Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 9, 2015	2015_235507_0019	026767-15	Critical Incident System

Licensee/Titulaire de permis

THE KENSINGTON HEALTH CENTRE
25 BRUNSWICK AVENUE TORONTO ON M5S 2L9

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

THE KENSINGTON GARDENS
25 BRUNSWICK AVENUE TORONTO ON M5S 2L9

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

STELLA NG (507)

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): September 29, 30, October 1 and 2, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Resident Care (DORC), Nurse Manager (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Attendants (PCAs), Social Worker (SW), and substitute decision maker (SDM).

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to protect a resident from sexual abuse from another resident.

In accordance with the definition identified in subsection 2(1) of the Act, sexual abuse includes 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) Review of the progress notes of an identified resident and interviews with identified staff revealed the resident had a history of inappropriate sexual behaviours towards other residents and staff.

Review of the progress notes of a second identified resident and interviews with identified staff, revealed that the resident understands simple English and required assistance for transfer.

Observations conducted on an identified date, and interview with an identified staff confirmed that both residents share the same washroom, and both could access the washroom through the door from their respective rooms. Both washroom doors can be locked from inside.

b) Review of the progress notes for both above mentioned residents, and interview with an identified staff, revealed that on an identified date, the identified staff went to the second identified resident's room and the resident was not in the room at the time. The identified Staff tried to open the washroom door from the second identified resident's room and found the washroom door was locked. The identified staff went to the first identified resident's room and was able to open the washroom door from the first identified resident's room. When the washroom door was open, the identified staff observed the first identified resident came out of the washroom and the second identified resident was standing by the sink.

Interview with another identified staff revealed that the first identified resident stated that the second identified resident spent a long time in the washroom and he/she needed to use the washroom. As a result, the first identified resident entered the washroom without waiting for it to be vacant. The identified staff further revealed that the second identified resident was not asked what happened while both residents were in the washroom because no staff member working on the unit on that day speaks the resident's primary language. The identified staff further revealed that he/she found the situation suspicious, although he/she did not witness any wrong doing of the first identified resident. Interview with another identified staff revealed that he/she was informed by the first identified staff of the above mentioned incident, and the first identified staff found the situation

suspicious. The second identified staff further revealed that he/she did not report to the manager on-call as required by the home's "Abuse and Neglect" policy (M1-010, revised June 2014). The second identified staff confirmed that the Ministry and the police were not notified of the incident as required under the Act.

Interviews with the DORC and the Social Worker revealed that they became aware of the above mentioned incident two days later, and confirmed that no follow up actions were taken or interventions were implemented except reminding the first identified resident to be respectful of other residents' privacy.

c) Review of the progress notes for the above mentioned residents and interview with an identified staff revealed that on another identified date, two weeks after the above mentioned incident, the identified staff observed the second identified resident went to the washroom, and the identified staff told the resident he/she would assist the resident for transfer after assisting another resident for toileting. A few minutes later, the identified staff entered the second identified resident's room and opened the washroom door. When the washroom door was open, the identified staff observed the second identified resident was sitting on the toilet and the first identified resident was standing in front of the second identified resident. The identified staff asked the first identified resident what he/she was doing, and the first identified resident left the washroom.

Review of the progress notes for the second identified resident and interview with an identified Nurse Manager revealed that the second identified resident was interviewed by staff with the assistance of an interpreter after the incident. During the interview, the second identified resident revealed that the first identified resident attempted to grab him/her, and the second identified resident was able to push the first identified resident away. The second identified resident further revealed that the first identified resident attempted to engage him/her in sexual behaviour. In addition, the first identified resident had similar attempt to the second identified resident two weeks prior.

Review of the progress notes for the first identified resident and interview with the DORC confirmed that the police were notified on the same day of the above mentioned incident. The identified DORC revealed that staff were aware of the first identified resident's inappropriate sexual behaviours towards resident and staff, and they did not realize the second identified resident could be at risk. The identified DORC also confirmed that the home did not aware of the possible sexual abuse would have occurred two weeks prior, and no interventions were taken to prevent recurrence.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
There was a lack of follow up actions to ensure the prevention of recurrence of sexual abuse to the second identified resident by resident the first identified.

The scope of the non-compliance is isolated to the first identified Resident.

There was no past history on non-compliance. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

a) Review of the progress notes of an identified resident and interviews with identified staff revealed the resident had a history of inappropriate sexual behaviours towards other

residents and staff.

Review of the progress notes of a second identified resident and interviews with identified staff, revealed that the resident understands simple English and required assistance for transfer.

Observations conducted on an identified date, and interview with an identified staff confirmed that both residents share the same washroom, and both could access the washroom through the door from their respective rooms. Both washroom doors can be locked from inside.

b) Review of the progress notes for both above mentioned residents, and interview with an identified staff, revealed that on an identified date, the identified staff went to the second identified resident's room and the resident was not in the room at the time. The identified Staff tried to open the washroom door from the second identified resident's room and found the washroom door was locked. The identified staff went to the first identified resident's room and was able to open the washroom door from the first identified resident's room. When the washroom door was open, the identified staff observed the first identified resident came out of the washroom and the second identified resident was standing by the sink.

Interview with another identified staff revealed that the first identified resident stated that the second identified resident spent a long time in the washroom and he/she needed to use the washroom. As a result, the first identified resident entered the washroom without waiting for it to be vacant. The identified staff further revealed that the second identified resident was not asked what happened while both residents were in the washroom because no staff member working on the unit on that day speaks the resident's primary language. The identified staff further revealed that he/she found the situation suspicious, although he/she did not witness any wrong doing of the first identified resident. Interview with another identified staff revealed that he/she was informed by the first identified staff of the above mentioned incident, and the first identified staff found the situation suspicious. The second identified staff further revealed that he/she did not initiate an investigation as required under the Act.

Interviews with the DORC and Social Worker revealed that they became aware of the first incident two days after it occurred, and confirmed that no investigation was conducted regarding the above mentioned incident. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #3: 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 :

The licensee failed to ensure that when a person who has reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur must immediately report the suspicion and the information upon which it is based to the Director.

a) Review of the progress notes of an identified resident and interviews with identified staff revealed the resident had a history of inappropriate sexual behaviours towards other residents and staff.

Review of the progress notes of a second identified resident and interviews with identified staff, revealed that the resident understands simple English and required assistance for transfer.

Observations conducted on an identified date, and interview with an identified staff confirmed that both residents share the same washroom, and both could access the washroom through the door from their respective rooms. Both washroom doors can be locked from inside.

b) Review of the progress notes for both above mentioned residents, and interview with an identified staff, revealed that on an identified date, the identified staff went to the second identified resident's room and the resident was not in the room at the time. The identified Staff tried to open the washroom door from the second identified resident's room and found the washroom door was locked. The identified staff went to the first identified resident's room and was able to open the washroom door from the first identified resident's room. When the washroom door was open, the identified staff observed the first identified resident came out of the washroom and the second identified resident was standing by the sink.

Interview with another identified staff revealed that the first identified resident stated that the second identified resident spent a long time in the washroom and he/she needed to use the washroom. As a result, the first identified resident entered the washroom without waiting for it to be vacant. The identified staff further revealed that the second identified resident was not asked what happened while both residents were in the washroom because no staff member working on the unit on that day speaks the resident's primary language. The identified staff further revealed that he/she found the situation suspicious, although he/she did not witness any wrong doing of the first identified resident. Interview with another identified staff revealed that he/she was informed by the first identified staff of the above mentioned incident, and the first identified staff found the situation suspicious. The second identified staff further revealed that he/she did not report the incident to the Ministry as required under the Act.

Interviews with the DORC revealed that he/she became aware of the first above mentioned incident two days after it occurred. The home did not see the incident as sexual abuse. and the incident was not reported to the Ministry as required. The home decided to report to the Ministry after the second similar incident occurred two weeks later involved both identified residents. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a person who has reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or a risk of aharm to the resident has occurred or may occur must immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: 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 :

The licensee failed to ensure that 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 offence.

a) Review of the progress notes of an identified resident and interviews with identified staff revealed the resident had a history of inappropriate sexual behaviours towards other residents and staff.

Review of the progress notes of a second identified resident and interviews with identified staff, revealed that the resident understands simple English and required assistance for transfer.

Observations conducted on an identified date, and interview with an identified staff confirmed that both residents share the same washroom, and both could access the washroom through the door from their respective rooms. Both washroom doors can be locked from inside.

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Interview with another identified staff revealed that the first identified resident stated that the second identified resident spent a long time in the washroom and he/she needed to use the washroom. As a result, the first identified resident entered the washroom without waiting for it to be vacant. The identified staff further revealed that the second identified resident was not asked what happened while both residents were in the washroom because no staff member working on the unit on that day speaks the resident's primary language. The identified staff further revealed that he/she found the situation suspicious, although he/she did not witness any wrong doing of the first identified resident. Interview with another identified staff revealed that he/she was informed by the first identified staff of the above mentioned incident, and the first identified staff found the situation suspicious. The second identified staff further revealed that he/she did not notify the police as required under the Act.

Interviews with the DORC revealed that he/she became aware of the first above mentioned incident two days after it occurred. The home did not see the incident as sexual abuse, and the police were not notified as required. The home decided to notify the police after the second similar incident occurred two weeks later involved the two identified residents. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 offence, to be implemented voluntarily.

Issued on this 22nd day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2015_235507_0019
Log No. / Registre no:	026767-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 9, 2015
Licensee / Titulaire de permis :	THE KENSINGTON HEALTH CENTRE 25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9
LTC Home / Foyer de SLD :	THE KENSINGTON GARDENS 25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William O'Neill

To THE KENSINGTON HEALTH CENTRE, 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 that all residents are protected from sexual abuse. The plan shall include, but not be limited to the following:

1) The development and implementation of a system of ongoing monitoring to ensure staff comply with the processes developed by the home to ensure all residents are protected from sexual abuse.
2) Ensuring education is provided to all staff including the definitions and different types of sexual abuse to ensure that all staff are able to identify signs of possible sexual abuse, and
3) The development and implementation of a process that clearly describes how and when staff who are responsible for investigating and reporting incidents of alleged sexual abuse, take the appropriate actions as required under the Act and Regulation.

This plan is to be submitted via email to inspector - stella.ng@ontario.ca by November 30, 2015.

Grounds / Motifs :

1. The licensee failed to protect a resident from sexual abuse from another resident.

In accordance with the definition identified in subsection 2(1) of the Act, sexual abuse includes 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) Review of the progress notes of an identified resident and interviews with identified staff revealed the resident had a history of inappropriate sexual behaviours towards other residents and staff.

Review of the progress notes of a second identified resident and interviews with identified staff, revealed that the resident understands simple English and required assistance for transfer.

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b) Review of the progress notes for both above mentioned residents, and interview with an identified staff, revealed that on an identified date, the identified staff went to the second identified resident's room and the resident was not in the room at the time. The identified Staff tried to open the washroom door from the second identified resident's room and found the washroom door was locked. The identified staff went to the first identified resident's room and was able to open the washroom door from the first identified resident's room. When the washroom door was open, the identified staff observed the first identified resident came out of the washroom and the second identified resident was standing by the sink.

Interview with another identified staff revealed that the first identified resident stated that the second identified resident spent a long time in the washroom and he/she needed to use the washroom. As a result, the first identified resident entered the washroom without waiting for it to be vacant. The identified staff further revealed that the second identified resident was not asked what happened while both residents were in the washroom because no staff member working on the unit on that day speaks the resident's primary language. The identified staff further revealed that he/she found the situation suspicious, although he/she did not witness any wrong doing of the first identified resident. Interview with another identified staff revealed that he/she was informed by the first identified staff of the above mentioned incident, and the first identified staff found the situation suspicious. The second identified staff further revealed that he/she did not report to the manager on-call as required by the home's "Abuse and Neglect" policy (M1-010, revised June 2014). The second identified staff confirmed that the Ministry and the police were not notified of the incident as

required under the Act.

Interviews with the DORC and the Social Worker revealed that they became aware of the above mentioned incident two days later, and confirmed that no follow up actions were taken or interventions were implemented except reminding the first identified resident to be respectful of other residents' privacy.

c) Review of the progress notes for the above mentioned residents and interview with an identified staff revealed that on another identified date, two weeks after the above mentioned incident, the identified staff observed the second identified resident went to the washroom, and the identified staff told the resident he/she would assist the resident for transfer after assisting another resident for toileting. A few minutes later, the identified staff entered the second identified resident's room and opened the washroom door. When the washroom door was open, the identified staff observed the second identified resident was sitting on the toilet and the first identified resident was standing in front of the second identified resident. The identified staff asked the first identified resident what he/she was doing, and the first identified resident left the washroom.

Review of the progress notes for the second identified resident and interview with an identified Nurse Manager revealed that the second identified resident was interviewed by staff with the assistance of an interpreter after the incident. During the interview, the second identified resident revealed that the first identified resident attempted to grab him/her, and the second identified resident was able to push the first identified resident away. The second identified resident further revealed that the first identified resident attempted to engage him/her in sexual behaviour. In addition, the first identified resident had similar attempt to the second identified resident two weeks prior.

Review of the progress notes for the first identified resident and interview with the DORC confirmed that the police were notified on the same day of the above mentioned incident. The identified DORC revealed that staff were aware of the first identified resident's inappropriate sexual behaviours towards resident and staff, and they did not realize the second identified resident could be at risk. The identified DORC also confirmed that the home did not aware of the possible sexual abuse would have occurred two weeks prior, and no interventions were taken to prevent recurrence.

The severity of the non-compliance and the severity of the harm and risk of

further harm is actual.
There was a lack of follow up actions to ensure the prevention of recurrence of sexual abuse to the second identified resident by resident the first identified.

The scope of the non-compliance is isolated to the first identified Resident.

There was no past history on non-compliance.

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 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 9th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : STELLA NG

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