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 sions de longue durée

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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
May 20, 2016;	2016_179103_0002 (A1)	003851-14, 006873-14, 007152-14, 000525-15, 001107-15	Critical Incident System

Licensee/Titulaire de permis

TRILOGY LTC INC.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

TRILOGY LONG TERM CARE
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

BARBARA PARISOTTO (558) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date has been changed from May 27, 2016 to June 30, 2016.

Issued on this 20 day of May 2016 (A1)

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

Original report signed by the inspector.

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

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340 McCowan Road SCARBOROUGH ON M1J 3P4

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

BARBARA PARISOTTO (558) - (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): April 4-8, 11-13, 2016

The following logs were included in this inspection: 003851-14 (transfer to hospital for injuries of unknown origin), 006873-14 (alleged staff to resident verbal abuse), 007152-14 (alleged staff to resident verbal abuse), 000525-15 (alleged resident to resident abuse), 001107-15 (alleged resident to resident sexual abuse).

During the course of the inspection, the inspector(s) spoke with residents, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal support workers (PSW), the Assistant Director of Care (ADOC) and the Administrator.

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The following finding relates to Logs #006873-14, #007152-14, #000525-15 and #001107-15:

The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents includes all of the required content in accordance with the legislation.

The home's abuse policy was reviewed, titled “Resident abuse-Abuse Prevention Program-Whistle Blowing Protection”, #LTC-CA-ALL-100-05-02, last revised on October 9, 2014.

The abuse policy fails to define all forms of abuse (emotional, financial, physical, sexual and verbal) in accordance with the legislated definitions outlined in O. Reg 79/10, s. 2(1). In addition, the definitions fail to distinguish between abuse as the result of a resident or staff member.

LTCHA, 2007, s. 20 (2) (d) indicates the zero tolerance of abuse policy shall contain

an explanation of the duty under section 24 to make mandatory reports.

LTCHA, 2007, s. 24, indicates "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 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 risk of harm to the resident,
3. Unlawful conduct that resulted in harm or risk of harm to a resident,
4. Misuse or misappropriation of a residents' money
5. Misuse or misappropriation of funding provided to the licensee under this Act or the Local Health System Integration Act, 2006.

The home's policy does not outline the above explanation of the duty to make mandatory reports under the LTCHA, 2007, s. 24. As outlined in the legislation.

The home's abuse policy fails to provide direction regarding the notification of the police in accordance with the legislated requirements.

O. Reg 79/10, s. 98 states that "every licensee of a long term care home shall ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence".

The home's abuse policy fails to provide direction regarding the notification of the Substitute Decision Maker (SDM) in accordance with the legislated requirements.

O. Reg 79/10, s. 97 (1) states, "every licensee of a long term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident",

a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

LTCHA, 2007, s. 20 (2) (f) states the zero tolerance of abuse policy shall "set out consequences for those who abuse or neglect residents. The home's policy in regards to the consequences is not clearly defined.

LTCHA, 2007, s. 76 (2) (3) and s. 76 (2) (4) states "every licensee shall ensure that no person shall perform their responsibilities before receiving training in the long term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24.

The home's policy indicates "in urgent situations" staff may work and be provided with the education within seven working days which is contrary to the legislation.

The above does not constitute a complete list of areas whereby the home's abuse policy is not in accordance with the legislated requirements. [s. 20. (2)]

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. 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 following finding relates to Log #007152-14:

The licensee has failed to ensure that an alleged incident of verbal abuse was immediately reported to the Director.

O. Reg 79/10, s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The home submitted a critical incident to report an incident of alleged staff to resident verbal abuse. The report indicated on an identified date, RPN #101 witnessed PSW #100 speaking to resident #003 in a loud and disrespectful manner. The RPN that witnessed the incident did not immediately report it to the Director. The RPN reported the incident to the home's management team four days later. [s. 24. (1)]

2. The following finding relates to Log #006873-14:

The licensee has failed to ensure that an alleged incident of staff to resident verbal abuse was immediately reported to the Director.

The home submitted a critical incident on an identified date to report an alleged staff to resident verbal abuse. The critical incident indicated resident #002 spoke with the home's ADOC on an identified date and that the resident was able to identify the PSW. This alleged verbal abuse was not reported to the Director until five days following the resident's discussion with the ADOC. [s. 24. (1)]

3. The following finding relates to Log 000525-15:

The licensee has failed to ensure that a witnessed incident of resident to resident sexual abuse was immediately reported to the Director.

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

The home submitted a critical incident indicating on an identified date, RPN #104 overheard resident #004 making sexual comments in the common room. The RPN entered the room and witnessed resident #004 inappropriately touching resident #007. The RPN requested that staff remove resident #004 from the common area, but did not report this incident to the RN in charge. Resident #007's health care record was reviewed and indicated the resident had an impaired ability to express them self and to understand others. Resident #007 was incapable of giving consent to resident #004's actions.

The following evening, RN #103 became aware of the incident and reported it to the MOHLTC after hours pager. [s. 24. (1)]

4. The following finding relates to Log #001107-15:

The home submitted a critical incident indicating on an identified date, a PSW working with the behavioural support team witnessed an incident whereby resident #005 was seen inappropriately touching resident #006. Resident #006 had a cognitive impairment and was deemed unable to provide consent to resident #005's actions. The PSW intervened by separating the residents and reported the incident to RPN #106. The RPN failed to report the incident to the RN in charge.

DOC #105 became aware of this incident seven days later during the behavioural support rounds and also became aware of a second incident between resident #005 and #006 which had occurred approximately seven weeks earlier .

The DOC did not report the two incidents of witnessed sexual abuse until two days after being made aware of the incidents. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following finding relates to Log #007152-14:

The licensee has failed to ensure the resident's substitute decision maker (SDM) was notified within twelve hours of becoming aware of an alleged incident of verbal abuse.

As outlined in WN #2, RPN #101 witnessed an alleged incident of verbal abuse involving resident #003. The incident was reported to management on an identified date.

The resident's SDM was not notified by the home of the alleged verbal abuse until two days later. [s. 97. (1) (b)]

2. The following finding relates to Log #006873-14:

The licensee has failed to ensure that the resident's SDM was notified within 12 hours of becoming aware of an alleged staff to resident abuse.

As per WN #3, the home became aware of an alleged staff to resident verbal abuse on an identified date. The critical incident indicated the SDM was not notified because resident #002 was their own power of attorney. However, during a review of the resident health care record, this inspector noted that the resident's SDM had been notified of two unrelated incidents that also occurred on the same date and there was no indication the resident had declined to have the SDM notified of the alleged abuse. [s. 97. (1) (b)]

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 :

1. The following finding relates to Log #001107-15:

The licensee has failed to ensure that the appropriate police force was immediately notified of a witnessed resident to resident sexual abuse.

As outlined in WN #3, upon becoming aware of the two witnessed incidents of resident to resident sexual abuse on an identified date, the home failed to immediately report these incidents to the police. [s. 98.]

2. The following finding relates to Log #000525-15:

The licensee has failed to ensure that the appropriate police force was immediately notified of a witnessed resident to resident sexual abuse.

As outlined in WN #3, upon becoming aware of the witnessed incident of resident to resident sexual abuse, the home did not immediately report the incident to the police. [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The following finding relates to Log #006873-14:

The licensee has failed to ensure that the report submitted to the Director in regards to an alleged verbal abuse included the names of any staff members who were present at or discovered the incident.

On an identified date, the home submitted a critical incident to report an alleged staff to resident verbal abuse. The critical incident failed to identify the staff member's full name that was the alleged abuser in the incident. Additionally, the report indicated an RPN was aware of the incident but failed to indicate the staff member's full name. [s. 104. (1) 2.]

Issued on this 20 day of May 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : BARBARA PARISOTTO (558) - (A1)

Inspection No. / No de l'inspection : 2016_179103_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 003851-14, 006873-14, 007152-14, 000525-15, 001107-15 (A1)

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

Report Date(s) / Date(s) du Rapport : May 20, 2016;(A1)

Licensee / Titulaire de permis : TRILOGY LTC INC.
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD : TRILOGY LONG TERM CARE
340 McCowan Road, SCARBOROUGH, ON, M1J-3P4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : MARVA GRIFFITH

To TRILOGY LTC INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

(A1)
The licensee is hereby ordered to ensure the home s abuse policy, titled "Resident abuse-Abuse Prevention Program-Whistle Blowing Protection", #LTC-CA-ALL-100-05-02, includes at a minimum, the requirements outlined in LTCHA, 2007, s.20 (2).

Additionally, the home s abuse policy must accurately reflect the legislated requirements for:

-notification of the resident s substitute decision-maker, if any and any other person specified by the resident as outlined in O. Reg 79 10, s. 97,

-police notification as outlined in O. Reg 79 10, s. 98,

-staff training as outlined in LTCHA, 2007, s. 76 (2) and

-ensure the policy accurately reflects the definitions of all forms of abuse including emotional, financial, physical, sexual and verbal abuse and neglect as defined by O. Reg 79 10, s. 2 (1), s. 2 (2) and s. 2 (5).

Grounds / Motifs :

1. The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents includes all of the required content in accordance with the legislation.

The home's abuse policy was reviewed, titled "Resident abuse-Abuse Prevention Program-Whistle Blowing Protection", #LTC-CA-ALL-100-05-02, last revised on October 9, 2014.

The abuse policy fails to define all forms of abuse (emotional, financial, physical, sexual and verbal) in accordance with the legislated definitions outlined in O. Reg 79/10, s. 2(1). In addition, the definitions fail to distinguish between abuse as the result of a resident or staff member.

LTCHA, 2007, s. 20 (2) (d) indicates the zero tolerance of abuse policy shall contain an explanation of the duty under section 24 to make mandatory reports.

LTCHA, 2007, s. 24, indicates "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 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 risk of harm to the resident,
3. Unlawful conduct that resulted in harm or risk of harm to a resident,
4. Misuse or misappropriation of a residents' money
5. Misuse or misappropriation of funding provided to the licensee under this Act or the Local Health System Integration Act, 2006.

The home's policy does not outline the above explanation of the duty to make mandatory reports under the LTCHA, 2007, s. 24. As outlined in the legislation.

The home's abuse policy fails to provide direction regarding the notification of the police in accordance with the legislated requirements.

O. Reg 79/10, s. 98 states that "every licensee of a long term care home shall ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence".

The home's abuse policy fails to provide direction regarding the notification of the Substitute Decision Maker (SDM) in accordance with the legislated requirements.

O. Reg 79/10, s. 97 (1) states, "every licensee of a long term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident",

a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

LTCHA, 2007, s. 20 (2) (f) states the zero tolerance of abuse policy shall "set out

consequences for those who abuse or neglect residents. The home's policy in regards to the consequences is not clearly defined.

LTCHA, 2007, s. 76 (2) (3) and s. 76 (2) (4) states “every licensee shall ensure that no person shall perform their responsibilities before receiving training in the long term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24.

The home's policy indicates “in urgent situations” staff may work and be provided with the education within seven working days which is contrary to the legislation.

The above does not constitute a complete list of areas whereby the home's abuse policy is not in accordance with the legislated requirements.

This inspector determined this non compliance required a compliance order based on the following:
-all four critical incidents related to abuse that were inspected as a part of this report (Log # 006873-14, 007152-14, 000525-15 and 001107-15) had identified non compliances related to the reporting of the abuse to MOHLTC, police and SDM. (severity-potential for risk of harm), and
-the home's abuse policy affects all residents living in the long term care home (scope-widespread) (103)

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

Jun 30, 2016(A1)

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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 sions 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

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 sions 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 20 day of May 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : BARBARA PARISOTTO - (A1)

Service Area Office / Bureau régional de services : Toronto