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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 26, 2015	2015_391603_0030	027328-15, 025225-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

SYLVIE LAVICTOIRE (603)

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): October 27-29, 2015.

During the course of the inspection, the inspector reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a daily walk-through of the home, observed the delivery of resident care and staff to resident interactions. The following logs related to the Ministry of Health and Long-Term Care were completed during the inspection: #027328-15 and 025225-15. For non compliances related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) and s. 6 (7), please see the Follow up Inspection #2015_391603_0031.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Ward Clerk, and Residents.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 VPC(s)**
- **3 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 :

1. The licensee has failed to ensure that resident #005 was protected from abuse by resident #006 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. The CI indicated that resident #005 was walking on their unit and asked a registered staff where their room was. While resident #005 asked for assistance, they made sure that resident #006, who they pointed at and said "that person right there", would not know where their room was. Resident #005 then explained that they had just asked resident #006 where their room was and resident #006 took resident #005's hand and put it on resident #006's private parts. Resident #005 did not cry but seemed concerned that resident #006 would know where they lived. At a later time, resident #005 was re interviewed by two staff members and the resident was able to repeat the same incident. Resident #005 was visibly upset with tears in their eyes. According to the CI report, resident #006 had a history of sexual behaviors, but had never gone to this extreme. Resident #006 was on a specific treatment every 2 weeks but had refused their treatment the week before the incident. The resident was spoken to by the Doctor the day before the incident and still refused to take the treatment.

Inspector reviewed resident #006's health care records and noted that the resident had ongoing problems with sexual behaviors, especially around certain residents with altered thought process. According to the progress notes, the resident had displayed sexual behaviors before this incident.

Inspector reviewed resident #006's care plan which had a focus of Locomotion On/Off the unit. The interventions included a badge programmed to alert staff when resident entered another resident's room and staff were to respond immediately to the pager call. Staff were to monitor whereabouts hourly, related to sexual behavior exhibited toward other residents. If resident was seen on a specific unit, staff were to question who they were visiting and ensure they only visited certain residents and then return to their unit. In this case, the staff on the resident's unit were not aware of the resident's whereabouts as required in their plan.

On a certain date, Inspector attempted to interview resident #006 who was not in their room or on their unit. Inspector interviewed S#103 and S#102 who did not know the resident's whereabouts. Staff #103 and #102 looked for the resident and consulted with another staff member who again, did not know the resident's whereabouts. Staff #103 explained that the resident often went to the auditorium or another unit. Staff #102 and #103 explained that the resident's badge was programmed to alert staff if they went into other residents' rooms. Staff #103 also explained that the staff on a specific unit knew to monitor resident #006's activities as they were known for sexual behaviors. Inspector

went to the auditorium and to a specific unit and could not find resident #006. The staff on the specific unit explained that they were familiar with resident #006 but had not seen them. Inspector went back to resident #006's unit where again, they were nowhere to be found.
Approximately 1/2 hour later, resident #006 returned. Staff #102 and #103 did not ask the resident where they had been for the past 30 minutes.

In the case of the CI, the staff on resident #006's unit were not aware of the resident's whereabouts. Again, during this inspection, staff were not aware of resident #006's whereabouts. On the date of the CI, staff did not protect resident #005 from abuse by resident #006. [s. 19. (1)]

2. The licensee has failed to ensure that resident #002 was protected from abuse by resident #001 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene. No further action was taken. Both residents' badges had been set up to ring and alert staff when either resident entered each others' room, as this type of behavior had happened in the past. On that day, resident #002's badge did not ring because they had not entered resident #001's room, rather stood at the doorway.

On October 28, 2015, Inspector interviewed S#100 who explained that resident #002 was a wanderer and tended to wander around resident #001's room. For this reason, the home had programmed resident #002's badge to alarm staff if they entered resident #001's room and the same would happen if resident #001 entered resident #002's room. At that time, the staff were trained to intervene immediately when they heard the residents' alarms. Staff #100 explained that resident #002 had exposed their private parts and approached other residents in the past. Staff #100 explained that resident #002's family was aware of this behavior. Inspector interviewed S#101 who explained that resident #002 was known to be displaying sexual behaviors. Staff #101 explained that the staff monitored the resident's whereabouts very closely.

Inspector reviewed the resident's health care records which indicated that resident #002 was a wanderer, approached other residents, occasionally exposing themselves to other

residents. Inspector reviewed the resident's care plan and there was a focus for Mood State & Behavior, where the resident was identified as being a wanderer, approaching other residents, and exposing themselves to other residents. An intervention included to allow resident to wander on unit with supervision. However, there were no interventions related to monitoring the resident's whereabouts. Both resident #001 and #002 had a history of sexual behaviors. Resident #002 was not protected from sexual abuse by resident #001. [s. 19. (1)]

3. The licensee has failed to ensure that resident #003 was protected from abuse by resident #001 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene and resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was in a chair, trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 a certain medication. No further action was taken.

On October 28, 2015, Inspector interviewed S#100 who explained that resident #003 was cognitively impaired but had lucid periods at times. At the time of the incident, resident #003 was able to voice their concerns to the staff member. Staff #100 explained that after the first incident, the staff expected resident #001 to stay in their room but they did not. Resident #001's badge was programmed to alarm when entering a resident room, however, not the unit's lounge. Resident #001 was independent and was free to walk on their own, however, staff were to monitor resident #001 closely due to their sexual behaviors towards other residents.

Inspector reviewed resident #001's health care records which indicated that the resident was known for displaying sexual behaviors. Inspector reviewed resident #001's care plan and under the focus of Mood State/Behavior, the resident was to be redirected from any

touching or inappropriate displays of affection immediately, to protect the rights and safety of others. There were no interventions for increased monitoring and documentation post sexual abuse incidents. In this case, the resident was left in their room with no other interventions or monitoring put in place. Resident #003 was not protected from sexual abuse by resident #001. [s. 19. (1)]

4. The licensee has failed to ensure that resident #004 was protected from abuse by #001 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI report, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene and resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was in a chair trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 an specific medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004, who was sitting in their chair. Resident #001 had exposed resident #004's private parts and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident with residents on that day and that this would not be tolerated.

Inspector reviewed resident #004's health care records which indicated that on date of the CI, resident #004 had sustained injuries.

Inspector interviewed S#100 and S#101 who explained that resident #004 was a wanderer and did go into different resident rooms. The resident's badge had been programmed to alert the staff if they entered resident #001's room. During the incident, when resident #004 entered resident #001's room, the badge did not alarm and the staff was not aware that the resident had entered resident #001's room.

Inspector reviewed resident #004's care plan and under the focus of Mood State/Behavior, it indicated that the resident was a wanderer and was at risk due to fellow co-residents with inappropriate sexual behavior. The interventions included: check resident hourly to ensure safety.

Inspector reviewed resident #001's health care records which indicated that the resident was known for displaying sexual behaviors. Inspector reviewed resident #001's care plan and under the focus of Mood State/Behaviour, the resident was to be redirected from any touching or inappropriate displays of affection, immediately to protect the rights and safety of others. There was no indication for increased monitoring and documentation needed post sexual abusive incidents. Inspector noted that it was not until the third incident of sexual abuse, by resident #001, that the Administrator was notified at 1630hrs and DOS charting and one to one nursing was started for the remainder of the shift. In this case, resident #004 was not protected from sexual abuse by resident #001. [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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of resident #001's behaviors, including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report which was reported to the Director. The CI indicated that resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene. Resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was sitting in a chair trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 a certain medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004 who was sitting in their chair. Resident #001 had exposed resident #004's private parts and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident with residents on that day and that this would not be tolerated.

On October 28, 2015, Inspector interviewed S#100 who confirmed that three different incidents of sexual abuse took place by resident #001 towards three different residents. Staff #100 explained that on that day, the staff did not monitor resident #001's behavior closely after the first and second incident as the staff were busy tending to other resident issues.

Inspector reviewed resident #001's health care records which indicated that the resident was known for displaying sexual behaviors. Inspector reviewed resident #001's care plan and under the focus of Mood State/Behaviour, the resident was to be redirected from any touching or inappropriate displays of affection immediately, to protect the rights and safety of others. There was no intervention to increase monitoring and documentation post incidents of sexual behaviors.

Inspector reviewed the home's Responsive Behaviors Policy, last revised on August, 2015. The policy indicated that registered staff are to put in place monitoring tools, such as DOS, as required to ensure the resident that is displaying responsive behaviors is not a threat to others. Under "When an Incident Occurs", 'use DOS when monitoring a resident when there has been an escalation in responsive behaviors..ie. Q15 minutes checks'.

According to the CI, Inspector noted that it was not until the third incident of sexual abuse that the Administrator was notified, DOS charting and one to one nursing was started for the remainder of the shift. [s. 55. (a)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written Zero Tolerance of Abuse and Neglect Policy, last revised on January 2015, was complied with.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. The CI indicated that resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 a specific medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004 who was sitting in their chair. Resident #001 had exposed resident #004's private parts and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident with residents on that day and that this would not be tolerated. After the third incident, S#110 notified the Administrator, a stat medication was administered to resident #001, DOS charting was started, and one to one nursing was started for the remainder of the shift.

On October 28, 2015, Inspector interviewed S#100 who confirmed that three different incidents of sexual abuse took place by resident #001 towards three other residents on the same day. Staff #100 explained that the staff did not monitor resident #001's behavior closely after the first and second incident as the staff was busy tending to other resident issues.

Inspector reviewed the home's Zero Tolerance of Abuse and Neglect Policy, last revised on January, 2015. The policy indicated 'The staff of the Home will ensure appropriate action is taken in response to any alleged, witnessed or unwitnessed incident of resident abuse'. From the CI report, Inspector noted that it was not until the third incident of sexual abuse, that action was taken to protect other residents from sexual abuse by resident #001. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse by anyone that resulted in harm, immediately report the suspicion and the information upon which it was based to the Director.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene and resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was in a chair trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 a specific medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004 who was sitting in their chair. Resident #001 had exposed resident #004's and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident of sexual abuse with residents on that day and that this would not be tolerated.

According to the CI Report, the three incidents of sexual abuse happened on on the same day. The staff did not immediately report any of the critical incidents to the Director; in fact, the Administrator was notified only after the third incident. The Administrator did not report the CI to the Director until the next day.

Inspector reviewed the home's Critical Incident Reporting Policy last reviewed on September, 2015. The Policy indicated that 'Abuse of a resident by anyone that resulted in harm or a risk of harm to a resident', must immediately be reported to the Director upon becoming aware of the incident. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On October 27, 2015, Inspector reviewed a Critical Incident (CI) Report which was reported to the Director. According the CI, a staff member reported to the RN in charge that resident #005 was walking on their unit and asked where their room was. Resident #005 wanted to make sure that "the person right there" (pointed at resident #006) did not see where their room was. Resident #005 explained that they had just asked resident #006 where their room was and resident #006 took resident #005's hand and put it on resident #006's private parts. Resident #005 was not crying but seemed concerned that resident #006 would know where they lived. Two staff members re interviewed resident #005 who repeated the same incident. Resident #005 was visibly upset with tears in their eyes.

While reviewing the CI report, Inspector noted that S#107 who reported the CI to the Director did not notify the Substitute Decision Maker (SDM). On October 29, 2015, Inspector #603 interviewed S#107 who explained that they did not notify resident #005's listed SDM of the incident because the SDM had not been involved with the resident's care for some time. Staff #107 did confirm that if resident #005 would become ill or would be involved in an accident, they would contact the listed SDM. [s. 97. (1) (a)]

Issued on this 27th 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) :	SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2015_391603_0030
Log No. / Registre no:	027328-15, 025225-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 26, 2015
Licensee / Titulaire de permis :	CORPORATION OF THE TOWN OF KIRKLAND LAKE 3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4
LTC Home / Foyer de SLD :	TECK PIONEER RESIDENCE 145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Theriault

To CORPORATION OF THE TOWN OF KIRKLAND LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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 for ensuring that every resident in the home, is protected from abuse by resident #001 and #006. The plan shall address, but is not limited to the following:

- that the plans of care for resident #001 and #006 are reviewed and updated with clear directions for managing these residents' sexually abusive behaviors
- that the plan of care for resident #002 is reviewed and updated with clear directions for managing this resident's sexually responsive behaviors
-that the plan of care for resident #004 is reviewed and updated with clear directions for managing this resident's responsive wandering behaviors
- identification of the sexual behavior triggers for resident #001, #002 and #006, how these triggers will be minimized and the response to be taken by each staff discipline related to the triggers
- immediate re-training for staff specific to the management and monitoring of sexually responsive and abusive behaviors
- continuous monitoring of the above steps to ensure that the plan is relevant if/when contributing factors change.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by December 4, 2015, with full compliance by December 18, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #004 was protected from

abuse by #001 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI report, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene and resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was in a chair trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 an specific medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004, who was sitting in their chair. Resident #001 had exposed resident #004's private parts and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident with residents on that day and that this would not be tolerated.

Inspector reviewed resident #004's health care records which indicated that on date of the CI, resident #004 had sustained injuries.

Inspector interviewed S#100 and S#101 who explained that resident #004 was a wanderer and did go into different resident rooms. The resident's badge had been programmed to alert the staff if they entered resident #001's room. During the incident, when resident #004 entered resident #001's room, the badge did not alarm and the staff was not aware that the resident had entered resident #001's room.

Inspector reviewed resident #004's care plan and under the focus of Mood State/Behavior, it indicated that the resident was a wanderer and was at risk due to fellow co-residents with inappropriate sexual behavior. The interventions included: check resident hourly to ensure safety.

Inspector reviewed resident #001's health care records which indicated that the resident was known for displaying sexual behaviors. Inspector reviewed resident #001's care plan and under the focus of Mood State/Behaviour, the resident was to be redirected from any touching or inappropriate displays of affection, immediately to protect the rights and safety of others. There was no indication for increased monitoring and documentation needed post sexual abusive incidents. Inspector noted that it was not until the third incident of sexual abuse, by resident #001, that the Administrator was notified at 1630hrs and DOS charting and one to one nursing was started for the remainder of the shift. In this case, resident #004 was not protected from sexual abuse by resident #001. (603)

2. The licensee has failed to ensure that resident #003 was protected from abuse by resident #001 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene and resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was in a chair, trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 a certain medication. No further action was taken.

On October 28, 2015, Inspector interviewed S#100 who explained that resident #003 was cognitively impaired but had lucid periods at times. At the time of the incident, resident #003 was able to voice their concerns to the staff member. Staff #100 explained that after the first incident, the staff expected resident #001 to stay in their room but they did not. Resident #001's badge was programmed to alarm when entering a resident room, however, not the unit's lounge. Resident #001 was independent and was free to walk on their own, however,

staff were to monitor resident #001 closely due to their sexual behaviors towards other residents.

Inspector reviewed resident #001's health care records which indicated that the resident was known for displaying sexual behaviors. Inspector reviewed resident #001's care plan and under the focus of Mood State/Behavior, the resident was to be redirected from any touching or inappropriate displays of affection immediately, to protect the rights and safety of others. There were no interventions for increased monitoring and documentation post sexual abuse incidents. In this case, the resident was left in their room with no other interventions or monitoring put in place. Resident #003 was not protected from sexual abuse by resident #001. (603)

3. The licensee has failed to ensure that resident #002 was protected from abuse by resident #001 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI, resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene. No further action was taken. Both residents' badges had been set up to ring and alert staff when either resident entered each others' room, as this type of behavior had happened in the past. On that day, resident #002's badge did not ring because they had not entered resident #001's room, rather stood at the doorway.

On October 28, 2015, Inspector interviewed S#100 who explained that resident #002 was a wanderer and tended to wander around resident #001's room. For this reason, the home had programmed resident #002's badge to alarm staff if they entered resident #001's room and the same would happen if resident #001 entered resident #002's room. At that time, the staff were trained to intervene immediately when they heard the residents' alarms. Staff #100 explained that resident #002 had exposed their private parts and approached other residents in the past. Staff #100 explained that resident #002's family was aware of this behavior. Inspector interviewed S#101 who explained that resident #002 was known to be displaying sexual behaviors. Staff #101 explained that the staff monitored the resident's whereabouts very closely.

Inspector reviewed the resident's health care records which indicated that resident #002 was a wanderer, approached other residents, occasionally exposing themselves to other residents. Inspector reviewed the resident's care plan and there was a focus for Mood State & Behavior, where the resident was identified as being a wanderer, approaching other residents, and exposing themselves to other residents. An intervention included to allow resident to wander on unit with supervision. However, there were no interventions related to monitoring the resident's whereabouts. Both resident #001 and #002 had a history of sexual behaviors. Resident #002 was not protected from sexual abuse by resident #001. (603)

4. The licensee has failed to ensure that resident #005 was protected from abuse by resident #006 in the home.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. The CI indicated that resident #005 was walking on their unit and asked a registered staff where their room was. While resident #005 asked for assistance, they made sure that resident #006, who they pointed at and said "that person right there", would not know where their room was. Resident #005 then explained that they had just asked resident #006 where their room was and resident #006 took resident #005's hand and put it on resident #006's private parts. Resident #005 did not cry but seemed concerned that resident #006 would know where they lived. At a later time, resident #005 was re interviewed by two staff members and the resident was able to repeat the same incident. Resident #005 was visibly upset with tears in their eyes. According to the CI report, resident #006 had a history of sexual behaviors, but had never gone to this extreme. Resident #006 was on a specific treatment every 2 weeks but had refused their treatment the week before the incident. The resident was spoken to by the Doctor the day before the incident and still refused to take the treatment.

Inspector reviewed resident #006's health care records and noted that the resident had ongoing problems with sexual behaviors, especially around certain residents with altered thought process. According to the progress notes, the resident had displayed sexual behaviors before this incident.

Inspector reviewed resident #006's care plan which had a focus of Locomotion On/Off the unit. The interventions included a badge programmed to alert staff when resident entered another resident's room and staff were to respond

immediately to the pager call. Staff were to monitor whereabouts hourly, related to sexual behavior exhibited toward other residents. If resident was seen on a specific unit, staff were to question who they were visiting and ensure they only visited certain residents and then return to their unit. In this case, the staff on the resident's unit were not aware of the resident's whereabouts as required in their plan.

On a certain date, Inspector attempted to interview resident #006 who was not in their room or on their unit. Inspector interviewed S#103 and S#102 who did not know the resident's whereabouts. Staff #103 and #102 looked for the resident and consulted with another staff member who again, did not know the resident's whereabouts. Staff #103 explained that the resident often went to the auditorium or another unit. Staff #102 and #103 explained that the resident's badge was programmed to alert staff if they went into other residents' rooms. Staff #103 also explained that the staff on a specific unit knew to monitor resident #006's activities as they were known for sexual behaviors. Inspector went to the auditorium and to a specific unit and could not find resident #006. The staff on the specific unit explained that they were familiar with resident #006 but had not seen them. Inspector went back to resident #006's unit where again, they were nowhere to be found.
Approximately 1/2 hour later, resident #006 returned. Staff #102 and #103 did not ask the resident where they had been for the past 30 minutes.

In the case of the CI, the staff on resident #006's unit were not aware of the resident's whereabouts. Again, during this inspection, staff were not aware of resident #006's whereabouts. On the date of the CI, staff did not protect resident #005 from abuse by resident #006.

LTCHA, 2007 S.O. 2007, s. 19. (1) was issued previously as WN and CO during Inspection #2014_283544_0026.

The decision to issue this compliance order was based on the scope which involved four out of six residents inspected during the inspection, the severity which indicated actual harm/risk and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2015

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

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's responsive behaviors, including the following:

-a communication process that will ensure all direct care staff are aware of each resident whose behaviors, including responsive behaviors, require heightened monitoring because those behaviors pose a potential risk to other residents
-that staff implement the home's Responsive Behaviors Policy and put into place monitoring tools such as DOS charting and q15 minute checks when a resident's behavior poses a risk of harm to residents.
-that information related to abuse is immediately brought forward to supervisory and management staff related to residents, whose responsive behaviors pose a potential risk to other residents or when residents have been harmed.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of resident #001's behaviors, including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report which was reported to the Director. The CI indicated that resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene. Resident #001 went back into their room. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member saw resident #001 sitting on top of resident #003 who was sitting in a chair trying to touch their private parts. The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room and gave resident #001 a certain medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004 who was sitting in their chair. Resident #001 had exposed resident #004's private parts and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident with residents on that day and that this would not be tolerated.

On October 28, 2015, Inspector interviewed S#100 who confirmed that three different incidents of sexual abuse took place by resident #001 towards three different residents. Staff #100 explained that on that day, the staff did not monitor resident #001's behavior closely after the first and second incident as the staff were busy tending to other resident issues.

Inspector reviewed resident #001's health care records which indicated that the resident was known for displaying sexual behaviors. Inspector reviewed resident #001's care plan and under the focus of Mood State/Behaviour, the resident was to be redirected from any touching or inappropriate displays of affection immediately, to protect the rights and safety of others. There was no intervention to increase monitoring and documentation post incidents of sexual behaviors.

Inspector reviewed the home's Responsive Behaviors Policy, last revised on

August, 2015. The policy indicated that registered staff are to put in place monitoring tools, such as DOS, as required to ensure the resident that is displaying responsive behaviors is not a threat to others. Under "When an Incident Occurs", 'use DOS when monitoring a resident when there has been an escalation in responsive behaviors..ie. Q15 minutes checks'.

According to the CI, Inspector noted that it was not until the third incident of sexual abuse that the Administrator was notified, DOS charting and one to one nursing was started for the remainder of the shift. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

Order # / Ordre no : 003

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 re-educate all staff and others who provide direct care to the residents on the home's written Zero Tolerance of Abuse and Neglect Policy, last revised on January 2015. The re education must include the importance of monitoring residents who are at risk or who display sexually by responsive and abusive behaviors. The licensee shall keep a written record of all staff and others who have been re educated on the above. The licensee shall also develop a process to monitor how effective this re-education is related to implementation of the home's Zero Tolerance of Abuse and Neglect Policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the written Zero Tolerance of Abuse and Neglect Policy, last revised on January 2015, was complied with.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. The CI indicated that resident #002 stood in resident #001's bedroom doorway and exposed their private parts to resident #001. Resident #001 came up to resident #002 and started touching resident #002 sexually. A staff member was coming down the hallway and witnessed this and removed resident #002 from the scene. No further action was taken. Approximately 10 minutes later, resident #001 left their room and went to the unit's lounge. The staff member, who was at the nursing station heard resident #003 calling out "stop that, get off me". The staff member responded immediately by getting resident #001 off resident #003 and bringing resident #001 to their room. The staff member reported the incident to S#108 and registered S#109. Staff #109 instructed resident #001 to remain in their room

and gave resident #001 a specific medication. Subsequent to this second incident of sexual abuse, no further action was taken. At 1616hrs, a registered staff opened resident #001's bedroom door and saw resident #001 leaning into resident #004 who was sitting in their chair. Resident #001 had exposed resident #004's private parts and attempted to touch resident #004 sexually. Staff #109 immediately intervened by removing resident #004 from the room, spoke with resident #001 firmly, explaining that this was the third incident with residents on that day and that this would not be tolerated. After the third incident, S#110 notified the Administrator, a stat medication was administered to resident #001, DOS charting was started, and one to one nursing was started for the remainder of the shift.

On October 28, 2015, Inspector interviewed S#100 who confirmed that three different incidents of sexual abuse took place by resident #001 towards three other residents on the same day. Staff #100 explained that the staff did not monitor resident #001's behavior closely after the first and second incident as the staff was busy tending to other resident issues.

Inspector reviewed the home's Zero Tolerance of Abuse and Neglect Policy, last revised on January, 2015. The policy indicated 'The staff of the Home will ensure appropriate action is taken in response to any alleged, witnessed or unwitnessed incident of resident abuse'. From the CI report, Inspector noted that it was not until the third incident of sexual abuse, that action was taken to protect other residents from sexual abuse by resident #001. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

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 26th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Lavictoire

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