Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 24, 2014	2014_247508_0016	H-000415-14	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

ANSON PLACE CARE CENTRE
85 Main Street North, Hagersville, ON, N0A-1H0

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 10, 11, 12, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Assessment Instrument Co-ordinator (RAI Co-ordinator), Registered staff, Personal Support Workers (PSW), Registered Dietitian, residents and family

During the course of the inspection, the inspector(s) toured the home, observed provision of care, observed meal service, reviewed resident's clinical records, relevant policies and procedures, the complaint log, interviewed staff, residents and family

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Pain
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that when the resident was taking a drug, there was monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level.

Resident #001 was ordered a narcotic patch to manage their pain in March, 2014. This medication was started two days later, then the dosage was increased a week after it was started. Two days later, resident #001 became unresponsive as a result of this medication. Staff reported the resident's change in condition to the charge nurse that morning and regular medications were held in the morning and afternoon. The clinical record and the internal investigative notes indicated that the resident was not assessed until the resident's family member came into visit, found the resident, and requested they be sent to the hospital that afternoon. The resident's clinical record indicated that the resident was not monitored for the effectiveness and the resident's response was not documented after this increase. It was confirmed by the Director of Care that staff did not monitor the resident after the dosage was increased. [s. 134. (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that all residents, including resident #001, were cared for in a manner consistent with their needs, including, the monitoring of medication side effects, and the need for continuous oxygen.

In April, 2014, the Registered Practical Nurse (RPN) documented that resident #001 was difficult to arouse that morning. The resident's narcotic medication had been increased two days prior to manage the resident's pain. During that period, the resident had not been monitored by staff for the effects of the increase in medication. Staff notified the nurse in charge regarding the resident's change in condition, however, the resident was not assessed until later that afternoon when family came into visit and discovered the resident to be unresponsive. When the family member found the resident, the resident's oxygen nasal prongs were on the resident but the oxygen tank was empty. The resident was transferred to the hospital and received medication to reverse the side effects of the narcotic and admitted to the hospital for three days. According to the hospital documentation, the resident's oxygen saturation level was low and the resident was also dehydrated. It was confirmed by the DOC that staff did not monitor the resident for side effects of the narcotic and the resident was hospitalized for three days due to these medication side effects.

The resident was re-admitted to the home three days later. An interview with staff and the resident confirmed that the oxygen tank is not being checked every shift and the resident has run out of oxygen since their re-admission. [s. 3. (1) 4.]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #001 required continuous oxygen due to health conditions and used a portable oxygen tank. The resident's family member reported a concern to the Director of Care (DOC) when the resident was found by that family member with the oxygen tank empty.

Due to this concern, the home implemented a sign off sheet for staff with the direction to check the oxygen tank every shift to ensure it is full and sign off when this check was done.

The resident's plan of care that staff refer to for direction, did not provide this information. Staff interviewed by the compliance inspector were not aware of this intervention. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001's plan of care directed staff to administer continuous oxygen via nasal prongs at 2L/minute due to the resident's health condition. The plan of care also directed staff to document the resident's oxygen rate, concentration, and the resident's tolerance every shift. A review of the resident's clinical record indicated that the staff are not documenting this information every shift. An interview with the resident confirmed that their oxygen is not being monitored every shift according to their plan of care. On three occasions in 2014, the resident's oxygen tank was not monitored and the resident ran out of oxygen. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents including resident #001 is cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy, Resident Hydration (RCS C-40), in the Resident Care and Services Manual directs night registered staff to total the amount of fluid consumed by the resident on a 24-hour basis for comparison to the amount specified in the plan of care. Residents that do not meet their identified fluid requirements are to be listed on the 24-hour report and on the "total" column/box of the fluid sheet.

a) A review of the Residential Nutritional and Intake Records for Resident #001, #002, and #003 for April, May, and June, 2014 indicated that the night registered staff are not documenting 100 percent of the time that the 24-hour fluid intake for these resident's were reviewed. It was confirmed by the Director of Care that staff were not following their policy. [s. 8. (1) (b)]

2. In April, 2014, the home implemented a procedure to ensure that staff monitor a resident's oxygen tank and sign off on every shift to prevent the tank from out of oxygen.

A review of the sign off sheets for April, May, and June, 2014, indicated that the staff were not consistently checking the oxygen tank and signing off every shift as directed. From April 9th, to June 12, 2014, there were five days that the staff did not sign off on any of the three shifts that the oxygen had been checked. It was confirmed by staff and an interview with the resident that the staff are not consistently checking and filling the oxygen tank. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #002 was admitted to the home in January, 2014. The resident's plan of care developed upon the resident's admission to the home indicated that the resident was incontinent of bladder. A review of the resident's clinical record indicated that the resident did not receive an admission continence assessment using a clinically appropriate assessment instrument. It was confirmed by registered staff and the DOC that the assessment was not done. [s. 51. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee did not assess the resident when their pain was not relieved by initial interventions using a clinically appropriate assessment instrument specifically designed for the purpose.

Resident #001 had chronic pain and received regular and breakthrough medications. A quarterly pain assessment was completed in March, 2014, indicating that the interventions at the time of the assessment were managing the resident's pain. Resident #001 reported to staff that they had pain in March, and in April, 2014. Medication adjustments were done during this time. Staff did not reassess the resident using the clinically appropriate assessment instrument until the quarterly pain assessment was completed in May, 2014. [s. 52. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was informed of the following incident in the home after the occurrence of this incident, followed by a report required under subsection (4) when a medication incident and adverse drug reaction in respect of which a resident was taken to hospital.

Resident #001 was ordered a narcotic patch for pain management in March, 2014. A review of the clinical record indicated that a week later, this medication was increased due to the resident reporting to staff that the dosage initially prescribed was ineffective in managing their pain.

Two days after the medication dosage was increased, the resident's clinical record indicated that the resident was difficult to arouse. Registered staff documented on this day that the resident's medication was held due to their unresponsiveness and resident #001 was then transferred to hospital after consultation with the Physician.

Resident #001 was administered a medication in the emergency department to reverse the effects of the narcotic and was then admitted to hospital for three days.

It was confirmed by the Director of Care that the home was aware of this incident and did not report this incident to the Director. [s. 107. (3) 5.]

Issued on this 27th day of June, 2014

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_247508_0016
Log No. / Registre no:	H-000415-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 24, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	ANSON PLACE CARE CENTRE 85 Main Street North, Hagersville, ON, N0A-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA ROTH (ACTING)

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall ensure that when residents are taking a drug, there is monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level.

Grounds / Motifs :

1. The licensee did not ensure that when the resident was taking a drug, there was monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level.

Resident #001 was ordered a narcotic patch to manage their pain in March, 2014. This medication was started two days later, then the dosage was increased a week after it was started. Two days later, resident #001 became unresponsive as a result of this medication. Staff reported the resident's change in condition to the charge nurse that morning and regular medications were held in the morning and afternoon. The clinical record and the internal investigative notes indicated that the resident was not assessed until the resident's family member came into visit, found the resident, and requested they be sent to the hospital that afternoon. The resident's clinical record indicated that the resident was not monitored for the effectiveness and the resident's response was not documented after this increase. It was confirmed by the Director of Care that staff did not monitor the resident after the dosage was increased. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that all residents, including resident #001, are cared for in a manner consistent with their needs, including, the monitoring of medication side effects, and the need for continuous oxygen.

Grounds / Motifs :

1. The licensee did not ensure that all residents, including resident #001, are cared for in a manner consistent with their needs, including, the monitoring of medication side effects, and the need for continuous oxygen.

In April, 2014, staff documented that resident #001 was difficult to arouse that morning. The resident's narcotic medication had been increased two days prior to manage the resident's pain. During that period, the resident had not been monitored by staff for the effects of the increase in medication. Staff notified the nurse in charge regarding the resident's change in condition, however, the resident was not assessed until later that afternoon when family came into visit and discovered the resident to be unresponsive. When the family member found the resident, the resident's oxygen nasal prongs were on the resident but the oxygen tank was empty. The resident was transferred to the hospital and received medication to reverse the side effects of the narcotic and admitted to the hospital for three days. According to the hospital documentation, the resident's oxygen saturation level was low and the resident was also dehydrated. It was confirmed by the DOC that staff did not monitor the resident for side effects of the narcotic and the resident was hospitalized for three days due to these medication side effects.

The resident was re-admitted to the home in April, 2014. An interview with staff and the resident confirmed that the oxygen tank is not being checked every shift and the resident has run out of oxygen since their re-admission in April, 2014. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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
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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 24th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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