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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 25, 2014	2013_215123_0020	H-001500-12,H-000634-13	Critical Incident System

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave, HAMILTON, ON, L9C-7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue, HAMILTON, ON, L9C-7W9

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

MELODY GRAY (123)

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): November 13, 14, 15, 18, 19, 20, 22 and 26, 2013

Concurrent Inspections: H-001372-12, H-000672-13

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, housekeeping staff, dietary staff, registered staff and management team members including the Administrator and Directors of Care.

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed the residents' records, observed residents, observed resident-to-resident interactions and observed staff-to-resident interactions.

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

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Previously issued as VPC on June 17, 2013

The licensee did not ensure that the following rights of residents are fully respected and promoted: (2.) Every resident has the right to be protected from abuse.
The home's records and the records of identified residents #003, #004, #005, #006, #007, #009, #0010, #0011, #0012 were reviewed. It was noted that in July, 2012 an identified resident #005 was physically abused by an identified resident #006. The resident #006 entered the room of resident #005. When resident #005 asked resident #006 to leave their room, resident #006 hit resident #005 which resulted in injury to resident #005.
The home's records and the residents' records also noted that on multiple occasions, from April, 2013 through September, 2013 the identified resident #007 sexually abused other co-residents including residents #009, #0010, #0011 and #0012.
It is also documented that the identified resident #007 sexually abused the identified resident #004 in September, 2013 who displayed a negative response to being touched.
Front line staff and management team members were interviewed and confirmed the sexual abuse of the female co-residents by resident #007 from April, 2013 through September, 2013.
The licensee did not ensure that every resident was protected from abuse. [s. 3. (1) 2.]

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. 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. Previously issued as VPC on June 17, 2013

The licensee failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with. The home's policy Non-Abuse of Residents #2-60 was reviewed and the information included that: All incidents of alleged, suspected or witnessed resident abuse or neglect must be reported immediately to the Nurse in charge; The nurse in charge must immediately report to a member of the leadership team; Choose the appropriate Abuse Decision Tree to determine if communication with the Ministry of Health and Long-Term Care (MOHLTC) is needed and if so, when and how to communicate this information; Using the information from the decision tree, initiate the Critical Incident System (CIS) report or if after hours call the MOHLTC emergency on call pager; The resident's substitute decision-maker will be made aware immediately of an alleged, suspected or witnessed incident of an alleged, suspected or witnessed incident of abuse; Contact or leave a message for the Resident Advisor to inform of the alleged, suspected, or witnessed abuse and that the resident who has been a victim of abuse will be visited by the Resident Advisor or delegate on the next business day.
The home's records were reviewed and it was noted that in September, 2013 the identified resident #007 sexually abused identified resident #004. The review of the home's records indicated that the identified residents #008, #009, #0010, #0011 and #0012 were identified by the home as suspected victims of sexual abuse by resident #007. The residents' records were reviewed and documentation was found related to the incidents of sexual abuse of identified residents #004, #009, #0010, #0011, #0012 and other residents by the identified resident #007. The review of the home's records and the residents' records found that the substitute decision-makers (SDM) of identified residents #004, #009, #0010, #0011 and #0012 were not immediately made aware of the sexual abuse incidents by the home as per the home's policies and procedures. They were informed weeks later by the Director of Care (DOC).
The review of the home's records also revealed that the investigations of the sexual abuse incidents were not immediately initiated by the home and that the Resident Advisor was not informed of the sexual abuse incidents as per the home's policy and procedures.
Front-line staff members were interviewed and reported that; the resident #007 sexually abused the female co-residents, the registered staff were informed of the sexual abuse incidents, the behavior continued and investigations of the sexual abuse incidents were not immediately initiated as per the home's policies and procedures. The staff reported the sexual abuse incidents to the Director of Care (DOC).
The Directors of Care (DOC) were interviewed and reported that the registered staff was informed of the abuse incidents by the front-line staff and documented the incidents in the residents' records in a general manner in some instances. The

Registered Nurse (RN) or the Nurse-in-Charge was not immediately informed of the sexual abuse incidents as per the home's policy and procedures. In September, 2013, the staff reported the sexual abuse incidents directly to the DOC and the DOC initiated an investigation. As a result of the Nurse-in- Charge not being informed of the sexual abuse incidents: the leadership team was not immediately informed; the MOHLTC was not informed of the abuse within the required time-frame; the residents' substitute decision-makers (SDM) were not immediately informed of the abuse; the Resident Advisor was not informed of the sexual abuse and investigations of the sexual abuse incidents were not immediately initiated as per the home's policy and procedures.
The home failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 :

1. The licensee failed to ensure that 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: 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.
Residents' records and the home's records were reviewed and the documentation revealed that in July, 2012 an identified resident #006 physically abused an identified resident #005 resulting in injury to identified resident #005. The home notified the Director two days later.
The home's records and the record of identified residents #007 and the identified resident #004 were reviewed and it was documented that the identified resident #007 sexually abused the identified resident #004 in September, 20013. The home reported the sexual abuse to the Director 18 days later.
During the review of the home's records, documentation was found that the home reported to the Police that the identified residents #003, #004, #008, #009, #0010, #0011 and #0012 were suspected victims of sexual abuse by the identified resident #007. The records of identified residents #003, #004, #007, #008, #009, #0010, #0011 and #0012 were also reviewed and the documentation indicated that the residents #009, #0010, #0011, #0012 and other residents were also sexually abused by the identified resident #007. No records were found indicating that the home informed the Director of the sexual abuse of female residents #009, #0010, #0011, #0012 and other female co-residents by resident #007. Also, the documentation in the home's records and the records of identified residents #004, #007, #009, #0010, #0011 and #0012 indicate that from April 2013 to September 2013 there were multiple incidents of sexual abuse of the female residents by resident #007 and the home notified the Director of two incidents of actual or suspected sexual abuse of female residents by resident #007.
The Administrator and the Directors of Care (DOC) were interviewed and reported that the DOC was informed of the sexual abuse of residents and staff by staff in September, 2013 and an investigation was initiated which identified that multiple residents were sexually abused by resident #007. The DOC confirmed that the home did not notify the Director of the sexual abuse of identified residents #009, #0010, #0011, #0012 by resident #007.
The home did not immediately notify the Director of the sexual abuse of the identified residents #004 and #005. The home did not notify the Director of the sexual abuse of the identified residents #009, #0010, #0011 and #0012 as required. The home did not notify the Director of all incidents of sexual abuse of the the above residents by resident #007 that occurred between April 2013 and September 2013. [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 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: (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., to be implemented voluntarily.

Issued on this 25th day of March, 2014

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

M. GRAY

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELODY GRAY (123)
Inspection No. / No de l'inspection :	2013_215123_0020
Log No. / Registre no:	H-001500-12,H-000634-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 25, 2014
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To ST. PETER'S CARE CENTRES, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that every resident including identified residents #003, #004, #005, #009, #0010, #0011 and #0012 are protected from abuse.

Grounds / Motifs :

1. Previously issued as VPC on June 17, 2013

The licensee did not ensure that the following rights of residents are fully respected and promoted: (2.) Every resident has the right to be protected from abuse.
The home's records and the records of identified residents #003, #004, #005, #006, #007, #009, #0010, #0011, #0012 were reviewed. It was noted that in July, 2012 the identified resident #005 was physically abused by the identified resident #006. The resident #006 entered the room of resident #005. When resident #005 asked resident #006 to leave their room, resident #006 hit resident #005 which resulted in injury to resident #005.
The home's records and the residents' records also noted that on multiple occasions, from April, 2013 through September, 2013 the identified resident #007 sexually abused female co-residents including residents #009, #0010, #0011 and #0012.
It is also documented that the identified resident #007 sexually abused the identified resident #004 in September, 2013 who displayed a negative response to being touched.
Front line staff and management team members were interviewed and confirmed the sexual abuse of the female co-residents by resident #007 from April, 2013 through September, 2013.
The licensee did not ensure that every resident was protected from abuse. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Grounds / Motifs :

1. Previously issued as VPC on June 17, 2013

The licensee failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with.
The home's policy Non-Abuse of Residents #2-60 was reviewed and the information included that: All incidents of alleged, suspected or witnessed resident abuse or neglect must be reported immediately to the Nurse in charge; The nurse in charge must immediately report to a member of the leadership team; Choose the appropriate Abuse Decision Tree to determine if communication with the Ministry of Health and Long-Term Care (MOHLTC) is needed and if so, when and how to communicate this information; Using the information from the decision tree, initiate the Critical Incident System (CIS) report or if after hours call the MOHLTC emergency on call pager; The resident's substitute decision-maker will be made aware immediately of an alleged, suspected or witnessed incident of an alleged, suspected or witnessed incident of abuse; Contact or leave a message for the Resident Advisor to inform of the alleged, suspected, or witnessed abuse and that the resident who has been a victim of abuse will be visited by the Resident Advisor or delegate on the next business day.

The home's records were reviewed and it was noted that in September, 2013 the identified resident #007 sexually abused identified resident #004. The review of the home's records indicated that the identified residents #008, #009, #0010, #0011 and #0012 were identified by the home as suspected victims of sexual abuse by resident #007. The residents' records were reviewed and documentation was found related to the incidents of sexual abuse of identified residents #004, #009, #0010, #0011, #0012 and other residents by the identified resident #007. The review of the home's records and the residents' records found that the substitute decision-makers (SDM) of identified residents #004, #009, #0010, #0011 and #0012 were not immediately made aware of the sexual abuse incidents by the home as per the home's policies and procedures. They were informed weeks later by the Director of Care (DOC).
The review of the home's records also revealed that the investigations of the sexual abuse incidents were not immediately initiated by the home and that the Resident Advisor was not informed of the sexual abuse incidents as per the home's policy and procedures.
Front-line staff members were interviewed and reported that; the resident #007 sexually abused the female co-residents, the registered staff were informed of the sexual abuse incidents, the behavior continued and investigations of the sexual abuse incidents were not immediately initiated as per the home's policies and procedures. The staff reported the sexual abuse incidents to the Director of Care (DOC).
The Directors of Care (DOC) were interviewed and reported that the registered staff was informed of the abuse incidents by the front-line staff and documented the incidents in the residents' records in a general manner in some instances. The Registered Nurse (RN) or the Nurse-in-Charge was not immediately informed of the sexual abuse incidents as per the home's policy and procedures.
In September, 2013, the staff reported the sexual abuse incidents directly to the DOC and the DOC initiated an investigation. As a result of the Nurse-in- Charge not being informed of the sexual abuse incidents: the leadership team was not immediately informed; the MOHLTC was not informed of the abuse within the required time-frame; the residents' substitute decision-makers (SDM) were not immediately informed of the abuse; the Resident Advisor was not informed of the sexual abuse and investigations of the sexual abuse incidents were not immediately initiated as per the home's policy and procedures.
The home failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.
(123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2014

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.

Ministry of Health and Long-Term Care	Ministére 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

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.

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

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 25th day of March, 2014

Signature of Inspector /
Signature de l'inspecteur : M. GRAY

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

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