #004 therefore consent was deemed as "undetermined" for this incident.

One documented incident can be determined as non-consensual as resident #003 was documented stating "no".

Another documented incident can be determined as non-consensual as resident #003 was being held down by resident #001.

The documented incident indicating resident #003 stated "I want to go; I don't want to be here" can be determined as non-consensual.

For the remaining incidents, consent was not obtained from any of the residents who were allegedly sexually abused by resident #001.

The licensee failed to comply with:

1. LTCHA 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. (Refer to WN #003)

2. 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.(Refer to WN #004)

3. O. Reg 79/10 s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Refer to WN #005)

4. O. Reg 79/10 s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. (Refer to WN #006)

5. 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. (Refer to WN #007)

6. O. Reg 79/10 s.104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. (Refer to WN #008)

7. O. Reg 79/10 s.131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. (Refer to WN #009) [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program policies were complied with.

LTCHA 2007 s. 8(1) states every licensee of a long-term care home shall ensure there is an organized program of nursing services for the home to meet the assessed needs of the residents. As per O. Reg. 79/10 s. 30(1) the home is required to have goals, objectives and relevant policies, procedures and protocols for the nursing and personal support program. The responsive behaviour program is considered part of the nursing and personal support program.

Inspector #541 requested all policies related to the home's responsive behaviour program. Inspector was provided with the following policies:
- Policy # RCSM-K-50 titled Responsive Behaviors
- Policy # RCSM-E-105 titled Management of Aggressive Resident Behavior

Under Procedure, policy #RCSM-K-50 titled Responsive Behaviors states the following:

1. Identification by staff of a change in resident's behavior or mood
2. Initiate responsive behavior checklist (found on common drive) and notify Responsive behavior team via email and Clinical Nurse Manager via email.
3. Pain - Use Pain Assessment Tool for assessment. Is the resident on analgesics on a regular basis? If pain is an issue refer to Palliative Pain & Symptom Management Consultation Service. Palliative care pain and symptoms.
4. Request physician to assess and initiate treatment as needed for underlying issues
5. Behavior or mood concern resolved. Plan of care updated to reflect change in care of deliver
6. If the resident's behavior or mood concern is not resolved - Psychogeriatric External Referral - notify Clinical Nurse Manager (CNM), who is responsible for referrals. Psycho-Geriatric forms will be given to RPN/RN to complete.
7. If it is determined that the resident is a danger to self or others and assessment is needed within hours, the physician and CNM must be notified.
8. Psycho-Geriatric forms will be reviewed by CNM for completion and necessity for referral

According to resident #001's progress notes and interviews with staff, the first incident of resident #001 displaying sexual behaviour directed towards another resident was on a specified date when resident #001 was observed with hands on waist of resident #004 and kissed resident #004 on the lips.

It was not until after the second incident with resident #001 approximately one month later as documented in WN #003, that the home referred resident #001 to Behaviour Support Outreach (BSO) for further support with managing resident's behaviour.

As per interview with BSO RN #106, the recommended interventions for resident #001's sexual behaviours were: treatment of a UTI, continue with recent restart of a specified medication, and frequent checks. No further behaviours were reported by the home and resident #001 was discharged from the BSO program.

Inspector #602 interviewed RPN #109 who works full time on the unit where resident #001 resides and works one day per week with the responsive behaviour program. RPN #109 confirmed that resident #001 was not referred to BSO or any other resource after the discharge on a specified date until an incident occurred four months later at which time another referral was initiated to BSO. RPN #109 was unsure why resident #001's behaviours that occurred during the specified four month period did not result in a referral for further assistance with managing the resident's behaviours.

RPN #109 advised that her practice as per policy would have been to report each specified incident to the RN manager, who would have notified the CNM and DOC as appropriate for a referral to BSO for assistance.

During an interview with CNM #107, she indicated to inspectors #541 and #602 that staff will notify her of a resident requiring referral to the responsive behaviour program. CNM #107 further stated that should staff not notify her, she reviews the progress notes and clinical reports daily and would identify residents exhibiting responsive behaviours. CNM #107 confirmed she is the home's liaison between the community resources and the home. During an interview with Inspectors #541 and #602, CNM #107 was unable to inform inspectors why the behaviours exhibited by resident #001 during a specified four month period did not result in a referral to BSO.

Under procedures, policy # RCSM-K-50 directs staff to initiate responsive behavior checklist (found on common drive) and notify Responsive behaviour team via email and Clinical Nurse Manager via email.

Inspector #541 requested any and all emails from the home containing resident #001, #002, #003 and #004's names. Upon review of emails provided by the home, there was no email sent to the Clinical Nurse Manager to notify her of resident #001's behaviours.

There was no evidence the Responsive Behavior Checklist was completed for resident #001.

Inspector #602 interviewed the home's physician. The physician confirmed being notified of resident #001's behaviours on a specified date as noted in the physician's book. The physician was aware resident #001 had ongoing behaviours during a specified time period but could not confirm being notified of each incident. Upon review of the physician's book, it is noted the physician was notified on three specified dates. There is no evidence the physician was notified of the remaining incidents of resident #001 displaying sexual behaviour as noted in WN #002.

As per review of resident #001's progress notes over a specified four month time period, strategies in place were not effective at managing the resident's sexual behaviours directed at co-residents. There is no evidence the home initiated any referral to the psychogeriatric external program as per policies # RCSM-K-50 titled Responsive Behaviors and # RCSM-E-105 titled Management of Aggressive Resident Behavior

related to resident #001's increasing sexual behaviours until an incident occurred on a specified date. [s. 8. (1) (a)]

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

Over a six month period, there were multiple documented incidents where resident #001 allegedly sexually abused residents #002, #003 and #004 (Refer to WN #001).

Upon entering the home, Inspector #541 requested the home's investigation into the incident that occurred on a specified date. Inspector was provided with a copy of resident #001's progress notes which reflected multiple incidents of sexual behaviour by resident #001 directed towards 3 co-residents dating back to a specified date.

CI #2982-000031-15 was submitted to the Director on a specified date for the incident that occurred on the day before. On a specified date the home updated the CI indicating this "was an isolated incident and POA's of both residents were understanding of the incident".

Inspector #541 asked the home to provide documentation to support that the home came to the conclusion that the incident was isolated. The home was unable to find any documented investigation and was unable to inform inspector how the incident was determined to be isolated.

No documented investigation was conducted into any of the above incidents except one incident on a specified date. [s. 23. (1) (a)]

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 licensee has failed to ensure that the person who had 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:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Over a specified six month period, there were multiple documented incidents where resident #001 allegedly sexually abused residents #002, #003 and #004 (Refer to WN #001).

Inspector #541 interviewed the home's Administrator and Director of Care (DOC) and confirmed that the Director was not notified of any of the incidents apart from the incidents on two specified dates when a Critical Incident Report was submitted.

It is noted the Director was not immediately notified of the alleged resident to resident sexual abuse that occurred on one of the specified dates at 2050 hours as the Director was not notified until the CIR was submitted on one day later at 1649 hours.

When asked why the Ministry of Health and Long-Term Care was not notified of any of the incidents apart from the incidents on two specified dates, the DOC stated because the residents had not had sexual intercourse. The DOC denied being aware of any of the above incidents. During an interview with inspector #541 on RPN #114 stated he informed the home's DOC of the incidents on two specified dates via email as directed by the RN Manager. Inspector #541 obtained copies of these emails and was able to confirm the home's DOC was notified of both incidents. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers been identified for resident #001 demonstrating responsive behaviours, where possible; strategies are developed and implemented to respond to these behaviours where possible and; actions are taken to respond to the needs of the resident including assessment, reassessments, interventions, and that the resident's responses to the interventions are documented.

Resident #001 started exhibiting sexual behaviors directed towards co-residents on a specified date as documented in WN #001. Resident #001 has cognitive impairment.

During an interview with PCP staff #104, resident #001 was described as being inappropriate with co-residents on the unit. PCP #104 stated resident #001 would try to coerce co-residents into resident #001's room. During an interview inspector #541 asked PCP what interventions were put in place to manage resident #001's behaviors and PCP #104 indicated staff were to keep a watch on the resident. PCP #104 was unaware of any other interventions to manage resident #001's sexual behaviors directed at co-residents.

Inspector #541 interviewed RPN staff #103 who is a full time staff member on the unit where residents #001, 002, 003 and 004 reside. RPN #103 stated resident #001 would sit outside a room and try to lure co-residents into the room. RPN #103 was of the understanding resident #001 was aware of his/her actions as the would tell staff he/she had a right to touch who he/she wanted to.

On March 9, 2015 PCP staff #110 was interviewed by Inspector #541 regarding resident

#001's behaviors. PCP #110 was of the understanding resident #001 was aware of what his/her actions as when the co-residents were removed from each incident, resident #001 became angry. PCP stated resident #001 would only approach residents who appeared less able to remove themselves from a situation.

During an interview with Inspector #541, RPN #114 stated resident #001 would lure co-residents into his/her room.

Inspector #602 interviewed PCP #101 who has been working with resident #001 since the resident moved to the new unit on a specified date. PCP #101 informed inspector #602 of being advised by staff from the resident's previous unit that resident #001 had been sexually aggressive toward co-residents on their unit. PCP #101 indicated being told resident #001 would seek out co-residents who did not know what is happening or what to do; the residents who would not know enough to tell the resident to go away.

RPN #109 works full time on the unit where resident #001 was residing and also works one day per week with the responsive behavior program. Inspector #602 interviewed RPN #109 who shared that from her observations of resident #001, the resident was deliberately approaching and coaxing certain residents to come in to his/her room. RPN #109 further shared that both residents #002 and #003 are likely not cognitively aware enough to understand and appreciate what resident #001 was wanting them to do. RPN #109 shared that resident #004 does have some behaviours where resident #004 sought out Resident #001, however resident #004 is cognitively impaired and ongoing ability to give consent is not determined.

Inspector #602 interviewed the home's current Assistant Director of Care (ADOC) #115 who indicated being aware resident #001 sought out resident #002, #003 and #004 although she did indicate sometimes resident #004 does seek out resident #001. When asked the intent of the interaction when resident #004 seeks out resident #001, ADOC #115 did state it is likely companionship resident #004 is seeking, not sexual activity. ADOC #115 confirmed that staff are to monitor resident #001's whereabouts and to intervene if sexual touching/activity observed. ADOC #115 acknowledged that resident #001's behaviour was typically deemed inappropriate as the activity was non-consensual and/or consent was unclear thus safety of the residents was the priority.

Critical Incident # 2982-000001-16 related to the incident between resident #001 and #002 indicates that the long term action planned to correct the situation includes monitoring resident #001 every 15 minutes. (Also to notify BSO and provide medications

as needed).

Inspector #541 interviewed Clinical Nurse Manager (CNM) #107 who is responsible for the home's responsive behavior program. CNM #107 indicated it would be her expectation that there would be interventions identified in the care plan for resident #001 to provide direction to staff for management of behaviors.

Resident #001's care plan in place effective on a specified date was reviewed. There is no focus, goal or intervention in this care plan related to resident #001's responsive behaviors and no triggers were identified for resident #001 sexual behavior directed at co-residents.

Resident #001's current care plan effective on a specified date indicates the following interventions regarding resident #001's sexual behaviors:
- Avoid any type of conversation that could encourage or initiate inappropriate behavior
- Constant supervision in recreation programs and monitor every 15 minutes
- Distract resident if possible
- Encourage attendance at recreational/activation programs
- Protect other resident if unable to protect themselves

There are no interventions in resident #001's current care plan identifying any triggers for sexual behavior.

All staff interviewed indicated that the interventions to manage resident #001's behavior are to keep an eye on the resident.

Critical Incident # 2982-000001-16 related to the incident between resident #001 and #002 indicates that the long term action planned to correct the situation includes monitoring resident #001 every 15 minutes.

As per review of resident #001's care plans effective on specified dates, interviews with staff and review of resident #001's progress notes, there is no evidence to support the home reassessed the intervention of "monitoring every 15 minutes" that was put in place to manage resident #001's sexual behavior directed at co-residents. No staff were able to identify any other behavior strategy to manage resident #001's behavior. [s. 53. (4)]

2. The licensee has failed to ensure that the behavioural triggers been identified for resident #004 demonstrating responsive behaviours (where possible).

Resident #004 was observed by inspector #541 during the inspection and found to be cognitively impaired and unable to appropriately answer simple questions.

RPN #114 was interviewed about one of the specified incidents and shared with inspector #541 that resident #004 is cognitively impaired and ongoing ability to give consent is not determined.

During an interview with PCP #110 the PCP indicated that resident #004 appears to not be aware of his/her actions. PCP stated that when resident #001 is approached by a co-resident, particularly resident #004, this is an opportunity for resident #001 and is an indication to staff they must "keep an eye" on resident #001.

On a specified date it is documented that as per discussion with the home's DOC #100, the bed alarm put in place on a specified is no longer needed as resident #004 does not get up at night. A few weeks later, the bed alarm removed from resident #004. On a specified date it is documented resident #004 has not had any sexual behaviours with resident #001.

Resident #004's progress notes were reviewed for a specified seven month time period.

Resident #004 has been documented kissing residents #006 and #007 in addition to the documented sexual behaviours with resident #001 (refer to WIN #002). In addition, resident #004 is documented as having physically aggressive behaviours (hitting and slapping PCPs during care) on multiple dates between over a specified five month period.

It is noted in WIN #002 there are three documented incidents of alleged sexual abuse by resident #001 towards resident #004 from August 28 to December 31, 2015.

Resident #004's care plan effective on a specified date was reviewed. There are no interventions in place to direct staff to keep resident #004 safe from resident #001 or to direct staff to manage resident #004's aggressive and sexual behaviours.

Resident #004's current care plan effective on a specified date lists the following interventions to reduce incidents of inappropriate sexual behaviour:

- Distract resident as soon as possible from other resident who may be sexually

inappropriate with him/her
- Encourage attendance at recreational/activation programs
- Intermittent supervision and monitor resident's whereabouts
- Remove resident from public area when behaviour is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behaviour and provide diversional activity

When interviewed, no staff member was able to tell inspectors #541 and 602 any interventions in place to manage resident #004's behaviours. [s. 53. (4) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that:

* resulted in a physical injury or pain to the resident, or
* caused distress to the resident that could potentially be detrimental to the resident' s health or well-being

There were multiple documented incidents where resident #001 allegedly sexually abused residents #002, #003 and #004 over a specified 6 month time period (as per WN #002).

The DOC confirmed with Inspector #541 that when the home contacts a resident's SDM it is typically documented in the resident's progress notes. Inspector #541 was able to confirm from a review of resident #001, #002, #003 and #004's progress notes that each of the resident's SDM's were notified of the above incidents that occurred on six specified dates.

For the remaining incidents, the home was unable to provide Inspector #541 with evidence that the SDM's for residents #001, #002, #003 and #004 were notified. [s. 97. (1) (a)]

WN #7: 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.

Over a specified seven month period there were multiple documented incidents where resident #001 allegedly sexually abused residents #002, #003 and #004 (Refer to WN #001).

The police were not notified of any of the above incidents until Inspector #541 requested the home contact the police on March 9, 2016. [s. 98.]

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

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that ensure that the report to the Director included the following description of the incident:
* type of incident
* area or location of the incident
* date and time of the incident, and
* events leading up to the incident

On a specified date a critical incident #2982-000031-15 was submitted for an incident that occurred the day before.

Under "Description of the Unusual Occurrence, including events leading up to the

occurrence" the CI states the following:
- PCP found resident #001 and resident #003 in resident #001's room with the residents in bed kissing. They were fully clothed and resident #001 was on top of resident #003 making thrusting motions.

The home was asked by the Ministry of Health and Long-Term Care to provide further information related to this incident, including if this was an isolated incident.

On a specified date the home updated the CI indicating this was an isolated incident.

Inspector #541 was able to determine that over a specified seven month period there were multiple documented incidents where resident #001 allegedly sexually abused residents #002, #003 and #004 (Refer to WN #001). The home was unable to show documented evidence that consent was obtained from any of the residents for any incident that occurred.

During this inspection, Inspector #541 asked the home to provide documentation to support that the home came to the conclusion that the reported incident on a specified was isolated. The home was unable to find any documented investigation and was unable to inform inspector how the incident was determined to be isolated.

Inspector interviewed RPN #114 who was witness to the reported incident that occurred on a specified date. RPN confirmed that he observed resident #001 to be fully naked on top of resident #003 who appeared to be stressed. RPN #114 described resident #001 as being angry at RPN #114 for removing resident #003 from the room.

The home failed to provide accurate details into the type of incident that occurred on the specified date. The home further failed to provide a description of events leading up to the incident by failing to mention any of the documented incidents where resident #001 allegedly sexually abused other residents prior to when the specified date when the reported incident occurred. [s. 104. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was demonstrating sexual behaviours directed at co-residents over a specified six month period (refer to WN #001).

A review of resident #001's Medication Administration Records (MARs) from a specified five month period, indicates resident #001 had an order for a specified medication to be given as needed, effective on a specified date. Over a specified six month period, resident #001 was given this medication on three specified occasions.

The administration of the as needed medication on a specified date does not coincide with a documented incident of sexual behavior as per review of resident #001's progress notes.

It is noted in resident #001's progress notes that on a specified date, the as needed medication was administered for "inappropriate behavior" and was assessed as effective as the resident was later sleeping.

On a specified date, the as needed medication was documented as administered at 1130 hours as "resident #001 was making sexual advances towards a co-resident". Effectiveness of the medication was not documented however it can be concluded the medication was not effective as documentation at 1522 hours indicates resident #001 witnessed in bed with resident #003. Resident #001 had his/her hand over resident #003's chest holding the resident down on the bed.

As per review of resident #001's MARs there were no other as needed medications ordered to aid in managing resident #001's behaviours.

Resident #001 was not administered the specified as needed medication as prescribed to manage responsive behaviours. Resident #001 exhibited multiple incidents of responsive behaviors over a specified five month period and was only administered specified medication on three occasions during that time period. [s. 131. (2)]

Issued on this 18th day of March, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	AMBER MOASE (541), WENDY BROWN (602)
Inspection No. / No de l'inspection :	2016_280541_0006
Log No. / Registre no:	000282-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 15, 2016
Licensee / Titulaire de permis :	2109577 ONTARIO LIMITED 195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5
LTC Home / Foyer de SLD :	2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS 564 Tanner Drive, KINGSTON, ON, K7M-0C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Sellery

To 2109577 ONTARIO LIMITED, 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 prepare, submit and implement a plan to ensure the following:

- The members of the management team including Registered Nurse Managers of the home are educated on the home's abuse policy #ADM-VI-06 and #RCSM-L-10

- The members of the management team including Registered Nurse Managers of the home are educated on the Long-Term Care Act and Regulations, specifically the following sections:
LTCHA s. 23. (1)
LTCHA s. 24. (1)
O. Reg 79/10 s. 97. (1)
O. Reg 79/10 s. 98
O. Reg 79/10 s.104. (1)

- All staff are educated on how to identify and report resident to resident sexual abuse

- A system is developed whereby the Director of Care and/or delegate is reviewing all communication from the front line staff at least daily to determine if any abuse has occurred in the home. This shall continue until compliance can be demonstrated.

- A system is developed whereby when there is reasonable grounds to suspect that abuse has occurred, the home shall immediately investigate and ensure that all legislative requirements have been fulfilled.

In addition to the above order, the home shall immediately ensure any resident currently exhibiting sexual behaviours is assessed, the plan of care is reviewed and revised and the home's policy #RCSM-K-50 titled "Responsive Behaviors" is complied with.

The plan shall be submitted by March 22, 2016 to Amber Moase via fax at 613-569-9670

Grounds / Motifs :

1. 1. The licensee failed to protect resident #002, #003 and #004 from abuse by resident #001.

On March 7, 2016 an inspection began for critical incident # 2982-000001-16, an allegation of resident to resident sexual abuse. The critical incident was as follows:

On a specified date resident #001 was witnessed sitting in the television room inappropriately touching resident #002. The critical incident indicates resident #002 was unaware of the situation as both residents are cognitively impaired.

O. Reg 79/10 s. 2(1)b defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee or staff member.

Upon entering the home, inspector #541 requested the home's investigation into the incident that occurred on a specified date. Inspector was provided with a copy of resident #001's progress notes which reflected multiple incidents of sexual behaviour by resident #001 directed towards 3 residents dating back to a specified date. The incidents were documented in resident #001's progress notes as follows:

On a specified date: Resident #001 observed with hands on waist of resident #004 and kissed resident #004 on the lips.

On a specified date: Resident #001 was found in "sexual act" with resident #004. Inspector interviewed the witnessing RPN staff #114 and it was determined that resident #001 was in bed on top of resident #004. Resident #004 appeared to have difficulty breathing due to the weight of resident #001.

On a specified date: Resident #001 was witnessed kissing resident #004.

On a specified date: Resident #001 was found in bed with resident #004 in a "sexual position." Inspector #541 interviewed witnessing PCP staff #110 and it was determined resident #001 was witnessed trying to have sexual intercourse with resident #004.

On a specified date: Resident #001 lying in bed with resident #004. Resident #001's pants were pulled down and resident #001 was trying to hug resident #004, who remained clothed.

On a specified date: Resident #001 was found with resident #004 in bed.

Resident #001's genitals were exposed, resident #004 was clothed.

On a specified date: Critical Incident (CI) #2982-000031-15 was submitted stating resident #001 was found on top of resident #003 kissing the resident and making thrusting motions. The CI submitted by the home stated this was an isolated incident. When Inspector #541 interviewed witnessing RPN #114 and it was determined that resident #001 was found fully naked on top of resident #003 who appeared to be stressed. Resident #001 was angry at RPN #114 for removing resident #003 from the room.

On a specified date: Resident #001 was found trying to touch and kiss resident #003. Both residents were fully clothed.

On a specified date: Resident #001 was found in bed with resident #004. Resident #001's genitals were exposed and resident #004's pants and brief were removed.

On a specified date: Resident #001 found kissing resident #003 in the tv room.

On a specified date: Resident #001 found with resident #004. Resident #004's pants were down but resident #001 fully clothed. A PCP intervened before anything further took place.

On a specified date: Resident #001 found with resident #003 on resident #001's bed. Resident was kissing resident #003's neck and was about to touch resident #003 when staff intervened.

On a specified date: Resident #001 was found at the end of the hallway kissing resident. Progress note indicates the resident is either resident #003 or #002.

On a specified date: Resident #001 witnessed kissing resident #002 in the hallway. Resident #002 stated "no" and resident #001 was being forceful as resident #002 was trying to get away.

On a specified date: Resident #001 and resident #003 found in bed together, both fully clothed and staff intervened before anything further took place.

On a specified date: Resident #001 witnessed rubbing resident #002's leg. When staff intervened, resident #001 was angry and stated that he/she should

be able to kiss and touch whoever he/she wants.

On a specified date: Resident #002's progress notes indicate the resident stated to staff "get that person away from me" and was referring to resident #001.

On a specified date: Resident #001 witnessed inappropriately touching resident #002. Critical Incident # 2982-000001-16 submitted.

On a specified date: Resident #001 witnessed in bed with resident #003. Resident #001 had a hand over resident #003's chest holding the resident down on the bed.

On a specified date: Behavior Support Staff (BSO) present with Resident #001 and watched this resident take resident #003 by the hand and lure resident #003 into a room. Resident #003 stated "I want to go; I don't want to be here". Resident #001 held resident #003 around the waist and would not let the resident go. BSO staff member then intervened.

On a specified date: Resident #001's progress notes indicate resident observed as having "stalking" behaviors. When staff were not within sight the resident would move closer to co-residents, when staff approached resident #001, the resident would then turn in the other direction.

On a specified date: Resident #001 indicated being aware staff were watching him/her trying to take a co-resident into a room, resident #001 informed staff that they did not catch him/her.

On a specified date: BSO Staff member reported to RPN that the previous day at 1550 hours and at 1620 hours resident #001 was observed touching a co-resident and trying to hold the co-resident's hand. Progress notes do not specify if this is resident #002 or #003.

On a specified date: Resident #002's progress notes indicate resident was observed weeping when resident #001 approached him/her.

On a specified date: Resident #001 witnessed approaching co-resident #002 or #003 three times trying to hold resident's hand and get a kiss.

On a specified date resident #001 was transferred to another unit in the home.

Inspector #541 was not able to obtain any information from the home to provide evidence that the home established consent in any of the above incidents.

Inspector #541 interviewed RPN staff #114 who witnessed the incidents one of the incidents. RPN #114 stated that he observed resident #001 in bed on top of resident #004. Resident #004 appeared to have difficulty breathing due to the weight of resident #001 on top of him/her. From this information, the incident can be defined as non-consensual.

RPN #114 was interviewed regarding another incident that was witnessed on a specified date. RPN #114 found resident #001 fully naked on top of resident #003 who appeared to be stressed. From this information, the incident can be defined as non-consensual.

Inspector #541 interviewed PCP staff #110 who witnessed an incident with resident #001 on a specified date. PCP indicated to inspector he saw resident #001 trying to have sexual intercourse with resident #004. PCP could not provide information to determine if consent was received from resident #004 therefore consent was deemed as "undetermined" for this incident.

One documented incident can be determined as non-consensual as resident #003 was documented stating "no".

Another documented incident can be determined as non-consensual as resident #003 was being held down by resident #001.

The documented incident indicating resident #003 stated "I want to go; I don't want to be here" can be determined as non-consensual.

For the remaining incidents, consent was not obtained from any of the residents who were allegedly sexually abused by resident #001.

The licensee failed to comply with:

1. LTCHA 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. (Refer to WN #003)

2. 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.(Refer to WN #004)

3. O. Reg 79/10 s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Refer to WN #005)

4. O. Reg 79/10 s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. (Refer to WN #006)

5. 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. (Refer to WN #007)

6. O. Reg 79/10 s.104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. (Refer to WN #008)

7. O. Reg 79/10 s.131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. (Refer to WN #009) [s. 19. (1)]

The home's compliance history was reviewed for the past 3 years:

In January 2016 the home was issued a Voluntary Plan of Correction (VPC) for failing to comply with LTCHA 2007 c. 8 s. 20 (failure to comply with the abuse policy).

In February 2015, the home was issued a Compliance Order (CO) for failing to comply with LTCHA 2007 c.8 s. 19 (failing to protect residents from abuse).

In December 2014, the home was issued a Written notification (WN) and a VPC for failing to comply with the LTCHA, 2007 s.24 (failure to immediately report instances of alleged abuse to the Director) and a WN for failing to comply with LTCHA, s. 23 (1) (failing to immediately investigate an allegation of abuse/neglect).

In October 2012, the home was issued a WN and a VPC for failing to comply with LTCHA, s. 23 (2) (failure to report to the Director the results of every investigation into allegations of abuse/neglect).

The severity of harm in the above incident was determined to be "actual harm" and the scope was identified as "pattern" as 3 residents were allegedly sexually abused by resident #001 over a specified six month period. (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 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
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 15th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amber Moase

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