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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2016;	2016_219211_0021 (A1)	026692-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please note the Compliance date has been extended to January 31, 2017 as requested.

Issued on this 23 day of December 2016 (A1)

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

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

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 31, September 1 and 2, 2016

This inspection Log #026692-16 was related to the alleged sexual abuse from a resident toward another resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses, Geriatric Outreach Nurse/Behavioural Supports Ontario (BSO) of Royal Hospital, Personal Support Workers, residents and a family member.

The inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home's policies and procedures related to abuse, staff work routines and schedules, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including residents to residents and residents to staff interactions.

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.

5 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Sexual abuse is defined by the LTCH, 2007, O.Reg 79/10, s.2 (1) as (a) a consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report (CIS) was submitted to the Director relating to alleged sexual abuse from resident #001 to residents #002 on an identified date. The CIS indicated that staff observed resident #001 and resident #002 exhibiting responsive behaviour in a sexual nature. An inspection was initiated by Inspector # 211 on August 31 2016. A second incident of alleged sexual abuse was identified as having occurred on an identified date during a review of resident #001's health care records. This incident was not reported to the Director.

On August 30 and September 1-2, 2016, Inspector #211 reviewed resident #001's health care records documentation and the sequences of events were as followed:

On an identified date, resident #001's health care records showed that the resident was transferred to an identified unit due two specified responsive behaviours. Resident #001's written plan of care, did not indicate that the resident had any previous physical or sexual responsive behaviours.

On an identified date, the progress notes indicated that resident #001 had an incident of physical responsive behaviour toward an identified nurse. A code white was initiated and the resident was sent to the hospital. The resident returned from the hospital on the same day. The current written plan of care doesn't indicate that

the resident had an episode of physical responsive behaviour incident and did not identified any interventions related to this new behaviour.

From an identified period of eight days, the progress notes indicated that resident #001 did not demonstrate any physical responsive behaviours but did indicate that the resident had another type of responsive behaviour.

On an identified day, resident #001 and #002 were observed exhibiting behaviours of a sexual nature.

The incidents of abuse are as follows:

At the beginning of the identified day, the staff observed resident #001 and #002 walking and holding hands on an identified unit hallway.

After an identified time, the staff observed that both residents were exhibiting behaviours of a sexual nature. A plan was implemented to visually monitor the safety of both residents.

Later during the day, RN #107 noticed that she did not see both residents in the unit. The RN asked the PSWs working on the unit to search for both residents.

PSW #105 found both residents in a room. Resident #002 and resident #001 were preparing to remove their clothes. The staff, RN #107 and PSW #105, tried to separate both residents but resident #001 became anxious and prevented the staff from entering the room by closing and then holding the door.

Both RN #107 and PSW #105 left the area for a few minutes hoping that the resident would stop holding the door closed. Approximately 45 minutes later, another PSW #111 was able to open the door and found both residents having responsive behaviours of a sexual nature. The residents were separated and brought to their rooms.

On the same day, RN #107, who was in charge of the unit, communicated the incident to the On-call manager, Manager of Resident Care and the Administrator. The RN also implemented a plan to visually monitor resident #001's and resident #002's behaviours. The frequency of the monitoring was not specified. The plan included that if both residents are seeking each other out, further intervention will need to be initiated. RN #107 was to communicate the incident to the other shifts,

ensure ongoing visual monitoring of the residents and to notify the On-Call Manager of any further issues arose.

The following day, Resident #001 and #002 were observed by staff to be together. Staff was able to separate the residents with difficulty.

The next day, PSW #103 observed resident #001 and #002 walking together in the hallway. Both residents went into another room and holding each other. The staff member asked them to leave the room but the residents refused. After several minutes, the PSW was able to persuade the residents to leave the room. This incident was documented in the resident #001's progress notes as a late entry two days later.

Later on during that evening, resident #001 was found by PSW #109 in resident #003's room. Resident #001 was exhibiting responsive behaviours of a sexual nature toward resident's #003. PSW #109 intervened and resident #001 left the room. Resident #003 was noted to be sleeping throughout the incident. PSW #109 reported this incident was communicated to the unit RN.

The next day, PSW #101 observed resident #002 having responsive behaviour of sexual nature toward resident #001 when both residents were sitting in the unit. There was no information found in the health care records related to staff interventions with residents #001 and #002.

Resident #001 has cognitive impairment and other medical health issues. The resident is independently mobile. The resident #001's written plan of care on an identified date, indicated the resident has specified responsive behaviours but not of sexual nature.

The resident's health care record indicates that the resident is being regularly seen by the Geriatric Outreach Nurse-BSO from Royal.

Resident #002 has cognitive impairment and other medical health issues. The resident needs a walker during mobility. Resident #002's current written plan of care on an identified date, indicated that resident has multiple behaviours.

Resident #003 admitted on an identified date was diagnosed with cognitive impairment and other medical health issues.

On September 1, 2016, Inspector #211 noted that resident #001's current plan of care did not indicate that the resident had demonstrated aggressive and sexual behaviors and that there were no identified interventions for these behaviours.

During the inspection, the interviews were as followed:

Interview with PSWs #101 and #102 on an identified date and who work on an identified unit, revealed they were familiar with resident #001 and to their knowledge the resident had never demonstrated sexual responsive behaviours in the past.

Interview with PSW #103 on an identified date, revealed that resident #001 likes to help other residents. When the resident was transfer to the other unit, resident #001 immediately developed signs of friendship with resident #002. Resident #001 was observed to be helping resident #002.

Interview with RN #107 on an identified date, revealed that she saw resident #001 and #002 sitting together in an area in the beginning of a specified shift on an identified date. Both residents were holding hands and looking at each other's eyes. This appeared to be consensual. After supper, RN #107 stated she saw both residents having responsive behaviours of a sexual nature in the hallway. RN #107 stated she informed the staff to monitor both residents since resident #002 can have abusive responsive behaviours. RN #107 indicated to the inspector, that she did not see residents #001 and #002 at a certain time and she immediately asked PSW #105 to search for both residents. RN #107 indicated that both resident #001 and #002 were found in a room by PSW #105. RN #107 reported when she was informed by PSW #105, they both went to the room and found both residents #001 and #002, having responsive behaviours in a sexual nature. They did not assess to determine if these sexual behaviours were consensual. RN #107 stated they tried to separate both residents but every time they were trying to open the door, resident #001 was holding the door. RN #107 revealed that she and PSW #105 left the area for a few minutes hoping that resident #001 would stop holding the door closed.

RN #107 revealed that she sent PSW #111 to supervise resident #001 and #002 while she called the evening coordinator and the On-Call Manager to get directives related to both residents. RN #107 reported that PSW #111 went to see both residents and returned to let her know that she found resident #001 and #002 exhibiting responsive behaviours in a sexual nature in the identified room. RN #107

reported that she informed the evening coordinator/RN #110 related to the sexual behaviours. RN #107 contacted the On-Call manager related to the sexual behaviours between residents #001 and #002. RN #107 also stated she communicated the information to the other shifts relating to the alleged behaviours of a sexual nature and to monitor both residents on the identified date. RN #107 did not determine if the sexual behaviours were consensual.

Interview with PSW #105 on August 31, 2016, indicated to the inspector that on the identified date, he was bringing an identified resident to a room after an identifed time when he found residents #001 and resident #002 together. The other identified resident was adamant to enter the room and it took some time to redirect the resident elsewhere in the interim. PSW #105 stated he went to see the nurse to let her know what was happening between resident #001 and #002. PSW #105 stated that when he returned with RN #107 to the room, they tried to separate both residents. Resident #001 became aggressive. Resident #001 pushed both of them out of the room and slammed the door shut. The PSW and the RN were unable to open the door since resident #001 was holding the door shut. The RN #107 left the scene to call management. PSW #105 indicated that he stayed by the door. A while later, he was able to slightly open the door to ensure there was no violence between both residents. PSW #105 reported that resident #001 and #002 were naked. He did not see any responsive behaviour of sexual nature between both residents. PSW #105 thought that both residents were consenting because there was no violence. PSW #105 revealed that after five minutes, he saw resident #002 getting up from the bed and he was able to enter the room. PSW #105 helped resident #002 to put the clothes and walked the resident back to the room. He saw resident #001 trying to put on the clothes and left the resident in the room. Resident #002 was brought to the room and did not demonstrate aggressive behaviours. Resident #002 was sleeping when he returned to check on the resident wellbeing.

Interview with PSW #111 on September 2, 2016, who indicated she saw resident #001 and #002 exhibiting responsive behaviour of sexual nature on an identified date. She tried to separate them without success. PSW #111 reported when she returned from her break and while walking in the hallway, she saw a door opened slightly and found resident #001 and #002 naked. She saw both residents and she believed that both residents were exhibiting responsive behaviours of a sexual nature. She ran to tell the nurse. PSW #111 did not determine if the behaviours were consensual

Interviews with RN #107, PSW #105 and PSW #111 resulted in providing an approximate time frame for the sequence of events:
• When both residents were found in the room by the PSW #105
• When PSW #105 was able to informed RN #107,
• When RN #107 and PSW #105 went to the room where both residents were found
• When RN #107 left the area to call management, and
• When PSW #105 was able to open the door to monitor both residents
• When PSW #111 found both residents having behaviours of a sexual nature and did not assess if the behaviours were consensual.

In regards of the second incident, PSW #103 on August 31, 2016, revealed she saw resident #001 and #002 on the identified date, walking together in the hallway. Both residents went into another room. They both stood beside the window and were observed to be holding each other. PSW #103 asked them to leave the room but they refused. They sat on the bed, talking and looking through the window. The touching of a sexual nature appeared to be consensual. PSW #103 stated she was able to persuade them to leave the room. PSW #103 confirmed that there was no 1:1 staff supervision on that day.

In regards to the third incident, interview with PSW #109 on September 2, 2016, who discovered resident #001 in resident 003's room, revealed that resident #001 was found having responsive behaviour of sexual nature toward resident #003. Resident #003 was still sleeping and was dressed. PSW #109 stated that resident #001 was surprised when she intervened and questioned the resident as to his/her actions. Resident #001 came out of the room angry. Resident #001 had non-consensual behaviours of sexual touching towards resident #003.

Interview with RN #112 on September 2, 2016, stated resident #001 was not monitored by a one to one staff on that third incident, but they were trying to supervise the resident closely. Interview with RN #110 indicated that the On-Call Manager and the police were not contacted because the staff stopped resident #001 from further non-consensual responsive behaviour of a sexual nature toward resident #003.

Interview with RN #110 on September 2, 2016, indicated that she was told on the above incident at a identified time by RN #112 and the PSW #111 that resident #001 was exhibiting responsive behaviour of sexual nature toward resident #003. RN #110 stated she did not call the On-Call Manager because the staff stopped

resident #001 from exhibiting further responsive behaviour of sexual nature toward resident #003 and resident #003 was sleeping.

Interview with PSW #101 on August 31, 2016, revealed that he saw resident #002 exhibiting behaviour of sexual nature toward resident #001 on an identified date, when both residents were sitting in the identified area in the unit. PSW #101 perceived that the action did not appear to be behaviours of a sexual nature and it was consensual. PSW #101 stated that he heard in the staff report meeting that it was not the first time that resident #002 was exhibiting this kind of behaviour toward resident #001.

Interview with resident #001 on an identified date, revealed that he/she doesn't remember exhibiting responsive behaviours of a sexual nature toward any resident in the home.

Interview with resident #003 on September 2, 2016, stated that he/she does not remember being touched in a sexual nature by another resident in the home.

Interview with the Administrator on September 2, 2016, stated that she was informed that resident #001 was closely monitored by a staff 1:1 after the first alleged sexual incident on an identified date. The Administrator stated she received an email from the manager on-call on that identified date, indicating that resident #001 was being monitored and if residents #001 and #002 are seeking each other out or having behaviours of a sexual nature that further interventions will need to be initiated. The plan was to monitor residents #001 and #002 in the unit and the dining room and to separate both residents if they were found close together. RN #107 was asked to communicate the alleged sexual incident to the other shifts. The Administrator stated she thought that resident #001 was receiving the 1:1 supervision during the identified period after the first incident of alleged sexual behaviours between residents #001 and #002. The Administrator stated that residents' SDM, the MOHLTC and the police force were contacted immediately relating to the first incident on the identified date. The Administrator also reported that both residents don't have the capacity to understand and to provide consent for having behaviours of a sexual nature. The 1:1 supervision was implemented the next day after the third alleged incident of sexual nature between resident #001 and #003.

The Administrator showed Inspector #211 on September 2, 2016, the review of the e-mail titled "Sexual Incident Report between two residents" on an identified date

that was sent by the Administrator asking the On-Call Manager on duty on the first report of alleged sexual behaviour on the above identified date, to confirm if the staff were instructed to put a one on one monitoring. The On-Call Manager email response on the identified date indicated that he left a message the next day of the first alleged sexual incident, for nursing to notify him if both residents were still seeking each other out and having behaviours of a sexual nature and interventions would be reviewed at that time. The above email's information did not indicate any other interventions and the frequency of the monitoring.

The Administrator revealed that the Director was not informed immediately of the third alleged sexual behaviour on an identified date and CIS was not completed related to the alleged incident of sexual abuse from resident #001 to resident #003 because the On-Call Manager was never informed on that day of the incident. The RN responsible of the home during the specified shift on that identified date, should have called the On-Call Manager and contacted the police immediately. The Administrator stated that she forgot to complete the next CIS when she returned to work. The Administrator confirmed that there was no 1:1 staff supervision for resident #001 from the first incident of alleged sexual behaviour until four days later.

Interview with the Administrator on October 13, 2016, indicated resident #001 was evaluated and assessed by the physician and the Geriatric Outreach Nurse after the resident exhibited physical responsive behaviour incident on an identified date. The resident's physical responsive behaviour that was not of sexual nature only happened once.

The Administrator indicated on September 2, 2016, that resident #002 and resident #003 were not protected from resident #001's responsive behaviours of sexual nature from the first incident until four days later, when changes were made to the resident #001's plan of care.

The licensee failed to comply with:
1. LTCHA s. 20 (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #2)

2. 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 #3)

3. 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 #4)

4. 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 #5)

The severity of harm in the above incident was determined to be "actual harm" and the scope was identified as "pattern" as two residents were allegedly sexually abused by resident #001 on two identified dates. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse of residents, and shall ensure that the policy is complied with.

On an identified date, the progress notes indicated that resident #001 was found in resident #003's room. Resident #001 had exhibited behaviour of sexual nature toward resident's #003. Resident #003 was asleep.

Interview with PSW #109 on September 2, 2016 who discovered resident #001 in resident 003's room, revealed that resident #001 was found beside resident's #003's bed. Resident #001 was exhibiting behaviours of a sexual nature toward resident #003. Resident #003 was observed to be sleeping. Resident #001 was removed from the room. This was an incident of non-consensual touching of a sexual nature.

Interview with RN #110 on September 2, 2016, indicated that she was told by RN #112 and the PSW #109 that resident #001 had exhibited behaviour of sexual nature toward resident #003. RN #110 stated she did not call the On-Call Manager because the staff stopped resident #001 from having further sexual behaviour toward resident #003 and did not initiate an assessment of the residents or initiate an investigation into the incident.

Review of the home's policy and procedure #750.65 titled "Abuse" dated February 2016, indicated the following:

- Report immediately any suspicion or allegation of resident abuse to the Charge Nurse (Definition of abuse as per LTCA and appendix A).
- The Charge Nurse will immediately examine the resident.
- Document results of examination.

- Immediately report the allegation to the Administrator and Manager of Resident Care.
- Have a staff member reporting or making the allegation immediately write a report of what they saw or heard.
- The Administrator or delegate must immediately notify
• The Ottawa Police if it is believed that the incident constitutes a criminal offence.
• The Ministry of Health and Long Term Care

The above home's policy also indicated under the section "Duty to Report" that the reporting of any alleged harm, abuse or neglect done to a resident is mandatory. There are two different ways to report abuse or neglect:
1. Internally by telling a charge nurse or manager, as appropriate
2. Directly to the MOHLTC
a. By calling Long-Term Care Action line
b. By sending a written letter, by mail to the Director

Interview with the Administrator confirmed that the above subsequent items of the home's policy were not followed when there was allegation of non-consensual behaviour of a sexual nature by resident #001 towards resident #003 on the identified date. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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:
(a) every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows, or that is reported to the licensee, is immediately investigated,
(b) appropriate action is taken in response to every incident; and
(c) any requirement that are provided for in the regulation for investigating and responding as required under clause (a) and (b) are complied with.

On and identified date, the progress notes indicated that resident #001 was found in resident #003's room. Resident #001 had exhibited responsive of sexual nature toward resident's #003.

Interview with PSW #109 on September 2, 2016 who discovered resident #001 in resident 003's room, revealed that resident #001 was found beside resident's #003's bed. Resident #001 was exhibiting responsive behaviours of a sexual nature toward resident #003. Resident #003 was observed to be sleeping. This was an incident of non-consensual touching of a sexual nature.

Interview with RN #110 on September 2, 2016, indicated that she was told by RN #112 and the PSW #109 that resident #001 had exhibited responsive behaviour of sexual nature toward resident #003. RN #110 stated she did not call the On-Call Manager because the staff stopped resident #001 from exhibiting further responsive behaviour of sexual nature toward resident #003 and did not initiate an assessment of the residents or initiate an investigation into the incident.

The Administrator revealed that RN #110 responsible of the home during the specified shift on the identified date, should have called immediately the On-Call Manager when she was informed by RN #112 and PSW #109 that there was an allegation of sexual behaviour from resident #001 toward resident #003. The home did not take appropriate action in regards of the incident when they were made aware of this allegation of non-consensual touching of a sexual nature by resident #001 towards resident #003. [s. 23. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 when 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.

Inspector #211 reviewed resident #001 and resident #003's health care records documentation and there was no information indicating that the licensee reported immediately to the Director the alleged incident of sexual abuse on and identified date.

Interview with PSW #109 on September 2, 2016 who discovered resident #001 in resident 003's room, revealed that resident #001 was found beside resident's #003's bed. Resident #001' was exhibiting responsive behaviours of a sexual nature toward resident #003. Resident #003 was sleeping at the time.

Interview with RN #110 on September 2, 2016, indicated she did not call the On-Call Manager because the staff stopped resident #001 from exhibiting further responsive behaviour of sexual nature toward resident #003.

The Administrator revealed that the Director was not immediately informed on that identified date, when there was an allegation of non-consensual responsive behaviour of a sexual nature by resident #001 towards resident #003. [s. 24. (1)]

WN #5: 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 is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

On an identified date, there was an incident of alleged sexual abuse when there was non-consensual touching of a sexual nature by resident #001 to resident #003.

Interview with PSW #109 on September 2, 2016 who discovered resident #001 in resident 003's room, revealed that resident #001 was found beside resident's #003's bed. Resident #001's was exhibiting responsive behaviours of a sexual nature toward resident #003. Resident #003 was still sleeping.

Interview with RN #110 on September 2, 2016, indicated that she was told on an identified date by RN #112 and the PSW #109 that resident #001 had exhibited responsive behaviour of sexual nature toward resident #003. RN #110 indicated to the inspector that the police was not called because the staff stopped resident #001 from exhibiting further responsive behaviour of sexual nature toward resident #003 and resident #003 was sleeping.

The Administrator confirmed that the police should have been immediately contacted when the staff found resident #001 exhibited responsive behaviour of sexual nature toward resident #003. [s. 98.]

Issued on this 23 day of December 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA KLUKE (547) - (A1)

Inspection No. / No de l'inspection : 2016_219211_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 026692-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Dec 23, 2016;(A1)

Licensee / Titulaire de permis :
CITY OF OTTAWA
Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2

LTC Home / Foyer de SLD :
CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET, VANIER, ON, K1L-5C6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Louise Bourdon

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To CITY OF OTTAWA, 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. 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 that:

1. prompt action is taken to effectively protect all residents from abuse by resident #001.

2. a person who has reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to the resident, immediately report the suspicion to the Director, under the LTCHA, 2007, as per section 24(1) of the same Act.

2. the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offense

3. every alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee is aware of is immediately investigated.

4. home's written policy to promote zero tolerance of abuse of residents is complied with.

The plan should be submitted in writing by fax to Inspector Joelle Taillefer at 613-569-9670, no later than December 16, 2016.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Sexual abuse is defined by the LTCH, 2007, O.Reg 79/10, s.2 (1) as (a) a consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report (CIS) was submitted to the Director relating to alleged sexual abuse from resident #001 to residents #002 on an identified date. The CIS indicated that staff observed resident #001 and resident #002 exhibiting responsive behaviour in a sexual nature. An inspection was initiated by Inspector # 211 on August 31 2016. A second incident of alleged sexual abuse was identified as having occurred on an identified date during a review of resident #001's health care records. This incident was not reported to the Director.

On August 30 and September 1-2, 2016, Inspector #211 reviewed resident #001's health care records documentation and the sequences of events were as followed:

On an identified date, resident #001's health care records showed that the resident was transferred to an identified unit due two specified responsive behaviours. Resident #001's written plan of care, did not indicate that the resident had any previous physical or sexual responsive behaviours.

On an identified date, the progress notes indicated that resident #001 had an incident of physical responsive behaviour toward an identified nurse. A code white was initiated and the resident was sent to the hospital. The resident returned from the hospital on the same day. The current written plan of care doesn't indicate that the resident had an episode of physical responsive behaviour incident and did not identified any interventions related to this new behaviour.

From an identified period of eight days, the progress notes indicated that resident #001 did not demonstrate any physical responsive behaviours but did indicate that

the resident had another type of responsive behaviour.

On an identified day, resident #001 and #002 were observed exhibiting behaviours of a sexual nature.

The incidents of abuse are as follows:

At the beginning of the identified day, the staff observed resident #001 and #002 walking and holding hands on an identified unit hallway.

After an identified time, the staff observed that both residents were exhibiting behaviours of a sexual nature. A plan was implemented to visually monitor the safety of both residents.

Later during the day, RN #107 noticed that she did not see both residents in the unit. The RN asked the PSWs working on the unit to search for both residents.

PSW #105 found both residents in a room. Resident #002 and resident #001 were preparing to remove their clothes. The staff, RN #107 and PSW #105, tried to separate both residents but resident #001 became anxious and prevented the staff from entering the room by closing and then holding the door.

Both RN #107 and PSW #105 left the area for a few minutes hoping that the resident would stop holding the door closed. Approximately 45 minutes later, another PSW #111 was able to open the door and found both residents having responsive behaviours of a sexual nature. The residents were separated and brought to their rooms.

On the same day, RN #107, who was in charge of the unit, communicated the incident to the On-call manager, Manager of Resident Care and the Administrator. The RN also implemented a plan to visually monitor resident #001's and resident #002's behaviours. The frequency of the monitoring was not specified. The plan included that if both residents are seeking each other out, further intervention will need to be initiated. RN #107 was to communicate the incident to the other shifts, ensure ongoing visual monitoring of the residents and to notify the On-Call Manager of any further issues arose.

The following day, Resident #001 and #002 were observed by staff to be together.

Staff was able to separate the residents with difficulty.

The next day, PSW #103 observed resident #001 and #002 walking together in the hallway. Both residents went into another room and holding each other. The staff member asked them to leave the room but the residents refused. After several minutes, the PSW was able to persuade the residents to leave the room. This incident was documented in the resident #001's progress notes as a late entry two days later.

Later on during that evening, resident #001 was found by PSW #109 in resident #003's room. Resident #001 was exhibiting responsive behaviours of a sexual nature toward resident's #003. PSW #109 intervened and resident #001 left the room. Resident #003 was noted to be sleeping throughout the incident. PSW #109 reported this incident was communicated to the unit RN.

The next day, PSW #101 observed resident #002 having responsive behaviour of sexual nature toward resident #001 when both residents were sitting in the unit. There was no information found in the health care records related to staff interventions with residents #001 and #002.

Resident #001 has cognitive impairment and other medical health issues. The resident is independently mobile. The resident #001's written plan of care on an identified date, indicated the resident has specified responsive behaviours but not of sexual nature.

The resident's health care record indicates that the resident is being regularly seen by the Geriatric Outreach Nurse-BSO from Royal.

Resident #002 has cognitive impairment and other medical health issues. The resident needs a walker during mobility. Resident #002's current written plan of care on an identified date, indicated that resident has multiple behaviours.

Resident #003 admitted on an identified date was diagnosed with cognitive impairment and other medical health issues.

On September 1, 2016, Inspector #211 noted that resident #001's current plan of care did not indicate that the resident had demonstrated aggressive and sexual behaviors and that there were no identified interventions for these behaviours.

During the inspection, the interviews were as followed:

Interview with PSWs #101 and #102 on an identified date and who work on an identified unit, revealed they were familiar with resident #001 and to their knowledge the resident had never demonstrated sexual responsive behaviours in the past.

Interview with PSW #103 on an identified date, revealed that resident #001 likes to help other residents. When the resident was transfer to the other unit, resident #001 immediately developed signs of friendship with resident #002. Resident #001 was observed to be helping resident #002.

Interview with RN #107 on an identified date, revealed that she saw resident #001 and #002 sitting together in an area in the beginning of a specified shift on an identified date. Both residents were holding hands and looking at each other's eyes. This appeared to be consensual. After supper, RN #107 stated she saw both residents having responsive behaviours of a sexual nature in the hallway. RN #107 stated she informed the staff to monitor both residents since resident #002 can have abusive responsive behaviours. RN #107 indicated to the inspector, that she did not see residents #001 and #002 at a certain time and she immediately asked PSW #105 to search for both residents. RN #107 indicated that both resident #001 and #002 were found in a room by PSW #105. RN #107 reported when she was informed by PSW #105, they both went to the room and found both residents #001 and #002, having responsive behaviours in a sexual nature. They did not assess to determine if these sexual behaviours were consensual. RN #107 stated they tried to separate both residents but every time they were trying to open the door, resident #001 was holding the door. RN #107 revealed that she and PSW #105 left the area for a few minutes hoping that resident #001 would stop holding the door closed.

RN #107 revealed that she sent PSW #111 to supervise resident #001 and #002 while she called the evening coordinator and the On-Call Manager to get directives related to both residents. RN #107 reported that PSW #111 went to see both residents and returned to let her know that she found resident #001 and #002 exhibiting responsive behaviours in a sexual nature in the identified room. RN #107 reported that she informed the evening coordinator/RN #110 related to the sexual behaviours. RN #107 contacted the On-Call manager related to the sexual behaviours between residents #001 and #002. RN #107 also stated she communicated the information to the other shifts relating to the alleged behaviours of

a sexual nature and to monitor both residents on the identified date. RN #107 did not determine if the sexual behaviours were consensual.

Interview with PSW #105 on August 31, 2016, indicated to the inspector that on the identified date, he was bringing an identified resident to a room after an identifed time when he found residents #001 and resident #002 together. The other identified resident was adamant to enter the room and it took some time to redirect the resident elsewhere in the interim. PSW #105 stated he went to see the nurse to let her know what was happening between resident #001 and #002. PSW #105 stated that when he returned with RN #107 to the room, they tried to separate both residents. Resident #001 became aggressive. Resident #001 pushed both of them out of the room and slammed the door shut. The PSW and the RN were unable to open the door since resident #001 was holding the door shut. The RN #107 left the scene to call management. PSW #105 indicated that he stayed by the door. A while later, he was able to slightly open the door to ensure there was no violence between both residents. PSW #105 reported that resident #001 and #002 were naked. He did not see any responsive behaviour of sexual nature between both residents. PSW #105 thought that both residents were consenting because there was no violence. PSW #105 revealed that after five minutes, he saw resident #002 getting up from the bed and he was able to enter the room. PSW #105 helped resident #002 to put the clothes and walked the resident back to the room. He saw resident #001 trying to put on the clothes and left the resident in the room. Resident #002 was brought to the room and did not demonstrate aggressive behaviours. Resident #002 was sleeping when he returned to check on the resident wellbeing.

Interview with PSW #111 on September 2, 2016, who indicated she saw resident #001 and #002 exhibiting responsive behaviour of sexual nature on an identified date. She tried to separate them without success. PSW #111 reported when she returned from her break and while walking in the hallway, she saw a door opened slightly and found resident #001 and #002 naked. She saw both residents and she believed that both residents were exhibiting responsive behaviours of a sexual nature. She ran to tell the nurse. PSW #111 did not determine if the behaviours were consensual

Interviews with RN #107, PSW #105 and PSW #111 resulted in providing an approximate time frame for the sequence of events:
• When both residents were found in the room by the PSW #105
• When PSW #105 was able to informed RN #107,

• When RN #107 and PSW #105 went to the room where both residents were found
• When RN #107 left the area to call management, and
• When PSW #105 was able to open the door to monitor both residents
• When PSW #111 found both residents having behaviours of a sexual nature and did not assess if the behaviours were consensual.

In regards of the second incident, PSW #103 on August 31, 2016, revealed she saw resident #001 and #002 on the identified date, walking together in the hallway. Both residents went into another room. They both stood beside the window and were observed to be holding each other. PSW #103 asked them to leave the room but they refused. They sat on the bed, talking and looking through the window. The touching of a sexual nature appeared to be consensual. PSW #103 stated she was able to persuade them to leave the room. PSW #103 confirmed that there was no 1:1 staff supervision on that day.

In regards to the third incident, interview with PSW #109 on September 2, 2016, who discovered resident #001 in resident 003's room, revealed that resident #001 was found having responsive behaviour of sexual nature toward resident #003. Resident #003 was still sleeping and was dressed. PSW #109 stated that resident #001 was surprised when she intervened and questioned the resident as to his/her actions. Resident #001 came out of the room angry. Resident #001 had non-consensual behaviours of sexual touching towards resident #003.

Interview with RN #112 on September 2, 2016, stated resident #001 was not monitored by a one to one staff on that third incident, but they were trying to supervise the resident closely. Interview with RN #110 indicated that the On-Call Manager and the police were not contacted because the staff stopped resident #001 from further non-consensual responsive behaviour of a sexual nature toward resident #003.

Interview with RN #110 on September 2, 2016, indicated that she was told on the above incident at a identified time by RN #112 and the PSW #111 that resident #001 was exhibiting responsive behaviour of sexual nature toward resident #003. RN #110 stated she did not call the On-Call Manager because the staff stopped resident #001 from exhibiting further responsive behaviour of sexual nature toward resident #003 and resident #003 was sleeping.

Interview with PSW #101 on August 31, 2016, revealed that he saw resident #002

exhibiting behaviour of sexual nature toward resident #001 on an identified date, when both residents were sitting in the identified area in the unit. PSW #101 perceived that the action did not appear to be behaviours of a sexual nature and it was consensual. PSW #101 stated that he heard in the staff report meeting that it was not the first time that resident #002 was exhibiting this kind of behaviour toward resident #001.

Interview with resident #001 on an identified date, revealed that he/she doesn't remember exhibiting responsive behaviours of a sexual nature toward any resident in the home.

Interview with resident #003 on September 2, 2016, stated that he/she does not remember being touched in a sexual nature by another resident in the home.

Interview with the Administrator on September 2, 2016, stated that she was informed that resident #001 was closely monitored by a staff 1:1 after the first alleged sexual incident on an identified date. The Administrator stated she received an email from the manager on-call on that identified date, indicating that resident #001 was being monitored and if residents #001 and #002 are seeking each other out or having behaviours of a sexual nature that further interventions will need to be initiated. The plan was to monitor residents #001 and #002 in the unit and the dining room and to separate both residents if they were found close together. RN #107 was asked to communicate the alleged sexual incident to the other shifts. The Administrator stated she thought that resident #001 was receiving the 1:1 supervision during the identified period after the first incident of alleged sexual behaviours between residents #001 and #002. The Administrator stated that residents' SDM, the MOHLTC and the police force were contacted immediately relating to the first incident on the identified date. The Administrator also reported that both residents don't have the capacity to understand and to provide consent for having behaviours of a sexual nature. The 1:1 supervision was implemented the next day after the third alleged incident of sexual nature between resident #001 and #003.

The Administrator showed Inspector #211 on September 2, 2016, the review of the e-mail titled "Sexual Incident Report between two residents" on an identified date that was sent by the Administrator asking the On-Call Manager on duty on the first report of alleged sexual behaviour on the above identified date, to confirm if the staff were instructed to put a one on one monitoring. The On-Call Manager email response on the identified date indicated that he left a message the next day of the first alleged

sexual incident, for nursing to notify him if both residents were still seeking each other out and having behaviours of a sexual nature and interventions would be reviewed at that time. The above email's information did not indicate any other interventions and the frequency of the monitoring.

The Administrator revealed that the Director was not informed immediately of the third alleged sexual behaviour on an identified date and CIS was not completed related to the alleged incident of sexual abuse from resident #001 to resident #003 because the On-Call Manager was never informed on that day of the incident. The RN responsible of the home during the specified shift on that identified date, should have called the On-Call Manager and contacted the police immediately. The Administrator stated that she forgot to complete the next CIS when she returned to work. The Administrator confirmed that there was no 1:1 staff supervision for resident #001 from the first incident of alleged sexual behaviour until four days later.

Interview with the Administrator on October 13, 2016, indicated resident #001 was evaluated and assessed by the physician and the Geriatric Outreach Nurse after the resident exhibited physical responsive behaviour incident on an identified date. The resident's physical responsive behaviour that was not of sexual nature only happened once.

The Administrator indicated on September 2, 2016, that resident #002 and resident #003 were not protected from resident #001's responsive behaviours of sexual nature from the first incident until four days later, when changes were made to the resident #001's plan of care.

The licensee failed to comply with:
1. LTCHA s. 20 (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #2)

2. 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 #3)

3. 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 #4)

4. 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 #5)

The severity of harm in the above incident was determined to be "actual harm" and the scope was identified as "pattern" as two residents were allegedly sexually abused by resident #001 on two identified dates. [s. 19. (1)] (211)

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

Jan 31, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 23 day of December 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA KLUKE - (A1)

Service Area Office /
Bureau régional de services : Ottawa