

Adopted by Council at its meeting held May 8, 2012 [M223-2012]

/AA

Windsor, Ontario May 7, 2012

**REPORT NO. 23** of the  
**PUBLIC SAFETY STANDING COMMITTEE**  
of its meeting held April 18, 2012

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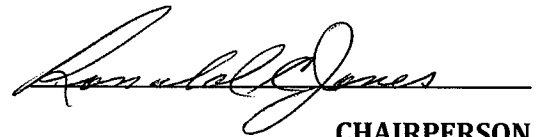
**Present:**

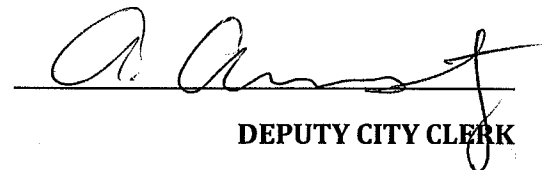
- Councillor Jones, Chair**
- Councillor Dilkens**
- Councillor Gignac**
- Councillor Maghnieh**
- Councillor Payne**

That the following recommendation of the Public Safety Standing Committee **BE APPROVED** as follows:

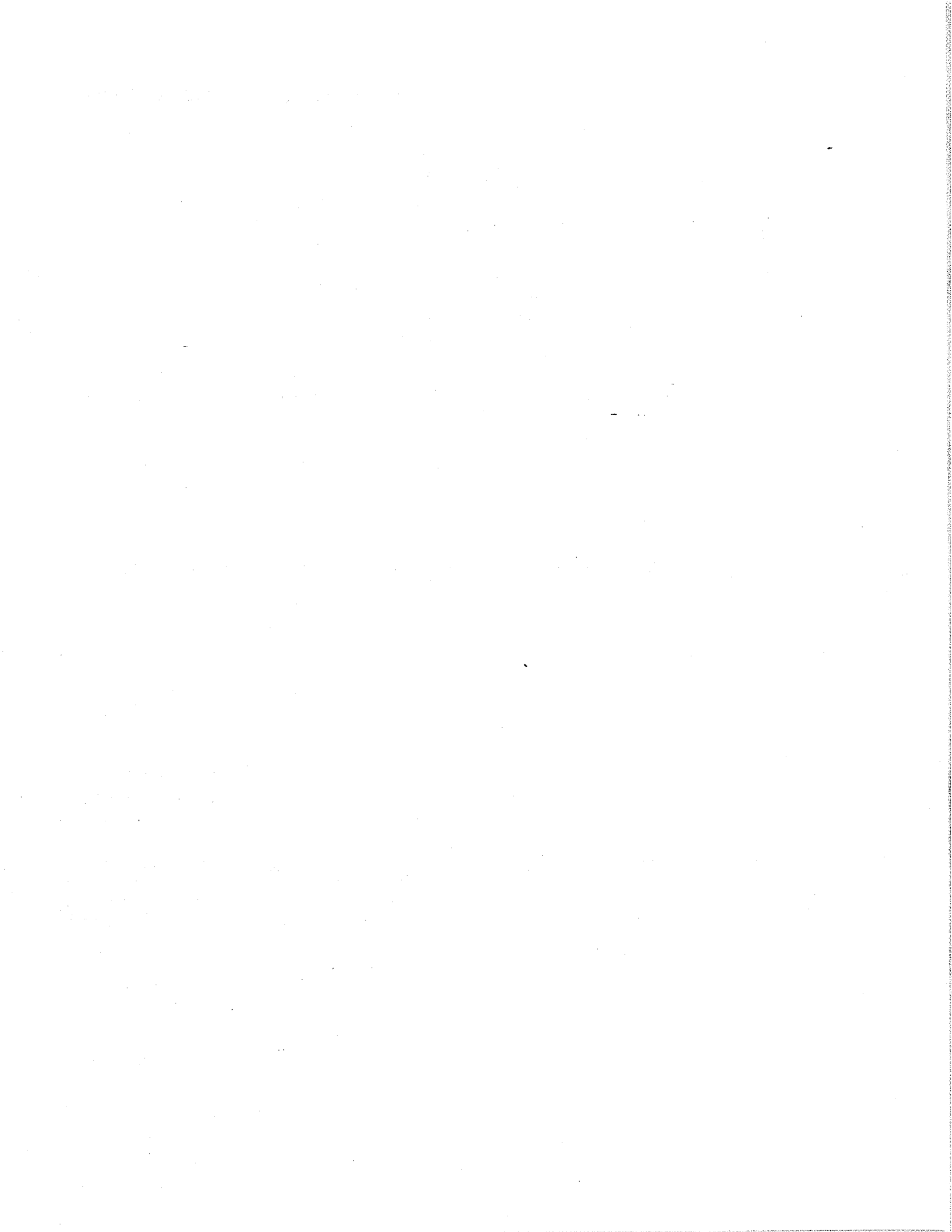
Moved by Councillor Dilkens, seconded by Councillor Maghnieh  
That the minutes of the Windsor Licensing Commission meeting held November 8, 2011 **BE RECEIVED** for information.  
Carried.

**Clerk's Note:** The minutes of the Windsor Licensing Commission meeting held November 8, 2011 are attached as background information.

  
**CHAIRPERSON**

  
**DEPUTY CITY CLERK**

<b>NOTIFICATION :</b>				
Name	Address	Email Address	Telephone	FAX



Windsor, Ontario November 8, 2011

A meeting of the **Windsor Licensing Commission** is held this day commencing at 9:30 o'clock a.m. in the City Council Chambers, 3<sup>rd</sup> floor, City Hall, there being present the following members:

Councillor Ron Jones, Chair  
Councillor Drew Dilkens  
- Jack Fathers  
Councillor Al Maghnieh  
Councillor Ed Sleiman

**Also present are the following resource personnel:**

Mario Bonas, Compliance and Enforcement Officer  
Dawn Bosco, Domiciliary Rest Home Supervisor  
Tricia Brisebois, Children's Services Caseworker  
Debbie Cercone, Executive Director, Housing & Children's Services  
Michael Chantler, Supervisor of Licensing and Deputy Licence Commissioner  
Gary Cian, Manager of Policy, Gaming & Licensing/Deputy Licence Commissioner  
Valerie Critchley, City Clerk/Licence Commissioner  
Lee Anne Doyle, Executive Director/Chief Building Official  
Susan Hirota, Legal Counsel  
Ann Kalinowski, Manager of Compliance and Enforcement  
Helga Reidel, Chief Administrative Officer  
Bill Tetler, Compliance and Enforcement Officer  
Ronna Warsh, Community Development & Health Commissioner  
George Wilkki, City Solicitor  
Karen Kadour, (A) Committee Coordinator

**1. CALL TO ORDER**

The Chair calls the meeting to order at 9:30 o'clock a.m. and the Commission considers the Agenda being Schedule "A" attached hereto, matters which are dealt with as follows:

**2. DISCLOSURE OF INTEREST**

None.

3. **REQUESTS FOR DEFERRALS, REFERRALS OR WITHDRAWALS**

None.

4. **APPLICATIONS/HEARINGS**

4(a) **1614890 Ontario Ltd. – Class II Lodging Home**

Bruck Easton, Solicitor representing 1614890 Ontario Ltd. operating under the name La Maison Royale and Grace Rosete-LaSala, President of 1614890 Ontario Ltd. are present. Mr. Easton's submission to the Windsor Licensing Commission is attached as Appendix "A".

The Licence Commissioner provides the following comments as it relates to the Class II Lodging House licenses at 1028 Pelissier and 1016 Pelissier:

*"Licensing records indicate that 1614890 Ontario Ltd. has been licensed as a Class II Lodging House since 2004 at 1028 Pelissier. Records indicate that the lodging home at 1016 Pelissier has been licensed since 2008 under the same numbered company. Although these are two separate locations and two separate lodging home licences, the owner, staff, policies and procedures of the homes are the same. Both properties are known to operate as "La Maison Royale". As it is the policies and procedures of 1614890 Ontario Ltd. that are of serious concern and relating to the licensing suspension, for the purpose of this report and associated hearing, the City of Windsor Administration will be considering both licences together."*

The Licence Commissioner states that Business Licensing Bylaw 395-2004 provides the following rationale for licensing this category of business:

*"**LODGING HOUSE**" for the purpose of protecting the health and safety of the persons residing in the house by ensuring that the building code regulations are met, medication is dispensed correctly and basic human needs are provided. As well as the required essentials such as plumbing and water are provided, for ensuring that the lodging house does not create a nuisance to the adjoining property or surrounding lands, and for consumer protection such that the persons residing in the house know whom to contact in the case of a problem or emergency within the building."*

The Licence Commissioner advises that By-law 395-2004, Schedule L1, Part II, Section 28(2) contains a provision with regard to the practices for administering medication and states:

*"(2) The operator shall establish a procedure and practice satisfactory to the Licence Commissioner for the safe administration and application of medication to the residents for whom the medication is prescribed. The following procedures must be included:*

- (a) *Any medication prescribed by the physician must remain in the original container bearing the resident's name;*
- (b) *An operator will ensure that medications are taken by the correct person from the individually labeled containers;*
- (c) *A daily record shall be prepared for each resident taking medication and shall specify the name of the medication, the dosage and the times it is to be given. The staff person giving the medication shall sign or initial on this record in the appropriate time slot each time the medication is given;*
- (d) *Medication required to be given by intramuscular or intravenous injection shall only be given by a registered nurse or duly qualified physician with a current Ontario licence;*
- (e) *All medication shall be kept in a securely locked cabinet unless such medication is in the sole possession of the resident."*

Subsection (3) states in part:

*"(3) (a) every occurrence of fire, assault and injury, or communicable disease which in the opinion of the attending physician requires medical treatment, shall be reported to the Licence Commissioner within 24 hours of the occurrence or where the occurrence takes place on a Saturday, Sunday or holiday on the next business day."*

The Licence Commissioner provides an overview of the chronology of events that clearly demonstrate the efforts of the City of Windsor to regulate this licensee for the purpose of protecting the health and safety of the persons residing in the house by ensuring that the building code regulations are met, medication is dispensed correctly and basic human needs are provided. It also reveals the licensee's inability to comply with the requirements of Business Licensing Bylaw 395-2004 and their efforts to comply only in response to orders from the City of Windsor.

The Licence Commissioner indicates that on October 26, 2011 she was informed by Compliance and Enforcement Officer Bill Tetler that he was notified by Social Services that a resident of La Maison Royale had been hospitalized due to an overdose earlier in the week. The Serious Occurrence Report had been sent to Ms. Kristen Marshall, Social Services on October 24, 2011 at 22:05 hours and was not sent by the operator to the Licence Commissioner as per Bylaw 395-2004, Schedule L1, Part II, Section 28 (3)(a). In addition, the Serious Occurrence Report did not indicate whether the occurrence was at 1016 or 1028 Pelissier. The fax cover sheet showed the address at 1028 Pelissier Street, however, upon investigation, it became clear that the resident had been housed at 1016 Pelissier Street and this is where the incident occurred.

The Licence Commissioner advises that the overdose is enough to believe residents are in serious danger and is recommending revocation of the licence.

Councillor Dilkens leaves the meeting at 10:00 o'clock a.m.

The salient points of Mr. Easton's submission to the Windsor Licensing Commission are as follows:

- Medication overdose on October 23, 2011 was the most serious occurrence that happened at La Maison Royale in the eight years that it has been a lodging home licensee under the ownership of the Rosete family
- Subsidized psychiatric patient advised the staffer on duty at the morning medication dispensing that he was leaving the home for three days to visit with his family. Staffer that morning, an 18 year old first year nursing student was on her first day on the job and made a mistake. She correctly noted the dispensing of the medicine as she had been shown but failed to note that the resident had left and medications have been given to him in advance. The resident did leave the home but later that day, after that staffer's weekend shift had ended, he returned to the home. The next day the resident took the three day's supply he had been given following his receipt of the usual dosage that was given by a different staffer on the morning of October 24, 2011. Seeing his strange behavior that evening, the resident was given plenty of water, an ambulance was called and he was taken to Hotel-Dieu Grace Hospital. Serious Occurrence Reports were filed with the City.
- The Rosetes instituted an immediate investigation into what happened. Pending the completion of that investigation they suspended all staff who had been involved with the dispensing of medication on October 23 and 24, 2011.
- The Rosetes arranged an in house meeting of all staff with their pharmacist to review medication dispensing procedures and all in house policies.
- This incident happened only one week after the Licence Commissioner had renewed the two La Maison Royal licences.
- The October 20, 2011 investigation and the Licence Commissioner's resulting letter threatening suspension was prompted by a call to Bylaw Enforcement from a La Maison Royale resident regarding a walkway issue at 1028 Pelissier. The complainant had tripped on the raised stones and had scraped her knee requiring a bandage.
- Domicillary Hostel Standards states -- "The Operator shall record and report all significant incidents occurring at the home such as accidents, injuries, alleged abuse or abuse of residents or staff, medication error, police intervention, fire, etc."
- The only actual Bylaw infraction noted in the letter from the Licensing Commissioner dated October 20, 2011 was the failure to make clearly visible two weeks worth of the menu for the residents.
- Not clear why two licences are required (1016 and 1028 Pelissier) as the houses are side by side, with less than 30 feet apart separated only by a driveway.
- A serious incident happened at La Maison Royale on October 24, 2011 when a resident overdosed on medication. La Maison Royale is as upset as anyone with this stain on its record, the first such incident in its eight years of operation. They are deeply sorry for what happened and it will not happen again.
- Reinstatement by the Commission for the two licences of La Maison Royale as a Class II lodging home is requested.

Councillor Dilkens returns to the meeting at 10:50 o'clock a.m.

Verbal Motion is presented by Councillor Dilkens, seconded by Councillor Maghnieh, to move In Camera at 11:25 o'clock a.m. for discussion of the following item:

Item No.	Subject	Section Pursuant to Municipal Act, 2001, as amended
5.0	Personal matters about an identifiable individual, including municipal or local board employees	s. 239(2)(b)

**Motion Carried.**

Discussion on the item of business.

Verbal Motion is presented by Councillor Dilkens, seconded Councillor Sleiman, to move back into public session at 11:35 o'clock a.m.

**Motion Carried.**

Councillor Sleiman leaves the meeting at 11:35 o'clock a.m.

In response to a question asked by J. Fathers regarding if any staff member was present with the first year nursing student, Mr. Easton states she was alone, however, the medication was dispensed properly but the additional three days of medication was not noted.

Discussion ensues regarding the bed bugs discovered in one of the resident's beds by Citizen Advocacy. Mr. Easton indicates that linen is changed weekly, staff are in the rooms on a regular basis and the bed bugs were only found in one room.

In terms of placing two weeks of menus on the board for the residents to peruse, Mr. Easton states that two weeks of menus will be available for viewing.

Grace Rosete-LaSala assures the Commission that Policies and Procedures for La Maison Royale have been placed in binders and are available at both locations.

In response to a question asked by J. Fathers regarding the necessity for 2 licences, the Licence Commissioner states there are two separate buildings which necessitate two separate licences. The Operator was aware of the requirement for the two separate licences when application was made.

The Commission recesses at 12:45 o'clock p.m.

The Commission returns at 1:15 o'clock p.m.

Moved by Councillor Dilkens, seconded by Councillor Maghnieh,  
**WLC57/11** That Licence #11-138435 and Licence #11-138437 – Class II Lodging House for 1614980 Ontario Ltd. operating as La Maison Royale, 1016 Pelissier and 1028 Pelissier, Windsor, Ontario **BE REINSTATED** with the following conditions:

- Monthly inspections by the Compliance Enforcement Division consisting of a Bylaw Enforcement Officer and a Manager;
- Any infraction of Bylaw 395-2004 be cause for immediate suspension of operating licences and further that 1614980 Ontario Ltd. operating as La Maison Royale be brought back to the Windsor Licensing Commission within fourteen (14) days if there are any infractions.

Carried.

5. **DATE OF NEXT MEETING**

The next meeting will be held November 16, 2011 at 9:30 o'clock a.m. in the Council Chambers.

6. **ADJOURNMENT**

There being no further business, the meeting is adjourned at 1:25 o'clock p.m.

\_\_\_\_\_  
CHAIR

\_\_\_\_\_  
SECRETARY



Mr. Chairman, Members of the Commission, there are two components to the relationship that the City has with my client, 1614890 Ontario Ltd. operating under the name La Maison Royale which I will sometimes refer to today as LMR.

On the one hand, the City has licenced La Maison Royale at its two locations, 1016 Pelissier and 1028 Pelissier to carry on the business of a Class II Lodging Home. As such, LMR is subject to the provisions of Schedule L1 of City By-law 395-2004 and the jurisdiction of the Licence Commissioner and of course ultimately to this Licencing Commission.

On the other hand, the City has entered into a series of contracts over the years with La Maison Royale for the provision of domicillary hostel services for a number of individuals who are subsidized pursuant to a jointly funded municipal provincial program. La Maison Royale's current contract provides for such services for 13 subsidized individuals at \$47.75 per day. The City oversees this contract through the Office of the Community Development and Health Commissioner, and formerly through the Offices of Social and Health Services.

I note this dichotomy because it is important to focus on what your job as Licencing Commission is today. You are not here to pass judgement on La Maison Royale's status as a Licencee, based on alleged breaches, minor or fundamental, of its contract with the City. That is not to say we are not prepared to discuss those alleged breaches. Indeed we are, as in our view, such breaches of the contract as have happened have been minor and were quickly remedied upon request. But that is not the focus of today's inquiry. Rather, it is your job to consider whether to accept the recommendation of the Licence Commissioner to now revoke the Lodging House licences issued to La Maison Royale for both 1016 and 1028 Pelissier, or instead, to reinstate those licences with or without conditions.

The Commissioner has stated in the Summary of the Report to this Commission that the Licencees "do not follow proper policies and procedures in order to comply with the By-law. They have consistently failed to comply with the By-law and to provide a healthy and safe environment for the residents". The Commissioner then notes a serious incident – a medication overdose that happened October 24<sup>th</sup> - and raises the spectre of potential municipal liability.

Let me start by dealing with this medication overdose. There is no doubt that this is the most serious occurrence that

has happened at La Maison Royale in the eight years that it has been a lodging home licensee under the ownership of the Rosete family. What happened is that on Sunday, October 23, one of the residents, a subsidized psychiatric patient advised the staffer on duty at the morning medication dispensing that he was leaving the home for three days to visit with his family. Unfortunately the staffer that morning, an 18 year old first year nursing student, was on her first day on the job and she made a mistake. She correctly noted the dispensing of the medicine as she had been shown but she failed to put down the notation that shows the resident had left and his medications had been given to him in advance. The resident did leave the home but later that day, after that staffer's weekend shift had ended, he returned to the home. The problem arose the next day when he decided to take the three day's supply he had been given following his receipt of the usual dosage that was given by a different staffer on the morning of October 24. Apparently that happened in his bedroom to which he had retired after lunch. It was only that evening that his resulting strange behavior was noted. The staff on hand dealt with it immediately. The resident was given plenty of water, an ambulance was called and he taken around the corner to Hotel-Dieu Hospital. At no time did the resident lose consciousness. Serious Occurrence Reports were filed forthwith with the City.

This is far and away the most serious incident that has ever happened at La Maison Royale. The Rosete family was deeply upset by what happened. The President of 1614890 Ontario Ltd. is Grace Rosete-LaSala who is herself a Nurse Practitioner which as we all know is a step up from being a Registered Nurse. Her brother and sister-in-law, Douglas and Sandra Rosete are the hands on managers of these facilities. The Rosetes are Filipinos who have a long history of providing excellent care in this country and La Maison Royale is no exception. Indeed the whole Rosete family is involved in La Maison Royale including the grandmother of Douglas and Grace who is in fact a resident of the home.

While this incident was properly handled once it came to light, there is no question it should not have happened. The Rosetes instituted an immediate investigation into what happened. Pending the completion of that investigation they suspended all staff who had been involved with the dispensing of medication on October 23 and 24 from dispensing further medication pending the completion of their investigation. They arranged an in house meeting of all staff with their pharmacist to review medication dispensing procedures and all in house policies in that regard. They further advised the Commissioner's staff in writing of these steps. La Maison Royale wants to make sure that this is the first and last such incident in its tenure as a lodging home operator in Windsor.

- PAUSE -

It is important to note that this one off incident happened only one week after the Licence Commissioner had renewed the two La Maison Royal licences. You will see these new licences at Appendix A and B of the Commissioner's report herein and you will note that they are dated October 17, 2011. I think we must presume that the Commissioner considered the matters listed in section 3.24 of By-law 395 in deciding to renew these licences. A number of those requirements are routine, such as whether the fee has been paid and the zoning is appropriate, but the two that are germane to this discussion are Paragraphs F and L. Paragraph F provides that where the licence holder is a corporation, the conduct of its officers or directors or shareholders who control 10% or more of its shares shall not afford reasonable cause to believe that the licence holder will not carry on the business in accordance with the law or with honesty and integrity. Paragraph L provides that the licence holder shall not carry on activities that are in contravention of this By-law. Presuming that the Commission has considered these matters in issuing the 2012 licences, it seems necessary to look to what happened in the 10 days thereafter as justification for the suspensions that were issued October 27 and the recommendation before you today that these licences should now be revoked.

Let me therefore turn to the other incident and resulting inspection that occurred between the licence renewal on October 17<sup>th</sup> and the licence suspension on October 27<sup>th</sup>. That is found with the pictures at Appendix O thru Appendix R and with the correspondence in Appendix S, T and U of the Commissioner's report. What gave rise to the October 20 investigation and the Commissioner's resulting letter threatening suspension was a call to the City Enforcement Office from an LMR resident to complain about the walkway at 1028 Pelissier. The picture in the Appendices were all apparently taken on October 20<sup>th</sup> and the sidewalk in question is noted in the top half of Appendix O. The resident who called you may recall from the newspaper where she was pictured crying and very upset about the closure of La Maison Royale. She had called however to complain about the sidewalk because two weeks earlier she had tripped there, the result of the raised stones that you can see in the picture. As a result of her fall, she had scraped her knee and required a bandage. At the time she was asked if she wanted to see a doctor and she declined. No Serious Occurrence Report in respect of her scraped knee was filed with the City. In my view no Serious Occurrence Report was merited in this case. Nonetheless this resident's resulting complaint about the sidewalk triggered an investigation by Bill Tetler, Compliance Enforcement Officer.

I do not know Mr. Tetler although I assume he is here today. I am told by my clients that he is a large, towering man. They are typical Filipinos and are much smaller in stature. He is a loud man; they are quiet. It occurs to me there may very well be a cultural dynamic to the relationship between them. My client tells me that Mr. Tetler was very clear when he attended La Maison Royale on October 20<sup>th</sup> saying "I am tired of coming here. I am going to get you shut down". For some reason there seems to be an animus between them which is not warranted by the facts.

Following Mr. Tetler's visit, a notice of threatened suspension was given that day by the Licence Commissioner which you will find at Appendix S. I find this notice seriously lacking in particulars with respect to the complaints numbered 1, 2, 6 and 7. Additionally, I note that the threatened suspension is based on subsection 151(2) of The Municipal Act which requires there be "immediate danger to the health and safety of the residents". I have to say that in light of the particulars given with respect to complaints 3, 4 and 5 and the lack of specifics otherwise, it is a serious stretch to say that the health and safety of the residents was in immediate danger, which I note is the necessary precondition for the Commissioner's power to suspend.

For instance, item 3 is the failure to post a required menu. Paragraph 28(7)(a) of Schedule L-1 to By-law 395-2004 provides that "menus shall be posted seven days in advance of the date on which the meals are to be served". The picture you see on the bottom half of Appendix O is simply the menu for the week. The menu for the following week which is necessary to meet the requirement exactly as worded in paragraph 28(7)(a) of the Schedule to the By-law is on a sheet behind the photographed menu. Mr. Tetler insists that both weeks menus have to be displayed to meet the wording of the By-law. This has now been done but clearly the residents were in no immediate danger.

Items 1 and 2 of the letter of October 20, 2011 are very difficult to respond to given the lack of particulars. Our client's response on October 21 found at Appendix T seems to adequately deal with the issues, noting the attendance of the Health Unit with their approval of the sanitary conditions in the homes in August, 2011 and noting the attendance of the registered dietician within the previous 12 months dealing with nutritional provisions for the residents. Similarly the response of our client with respect to the basement apartment noted in item 4 of the Commissioner's letter is quite compelling. The plans for the basement room were submitted and received by the Licencing Department in October, 2010. The resulting licence that was then issued for 1028 Pelissier was for 9 rooms and 14



occupants, up from the prior licence which was for 7 rooms and 13 occupants. Having viewed the basement room in question, I agree that the window was too small to meet the Bylaw test which provides in paragraph 14 that the window must be equal to 5% of the floor space, so maybe the room never should have been licenced. Nonetheless it had been licenced by the Commissioner for almost a year. Further it is noteworthy that the individual that was living in that basement unit had chosen it over sharing a room upstairs.

Allow me to digress for a moment to note the two current licences for La Maison Royale are for 14 and 23 occupants in 9 and 13 rooms respectively for a total of 37 occupants in 22 rooms. However La Maison Royale has never tried to operate at capacity. As of October 27<sup>th</sup> there were 18 occupants and everyone had their own room except for one instance where the occupants specifically requested double occupancy arrangements.

Of course many of these clients have psychiatric issues. That is the case for the resident in Room No. 6 in 1028 Pelissier. Pictures of her room and the window therein which is noted in item 5 of the Commissioner's October 20<sup>th</sup> letter are found at Appendix R. The damage shown to the window and to the wall was done by the resident herself. This is not an isolated

incident. She has been at La Maison Royale for 4 years and has broken furniture, such as armoires and dressers and the belongings of other residents. However her mother and step-father support her and on more than one occasion the step-father has attended at La Maison Royale to fix things that this resident has broken. Indeed he painted the room in question after she last damaged it. La Maison Royale understood that the step-father was coming again to fix this most recent damage. That said, as you will note in the response to the City found at Appendix T, upon receipt of the City's complaint the broken window noted was replaced forthwith.

Finally items 6 and 7 in the Commissioner's report are also difficult to respond to, given the lack of particulars with respect these alleged infractions. We understand however that they both flow from the discussions of Inspector Bill Tetler with the resident who complained about the sidewalk. We understand that Mr. Tetler believes that a Serious Occurrence Report should have been filed in respect the resident's scraped knee. In fairness it should be noted that this resident did walk over to Hotel Dieu Grace Hospital a couple of days later complaining that her hip hurt from the fall and ultimately I understand through her own doctor, she received some physiotherapy in that respect. Further given Mr. Tetler's expressed concern, a Serious Occurrence Report was filed by LMR with the City on October 20. This however was not required by the By-law which sets out in

paragraph 28(3) the obligation to report Serious Occurrences. Subparagraph A provides that "every occurrence of fire, assault and injury, or communicable disease which in the opinion of the attending physician requires medical treatment, shall be reported to the Licence Commissioner within 24 hours of the occurrence". Paragraph B provides that "all incidents or complaints of sexual assault be reported immediately to the Windsor Police Service and to the Licence Commissioner within 24 hours of the occurrence". In sum there are four instances which the By-law provides must be reported: fire, assault and injury, communicable disease and sexual assault. Clearly a scraped knee does not rise to that level to merit the filing of a Serious Occurrence Report.

I note however that the wording is different in the Domicillary Hostel Standards. That document states on Page 5

"The Operator shall record and report all significant incidents occurring at the home such as accidents, injuries, alleged abuse or abuse of residents or staff, medication error, police intervention, fire, etc."

Again I would not think most people would regard a band aid on a scraped knee as a significant incident but I concede that the event was accidental and it resulted in an injury, albeit a small one. The argument could therefore be made that under the wording of the Domicillary Hostel Standards, that a Serious

Occurrence Report should have been filed. I don't believe that argument is persuasive but at least there are grounds in the wording of the Domicillary Hostel Standards for saying so, contrary to the wording of the By-law. This distinction between the By-law wording and the wording of the Domicillary Hostel Standards is a very important one for this Commission. That is because the following the Domicillary Hostel Standards is not a requirement for the licencing of a Class II Lodging Home. Rather, the Domicillary Hostel Standards are a requirement that the City imposes on lodging homes pursuant to contracts for the placement of subsidized residents. Indeed there are some significant differences between the requirements for the licencing of a Class II Lodging Home under the By-law and the Domicillary Hostel Standards, although they are often conflated by City staff. Your job as Licencing Commission, as set out in 3.31 of the By-law, is simply to consider whether the By-law has been breached or whether the conduct of the officials of LMRs leads you to believe that La Maison Royale will not carry on its business in accordance with the law or with honesty and integrity.

We again see this conflation of the requirements of the By-law with the requirements of the Domicillary Hostel Standards in item 6 in the Commissioner's letter of October 20. Although it lacks particularity, we understand that the charge of failing to provide assistance to the residents for their health and personal

needs relates again to Mr. Tetler's discussion with the same resident where he was advised that she had not showered in two weeks. We believe that lack of bathing to be true and note that it is the result of the illness of a particular staff member who is the only person this resident would allow to assist her with her shower. Clearly it is a difficult situation where a person refuses both to shower on her own and refuses offered assistance for that purpose but it does not appear to be a breach of the By-law. Indeed the only reference in the By-law to personal washing is in paragraph 2 where the difference between a Class I and Class II Lodging House is defined as whether or not assistance is provided to residents "in caring for their health and for their personal needs, including washing, dressing or eating". There is no requirement in the By-law that a resident must have a shower or bath on any minimum schedule. The Domicillary Hostel Standards does provide somewhat more assistance on this issue. It states on page 15:

" the operator shall ensure that assistance with the routines of daily life, such as but not limited to eating, bathing, personal hygiene, toileting, dressing and the maintenance of privacy and personal dignity, as required by the residents, are provided. The Operator will provide support and encourage residents to perform daily living skills to the best of their ability".

I note however that even here the resident's consent or acquiescence is acknowledged as being necessary, saying that

the assistance with bathing is to be provided "as required by the resident".

In summary, in reviewing the complaints listed in the Commissioner's letter of October 20<sup>th</sup> to La Maison Royale as set out in Appendix S, it appears the only actual By-law infraction was the failure to make clearly visible two weeks worth of the menu. In light of that fact and the responses given by La Maison Royale as set out in Appendix T, it is not surprising that the Commissioner decided not to proceed with the threatened suspension and so advised La Maison Royale by letter dated October 21<sup>st</sup> which is found at Appendix U.

It is noteworthy that this threatened suspension was only in respect of 1028 Pelissier. Thus you will note the Commissioner's letters of October 20<sup>th</sup> and 21<sup>st</sup> are both addressed to La Maison Royale at 1028 Pelissier. This is in contrast to the Commissioner's letters of October 26<sup>th</sup> and 27<sup>th</sup> which are found at Appendix X and Appendix Z. Those letters are addressed to La Maison Royale at both 1016 and 1028 Pelissier. This is just one example of the confusion that has been occasioned by La Maison Royale having two separate licences for its establishments at 1016 and 1028 Pelissier.

It is not clear why two separate licences are required. The homes are side by side, less than 30 feet apart separated only by a driveway and the residents go freely back and forth between the two houses. The Rosete family bought the La Maison Royale business conducted at 1028 Pelissier through their corporation in 2004. In 2008 they sought to enlarge their operations by purchasing the adjoining property at 1016 Pelissier. Both houses carry on business under the name La Maison Royale. It is an arrangement that the Rosettes are familiar with because prior to becoming owners of the lodging home they themselves had worked at Marentette Rest Home which operated at the time in two adjacent buildings, albeit under one licence.

However from the time the Rosetes bought 1016 Pelissier to convert it to a lodging home, the Office of the City Licence Commissioner has taken the position that 1016 and 1028 Pelissier are two separate operations, each requiring its own licence. There have been a number of ramifications from this decision, the most challenging one from an economic perspective being the requirement that each home separately meet the staffing ratios set out in the By-law in paragraph 28(4).

That provision requires that there be one staff equivalent, which is defined as one person working an 8 hour shift, for

every seven residents, and that there be two staff persons on duty during the night shift. From an economic point of view, that means that the optimum size for a lodging house would be 28 occupants. That is because the minimum number of staff equivalents a home must have for every 24 hour period is four, one on each of the two day shifts and two for the night shift and given the required minimum ratio of seven occupants, that means four staff can serve a maximum of 28 residents.

I recall speaking to Council on this staffing matter when the requirement for two staff at night was added to the Lodging House By-law, noting that it would adversely impact the smaller lodging homes which often provide the best environment for the domiciliary hostel clientele. Consider briefly the math involved. 1028 Pelissier had eleven residents and if they are all subsidized clients, La Maison Royale would receive \$47.75 each for a total of \$525. If La Maison Royale has to provide 32 hours of staffing, at minimum wage that is \$336 plus CPP and EI, meaning that after wages there is less than \$175 per day for the groceries, supplies and utilities, etc. for these eleven residents. Worse there is only so much that can be done by the two staffers at night, such as laundry, so the night staff generally spend a great deal of time doing very little while the residents sleep. If La Maison Royale had one licence for its adjacent houses, as was the case for Marentette Rest Home, there would be considerable savings.



I can see nothing in the By-law that addresses the situation of adjacent buildings or that supports the City's position that separate licences are required. I therefore would like to make the suggestion to the Members of Council who are on this Commission that you ask Administration to consider refinements to the Lodging House By-law to deal with the issue of adjacent homes owned by the same lodging home operator. This situation is not analogous to that of a licensee who owns lodging homes in different areas of the City.

I note this issue of the separate La Maison Royale licences because it is at the root of a number of the various "infractions" that are cited by the Licence Commissioner in her report to this Commission. The most serious of those infractions occurred in May of this year when Douglas Rosete was acting as the second night staffer at both 1016 and 1028 Pelissier when Mr. Tetler showed up for an inspection. The staffers at both houses told him that Douglas Rosete was the second staffer and was on break. The result was that when Douglas returned a few minutes later he was charged with breach of the By-law at both locations as he could not be the second staffer at both. Accordingly he pled guilty on October 3 to one charge and was fined \$250 while the other charge was withdrawn. I note that there was a second such incident in June, 2011 where the second staffer in one of the homes became ill and was sent home prior to the arrival of inspectors but no charges resulted from that incident. I note the

date of Douglas Rosete's guilty plea of course because that was two weeks before the Licence Commissioner who was well aware of this matter, reissued both licences to La Maison Royale for 2012.

You will see other instances in the Commissioner's report where "infractions" are deemed to have occurred because of the buildings being adjacent. For instance, all of the staff records were initially kept at 1028 Pelissier where the central administration was. Food supplies at 1016 were deemed insufficient without reference to the food supplies at 1028. Many of these incidents are now several years old but they are indicative of the difficulties imposed by having to have two licences for two lodging homes less than ten yards apart that are owned by the same person.

Initially Social Services took the same approach as Licencing, saying their contract for subsidized residents was with 1028 Pelissier not 1016. Accordingly, notwithstanding the desires of a number of the subsidized residents to stay in the facilities at 1016, Social Services initially required them to move back to the smaller home at 1028 Pelissier. I note however that this stance was relaxed in June, 2011 and the 13 subsidized residents for La Maison Royale were allowed to stay in both homes. I think a significant factor in that decision was the

recognition that this allowed virtually all the subsidized residents to have their own room where as if they were all in 1028, most of them would have to double up.

Excuse me if I have gone on too long on the problems that have resulted from the two licences for the two adjacent buildings. It is however a useful lead in to a review of the Commissioner's letters of October 26 found at Appendix X and Z listing reasons why she was again considering suspension of the La Maison Royale licences, this time at both locations and then imposing that suspension. The only thing that has occurred since the Commissioner's decision on October 21<sup>st</sup> not to suspend the LMR licence at 1028 Pelissier was the medication overdose to the resident at 1016 Pelissier. In my submission, the Commissioner's letters are shocking in their lack of detail, in the lack of particulars as to the evidence that has given rise to the listed concerns. There are simply bald statements that a suspension appears warranted because of:

1. Concern with regard to nutritional provisions for residents;
2. Failure to provide assistance to the residents for their health and personal needs;
3. Failure to file Serious Occurrence Reports;
4. Failure to provide adequate levels of staffing.

The licensee is surely entitled to know what deficiencies are being complained of. You as Licencing Commissioners are entitled, indeed required to know, what failings this licensee has evidenced that demonstrate it is either stuck in an unremediable breach of the By-law or that its officials are determined not to carry on this lodging home business in accordance with the law and with honesty and integrity. Yet there is absolutely no such evidence set out in these letters of October 26<sup>th</sup> and 27<sup>th</sup>.

Further, I note both of these letters invoke subsection 151(2) of the Municipal Act claiming that there is an immediate danger to the health and safety of the residents as the basis for this suspension. Yet not a single fact is alleged in support of that conclusion. In our submission, the Commissioner has a duty to lay out chapter and verse as to why she believes there is an immediate danger to the residents for invoking this power to suspend the licence. She did not do that and absent those particulars, I do not believe the Commissioner had the authority to invoke the licence suspension that she nonetheless has imposed with grave injury to the reputation and purse of my client. My task today however is not to deal with whether the Commissioner failed in the execution of her duties. Rather the issue today is the Commissioner's recommendation to this Commission that the La Maison Royale licences should be revoked.

Nonetheless we do have to deal with the allegations in these letters which my clients tried to answer as best as they could in their handwritten response that is found at Appendix Y. Without particulars, this was a difficult task. For instance, the requirements for the nutritional provisions for residents are set out in paragraphs 128 (8)(a) through (g) of the By-law and we should review them. I can tell you that LMR endeavours to provide food with nutritional value in accordance with the daily requirements of Canada's Food Guide having energy values adequate to maintain the average weight of each resident. LMR provides breakfast, lunch and dinner well balanced in accordance with Canada's Food Guide. LMR provides healthful foods and snacks from one of Canada's food groups each day and evening. LMR ensures it always has a 24 hour supply of perishable foods for its residents and a 72 hour supply of non-perishable foods. Every year La Maison Royale has employed a registered professional dietician to review its menus and assist with the food's service. If there is some failing in the licensee's duties under the By-law, the Commissioner needs to state what that is because the licensee has been doing everything it can to meet its obligations.

On the question of providing assistance to the residents for their health and personal needs I have already discussed the one resident's lack of showers, which I submit does not constitute a breach of the By-law. I assume this topic also covers the

medication overdose in respect of which La Maison Royale both acknowledges its mistake and wishes to strongly assure this Commission that this will never ever happen again.

The Commissioner's third complaint is the failure to file Serious Occurrence Reports. We have discussed at length the fact that a Serious Occurrence Report was clearly not required under the By-law to be filed in respect of the scraped knee. I understand however that there is a further complaint that the Serious Occurrence Reports in respect of the overdose and the one eventually sent in respect of the scraped knee were not sent to the Licence Commissioner although they were sent to the Social Services offices. Thus if you look at Appendix V and Appendix W which deal with the overdose you will note that although the faxes are dated October 24<sup>th</sup> and October 27<sup>th</sup> respectively, they are both stamped as having been received by the Licence Division as of October 31<sup>st</sup>. I can advise this Commission that with respect to both Serious Occurrence Reports I have here the fax confirmation sheets showing they were sent both to the Social Services fax at 256-7107 and the Licence Commissioner's fax at 255-9467. However it appears that the fax number for the Office of the Commissioner changed at some point in 2011 to 255-6588. I note that this new number shows up on the correspondence to La Maison Royale in October, 2011 but all earlier correspondence in my client's possession shows the old fax number. One would think that

given the requirement for lodging home licences as well as presumably other licences to fax notices to the Office of the Commissioner that this change in the fax number would have been properly advertised but it does not appear that this was done, nor is it clear what happened to the faxes that were most definitely sent to 255-9467. We have a record of a good transmission to that number but of course do not know where that machine is now located. I submit that with respect to its reporting obligations, it is hard to find fault with this licencee. The reporting was handled properly, promptly and in accordance with the By-law.

Lastly, in her letter of October 26 the Commissioner notes concern over staffing levels, presumably a reference to the guilty plea on October 3 for breach May 29<sup>th</sup> of the By-law in respect of staffing at 1016 Pelissier. This however was apparently not an issue October 17<sup>th</sup> when the licence was renewed by the Commissioner, nor was it an issue noted in the Commissioner's letter of October 20<sup>th</sup> and it is therefore not clear why it is now an issue on October 26, save as an attempt to buttress a very weak case.

In sum the letters of October 26 and 27 are of no assistance to this Commission in determining why La Maison Royale should today have its licences revoked. Rather this Commission

will have to look to the background and summary of the Commissioner's Report where she states:

"It is the opinion of Administration that without constant inspection and instruction to comply, the Operator does not implement, and staff do not follow, proper policies and procedures in order to comply with the By-law. They have consistently failed to comply with the By-law and to provide a healthy and safe environment for the residents. Most recently this lack of proper procedure lead (sic) to a serious injury to one of the residents who had to be hospitalized as a result of an overdose of medication."

So let's look at this licensee's pattern of behavior. But let's begin by noting that this rationale, that there is a pattern of behavior that this licensee will not comply with the By-law unless big brother is standing over their shoulder is a far cry from the allegations made on October 26<sup>th</sup> and 27<sup>th</sup> when these licences were suspended on the basis of immediate danger to the residents. There was no immediate danger.

Unless the Commission thinks otherwise, I don't think that it will be particularly helpful to you for me to go through each of the various Appendices commenting on perceived infractions and responses from 2007 to date as I have done with the two



incidents or investigations that occurred after October 17 when the Commissioner renewed these licences for 2012.

I would however like to comment on 2 further Appendices. At Appendix AA you will see an email from Citizen Advocacy noting that bed bugs were found in one bedroom at 1016 Pelissier. As the Commission is undoubtedly aware, bed bugs are increasingly a problem for hotels and homes across Ontario. They are hard to see and difficult to get rid of and LMR was not aware they were in the home. The interesting thing is that the resident in that room gave no indication of a problem. Further he suffers from diabetes and has a wound on his foot. A registered nurse from CCAC has for months attended on him daily in his room to change the dressing on that wound. She too gave no indication of any such problem. The one good thing that can be said to have come out of October 27 is that these bugs were found and contained before they had spread to other rooms at LMR.

Secondly, I note a number of Appendices, specifically F, G, H, I and CC are communications with Social Services about issues arising from the City's contracts with LMR and accordingly they are not dealing with By-law issues that are relevant to this Commission. Still, I think it might be worthwhile to look at the allegations regarding breaches of the Domiciliary Hostel Standards that are set out in Appendix CC.

You will note on the first page of Appendix CC in the second paragraph that the Domiciliary Hostel Standards were implemented in the City of Windsor in 2007/2008 and to that end a meeting was held with the hostel operators in December 2008. Just under half of the "infractions" in Appendix CC (19 of 39), relate to this implementation

period when LMR at 1028 Pelissier, like all of the hostel operators, was subjected to reviews to bring their operations up to the new, improved standard.

Six of the alleged infractions of the Domiciliary Hostel Standards deal with the matters we have already discussed: the scraped knee, the night staffing, the overdose and the bathing. Nine of the alleged infractions of the Domiciliary Hostel Standards deal with the review of the operations of 1016 Pelissier that occurred in July of this year, after Social Services had agreed to lodge subsidized residents in that home. Like the alleged infractions from three years earlier, this was simply a case of making sure that this new licensee was compliant with the DHS. I note that the City has updated the Domiciliary Hostels Standards on a regular basis and that where required, changes in procedure have been made by LMR.

That leaves five items remaining all of which arose when Social Services accompanied Mr. Tetler when he visited the homes on October 20 and on October 24. Looking at the five, we agree that a couple of them require changes in procedure, and a couple simply arise from the operation of two homes side by each.

However, with all that has gone on with the Licensing Commissioner, my clients have not yet had a chance to respond, but they will do so promptly once their licenses are restored. Frankly, that is the way regulations should work, particularly as standards are regularly reviewed and changed. My clients have always desired to be compliant and as changes in the standards have been made, they have been implemented.

In that regard, one of the letters from Social Services that did not get included in the Commissioner's report is one from Social Services dated June 10, 2010, copies of which I will pass out. It reads:

"Re:: Annual Inspection of La Maison Royale May 31/10

I am pleased to inform you that your facility has consistently met the standards in all areas of the provincial standards for domiciliary hostels."

In summary, I have two comments to make on what has transpired over these last few weeks. Firstly, a serious incident happened at La Maison Royale on October 24. A resident overdosed on medication as a result of an unusual sequence of events. LMR is as upset as anyone with this stain on its record, the first such incident in its eight years of operation. They are here today to tell this Commission and the Commissioner that they are deeply sorry for what happened and that it will not happen again.

Secondly, as I consider all the matters that have been placed before this Commission today, I think we may have fallen into "gotcha" regulation. In my experience in dealing with Canada Revenue Agency for instance, I note that collection files are moved around between officers on a regular basis, usually every six months. I see the same thing happen with banks, where accounts are moved around amongst different loan officers. These types of rotations prevent both relationships that become too close from developing as well as the animosity that can come from familiarity. It prevents staleness and can bring fresh eyes to a situation that would be helpful here.

I want to apologize if I have in any way offended the Commissioner or Mr. Tetler with my remarks today. I recognize that they are doing an important and often difficult job

and have the interests of vulnerable residents at heart. However I have to say also that the Rosete family also have an important and difficult job in trying to accomodate a group of vulnerable residents. It is one they have done without a serious incident for eight years until October 24.

In conclusion, I ask this Commission to reinstate the two licences of La Maison Royale as a Class II lodging home, effective immediately.