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
Mar 20, 2014	2014_188168_0006	H-000863-13	Follow up

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET, HAMILTON, ON, L8R-3L8

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

LISA VINK (168), ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 27, 2014, and March 4, 5, 6, 7, 10, and 17, 2014.

This Inspection Report includes log numbers: H-000862-13, H-000863-13, H-000864-13, H-000865-13, H-000866-13 and H-000868-13.

Findings from this inspection related to LTCHA, 2007 section 6 and O. Reg 79/10 section 8 are included in Complaint Inspection Report H-000193-14 H-000194-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Registered Dietitian (RD), Food Service Manager (FSM), registered nursing staff, personal support workers (PSW), unregulated staff and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documentation including but not limited to: clinical health records, policies and procedures, and meeting minutes.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Safe and Secure Home

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. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. **Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. Not all residents with significant weight changes were assessed using an interdisciplinary approach nor were actions taken and out comes evaluated.

A. Resident #205 had a significant weight loss of 5.9 percent over one month in 2013, and a further significant weight loss of 4.9 percent from September to November 2013, (10.4% weight loss in six months). Progress notes dated November 18, 2013, and November 25, 2013, indicated dietary referrals were initiated related to diet change, weight loss, low fluid intake and one additional causative factor. The Dietary Referral Response nutrition notes documented by the RD on December 2, 2013, stated on textured modified diet diet and fluids. Continue current diet order as long as resident accept it. Progress notes of December 13, 2103, identified a significant weight warning triggered for a 10.4 percent weight loss over six months. The Registered Practical Nurse (RPN) indicated the reasons for weight. The dietary summary completed on January 20, 2014, by the RD stated the weight and BMI with gradual non-significant loss of 7% x 6 months. Weight just below target weight range. The progress notes, food and fluid intake documentation for December, 2013, and January 2014, and staff interview confirmed the resident was eating poorly, only consuming half of their meal for most lunch and dinner meals, was routinely refusing afternoon and evening nourishments and was not meeting hydration requirements. However, the review by the RD did not include an assessment of the resident in relation to weight loss and low food and fluid intake. The plan was to continue with the current nutrition interventions, which were not effective to address the ongoing poor intake and unplanned weight loss.

B. Resident #302 had a 7.6 percent significant weight loss from January to March 2014, which triggered a significant weight loss warning. The resident was admitted in 2014, and the weight was recorded. The residents weights for February 2014, and March 2014, were recorded with a weight loss. The plan of care identified the goal of the resident will weigh within realistic goal weight range and Basal Metabolic Index. However, action was not taken to address the weight loss and the resident was not reassessed by the RD.

C. Resident #300 had a significant unplanned weight gain and was not assessed using an interdisciplinary approach nor were actions taken and outcomes evaluated. A weight warning was triggered on December 26, 2013, for a significant weight gain of 5.6 percent over one month November to December 2013. On February 14, 2014, a further weight warning was triggered for a significant weight gain of 15.7 percent over six months. The quarterly summary documented by the RD on February 8, 2014, stated the current weight, BMI, and weight range; and noted adequate intake to maintain weight within target range and adequate hydration without over hydration.

The Resident Assessment Protocol (RAP) summary completed on January 8, 2014, stated "resident is responding to the interventions as outlined in the care plan. Resident's clinical assessment has not changed from the last assessment. Interventions continue to be effective in maintaining resident's nutrition status". However, the resident's clinical records indicated a change in health status, including unplanned weight gain and elevated lab values. The RD reviewed the resident related to the weight gain, however, interventions were not revised nor action taken to address the ongoing unplanned weight gain. [s. 69. 3.]

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. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The care set out in the plan of care was not provided to the resident as specified in the plan.

A. The plan of care for resident #201 indicated they were to be provided resource 2.0 at all meals. On February 27, 2014, the resident was observed to be fed by a PSW. The staff did not feed the resident resource at lunch. Dietary and nursing staff interviewed stated they were not aware of the resident receiving the resource at meals. The RD stated that a few months ago some changes were made to the

administration of resource. The supplement was taken off the dietary list and transferred on to the Medication Administration Record (MAR). The medication nurse was to prepare and administer the supplement, the dietary staff was no longer providing the supplement. The FSM confirmed the preparation and provision of resource 2.0 in the kitchen was discontinued on December 5, 2103. However, the medication nurse interviewed reported the information was not communicated and the supplement was not transferred to the MAR. There was no documentation to confirm if the resident was provided resource 2.0 at meals.

B. The plan of care for resident #203 identified a risk for constipation and an individualized bowel protocol. The clinical record, including the flow sheets and MAR identified that staff did not provide care to the resident as specified in the plan on the following occasions:

i. The resident had a bowel movement (BM) on December 31, 2013, and not again until January 4, 2014, however was not provided any additional interventions during this period of time to promote bowel functioning.

ii. The resident had a BM on February 16, 2014, and not again until February 20, 2014, however was not provided any additional interventions during this period of time to promote bowel functioning.

Interview with registered staff identified that although the individualized protocol included different medications than the established protocol of the home, staff were to provide intervention to the resident on the third day without a BM, which was not completed.

C. Resident #204 did not receive care as specified in the plan of care related to fluid restriction. The plan directed to provide specific quantities of fluids at meals and nourishment times. On March 4, 2014, the resident was observed during the noon meal service at 1220 hours. The resident received 200 ml of milk, 200 ml of water and 180 ml of coffee at lunch, which was contrary to the fluid restrictions ordered by the physician and the plan of care. A review of food and fluid intake record identified that most days fluid intake was over the daily target. The fluid intake record for January 2014, indicated that for 21 of 31 days the resident's fluid intake was over the daily target. The RD confirmed the resident's daily intake exceeded the fluid restriction.

D. The plan of care for resident #300 dated January 3, 2013, and the diet sheet identified the resident was to be provided salt on meals prior to serving and large portions at lunch and dinner as requested by the resident. On February 27, 2014, during the noon meal the resident was served regular portions of entrée and vegetables (grilled cheese sandwich, peas and carrots) and no salt on the meal, which was confirmed by staff. The health record indicated that the physician had ordered

salt on the meal as an intervention for a medical condition. [s. 6. (7)]

2. The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any time when care set out in the plan was not effective.

A. The plan of care dated February 2, 2014, for resident #302, related to risk for dehydration, poor oral intake and weight loss was not reviewed and revised to ensure different approaches were included in the revision of the plan when the resident was reassessed on March 5, 2014. The food and fluid intake records indicated the resident was eating poorly, and was routinely refusing the breakfast meal, afternoon and evening nourishment. The intake record indicated that most days the fluid intake was less than the minimum target fluid requirement. Documentation indicated that the resident had unplanned weight loss since admission. The assessment review was completed by the FSM on March 5, 2014. The dietary summary stated "food intake is good in general, consumes 75% to full, often fluid intake adequate for the assessed needs". The goals recorded stated "resident is responding to the interventions as outlined in their care plan continue to be effective in maintaining/keeping the RAP problem". The resident was assessed at moderate nutrition risk level despite weight loss, potential for dehydration and poor oral intake. The plan of care was not revised to reflect the identified nutritional concerns related weight loss, poor oral intake, and a triggered Resident Assessment Protocol (RAP) for dehydration.
B. Resident #205 was eating poorly, consuming half of most noon and evening meals, routinely refusing afternoon and evening nourishments and was not meeting their hydration requirement, which was supported by progress notes, food and fluid intake records for December 2013, and January 2014, and staff interview. Action was not taken by the RD to address the significant weight loss. The plan was to continue with the nutrition care plan, with the same interventions, which were not effective, to address the nutritional concerns related to poor oral intake and weight loss. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any time when care set out in the plan is not effective, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #005	2013_191107_0006	168
O.Reg 79/10 s. 231.	CO #008	2013_191107_0006	168
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2013_191107_0006	168

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

Issued on this 20th day of March, 2014

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

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) :	LISA VINK (168), ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2014_188168_0006
Log No. / Registre no:	H-000863-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 20, 2014
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	DUNDURN PLACE CARE CENTRE 39 MARY STREET, HAMILTON, ON, L8R-3L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBBIE BOAKES

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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that residents with significant weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

The plan is to be submitted electronically by April 15, 2014, to Long-Term Care Homes Inspector Asha Sehgal at: Asha.Sehgal@ontario.ca.

Grounds / Motifs :

1. Previously identified as non compliant with VPC on August 2, 2013.

1. Not all residents with significant weight changes were assessed using an interdisciplinary approach nor were actions taken and out comes evaluated.

A. Resident #205 had a significant weight loss of 5.9 percent over one month in 2013, and a further significant weight loss of 4.9 percent from September to November 2013, (10.4% weight loss in six months). Progress notes dated November 18, 2013, and November 25, 2013, indicated dietary referrals were initiated related to diet change, weight loss, low fluid intake and one additional causative factor. The Dietary Referral Response nutrition notes documented by the RD on December 2, 2013, stated on textured modified diet diet and fluids.

Continue current diet order as long as resident accept it. Progress notes of December 13, 2103, identified a significant weight warning triggered for a 10.4 percent weight loss over six months. The Registered Practical Nurse (RPN) indicated the reasons for weight. The dietary summary completed on January 20, 2014, by the RD stated the weight and BMI with gradual non-significant loss of 7% x 6 months. Weight just below target weight range. The progress notes, food and fluid intake documentation for December, 2013, and January 2014, and staff interview confirmed the resident was eating poorly, only consuming half of their meal for most lunch and dinner meals, was routinely refusing afternoon and evening nourishments and was not meeting hydration requirements. However, the review by the RD did not include an assessment of the resident in relation to weight loss and low food and fluid intake. The plan was to continue with the current nutrition interventions, which were not effective to address the ongoing poor intake and unplanned weight loss.

B. Resident #302 had a 7.6 percent significant weight loss from January to March 2014, which triggered a significant weight loss warning. The resident was admitted in 2014, and the weight was recorded. The residents weights for February 2014, and March 2014, were recorded with a weight loss. The plan of care identified the goal of the resident will weigh within realistic goal weight range and Basal Metabolic Index. However, action was not taken to address the weight loss and the resident was not reassessed by the RD.

C. Resident #300 had a significant unplanned weight gain and was not assessed using an interdisciplinary approach nor were actions taken and outcomes evaluated. A weight warning was triggered on December 26, 2013, for a significant weight gain of 5.6 percent over one month November to December 2013. On February 14, 2014, a further weight warning was triggered for a significant weight gain of 15.7 percent over six months. The quarterly summary documented by the RD on February 8, 2014, stated the current weight, BMI, and weight range; and noted adequate intake to maintain weight within target range and adequate hydration without over hydration. The Resident Assessment Protocol (RAP) summary completed on January 8, 2014, stated "resident is responding to the interventions as outlined in the care plan. Resident's clinical assessment has not changed from the last assessment. Interventions continue to be effective in maintaining resident's nutrition status". However, the resident's clinical records indicated a change in health status, including unplanned weight gain and elevated lab values. The RD reviewed the resident related to the weight gain, however, interventions were not revised nor action taken to address the ongoing unplanned weight gain. [s. 69. 3.] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2014

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0006, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures the care set out in the plan of care is provided to all residents, including residents #201, #204, #203 and #300 as specified in their plans, related to fluid restriction, management of constipation, diet and nutritional supplement.

The plan is to be submitted electronically by April 15, 2014, to Long-Term Care Homes Inspector Asha Sehgal at: Asha.Sehgal@ontario.ca.

Grounds / Motifs :

1. Previously issued August 2, 2013, as a Compliance Order.

1. The care set out in the plan of care was not provided to the resident as specified in the plan.

A. The plan of care for resident #201 indicated they were to be provided resource 2.0 at all meals. On February 27, 2014, the resident was observed to be fed by a PSW. The staff did not feed the resident resource at lunch. Dietary and nursing staff interviewed stated they were not aware of the resident receiving the resource at meals. The RD stated that a few months ago some changes were made to the administration of resource. The supplement was taken off the dietary list and transferred on to the Medication Administration Record (MAR). The medication nurse was to prepare and administer the supplement, the dietary staff was no longer providing the supplement. The FSM confirmed the preparation and provision of resource 2.0 in the kitchen was discontinued on December 5, 2103. However, the medication nurse interviewed

reported the information was not communicated and the supplement was not transferred to the MAR. There was no documentation to confirm if the resident was provided resource 2.0 at meals.
B. The plan of care for resident #203 identified a risk for constipation and an individualized bowel protocol. The clinical record, including the flow sheets and MAR identified that staff did not provide care to the resident as specified in the plan on the following occasions:
i. The resident had a bowel movement (BM) on December 31, 2013, and not again until January 4, 2014, however was not provided any additional interventions during this period of time to promote bowel functioning.
ii. The resident had a BM on February 16, 2014, and not again until February 20, 2014, however was not provided any additional interventions during this period of time to promote bowel functioning.
Interview with registered staff identified that although the individualized protocol included different medications than the established protocol of the home, staff were to provide intervention to the resident on the third day without a BM, which was not completed.
C. Resident #204 did not receive care as specified in the plan of care related to fluid restriction. The plan directed to provide specific quantities of fluids at meals and nourishment times. On March 4, 2014, the resident was observed during the noon meal service at 1220 hours. The resident received 200 ml of milk, 200 ml of water and 180 ml of coffee at lunch, which was contrary to the fluid restrictions ordered by the physician and the plan of care. A review of food and fluid intake record identified that most days fluid intake was over the daily target. The fluid intake record for January 2014, indicated that for 21 of 31 days the resident's fluid intake was over the daily target. The RD confirmed the resident's daily intake exceeded the fluid restriction.
D. The plan of care for resident #300 dated January 3, 2013, and the diet sheet identified the resident was to be provided salt on meals prior to serving and large portions at lunch and dinner as requested by the resident. On February 27, 2014, during the noon meal the resident was served regular portions of entrée and vegetables (grilled cheese sandwich, peas and carrots) and no salt on the meal, which was confirmed by staff. The health record indicated that the physician had ordered salt on the meal as an intervention for a medical condition. [s. 6. (7)]
(159)

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 : May 30, 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.

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

Ministère 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

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
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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 20th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : LVink

Name of Inspector / Nom de l'inspecteur : LISA VINK

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