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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Dec 19, 2017	2017_695156_0005	024589-17	Resident Quality Inspection

Licensee/Titulaire de permis

Rykka Care Centres LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

Wellington Park Care Centre
802 Hager Avenue BURLINGTON ON L7S 1X2

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

CAROL POLCZ (156), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 26, 27, 30, 31, November 1, 2017.

During this inspection the following inspections were conducted concurrently:

Complaints:
20286-16 related to abuse and neglect, falls prevention
27010-16 related to abuse and neglect
8353-17 related to responsive behaviours
14653-17 related to abuse and neglect
23001-17 related to coercion

Critical Incident Reports:
5156-17 related to abuse and neglect
7547-17 related to abuse and neglect
7704-17 related to falls prevention

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Clinical Director of Nursing, Resident Assessment Instrument Co-ordinator (RAI), Admission Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), family and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed a medication pass, reviewed clinical records, policy and procedures, investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. The nursing staff did not collaborate in the assessment of resident #011 when their care needs changed and when staff documented assessments in the resident’s clinical record which indicated that the resident demonstrated signs and symptoms of an infection.
i. On an identified date in April, 2017, resident #011 was complaining of symptoms of an

infection.
ii. Later that day the resident had an identified symptom and was complaining of pain and was given analgesic for the pain.
iii. A day later, resident #011 still had the identified symptom.
iv. Later that day, resident #011 remained in bed and had poor intake and was having pain. They were noted to have two identified symptoms. RN #111 called the physician and the physician ordered a diagnostic test and two medications. The physician confirmed that they felt they were treating for a specific condition. Interview with RN #111 on October 30, 2017, confirmed that when the they were speaking with the physician regarding resident #011's symptoms on that date, that they were unaware of the assessments that were documented previously related to the resident displaying signs and symptoms of a possible infection and did not report these symptoms to the physician.
v. The following day, the resident was noted to have additional symptoms. The registered staff called the physician and the resident was sent to the hospital.
vi. The resident was admitted to the hospital and a progress note written by the DOC in the clinical record on an identified date in April, 2017, indicated that the resident remained in the hospital with an identified diagnosis.
Interview with the DOC on October 31, 2017, confirmed that the staff did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
Staff failed to provide resident #032 with continence care as specified in the resident's plan of care. Resident #032's plan of care indicated the resident was incontinent and required extensive assistance of one to two staff to use the toilet. Care directions related to this concern were to assist the resident to toilet at scheduled times in order to meet the goal of maintaining the resident's current bladder function. On an identified date in March, 2017, resident #032 reported to staff providing care that on the previous day they had requested to be assisted to the toilet between breakfast and lunch, however PSW #114 refused to provide this care. The Administrator and documented notes made by leadership team members confirmed that PSW #114 had not documented that the specific care was provided, had not provided care to the resident and had not followed the care directions for care as specified in the resident's plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out

in the plan had not been effective.

Resident #002 sustained an unwitnessed fall on an identified date in April, 2017. The resident lost their balance and was found lying on the floor.
The care plan for resident #002 in effect on this date in April, 2017 indicated that the resident was at risk for falls. Interventions were noted in the care plan to reduce the risks to the resident from falls.

The following day, in April, 2017, the resident sustained another unwitnessed fall. Staff heard a noise and found the resident had sustained a fall. The care plan had not been changed since the previous fall and the interventions remained the same; care set out in the plan has not been effective as the resident sustained the second fall.

The following day, in April, 2017 the resident sustained another unwitnessed fall. The resident was found on the floor, sustained an injury and was complaining of pain. Awhile later, the resident was transferred to hospital and treated.

The care plan and interventions in effect had not been changed since either of the previous two falls on the previous two days. The resident was not reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective as confirmed with the DOC on November 1, 2017. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 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 the staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) required every licensee of a long term care home to ensure that the following interdisciplinary programs were developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. Section 30(1) requires that every program required under s. 48 of the Regulation have a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The home’s program, "Post Fall Assessment Policy” identified that all residents would be assessed post falls to determine the extent and type of injury and to assess contributing factors that may have caused the fall using a tool specifically designed for this purpose. The policy indicated that if there was evidence of a head injury, the head injury routine (HIR) would be initiated immediately and the HIR protocol would be followed. The Head Injury Routine dated December 19, 2000 and revised April 5, 2017 stated that the resident would be closely observed and assessed and vital signs would be monitored according to established guidelines subsequent to a head injury or a suspected head injury. Vital signs were to be checked and recorded for seventy-two (72) hours on the Neurological flow sheet as follows: every 15 minutes x 1 hour, every 30 minutes x 1 hour, every one hour x 4 hours and every 8 hours x 7 shifts. Vital assessment for this procedure included blood pressure, pulse, respiration, pupil reaction (PEARLA), level of

consciousness, movement, hand grasps, and verbal response.

A) On an identified date in September, 2017, resident #004 sustained an unwitnessed fall. The resident complained of pain in an identified area and said that they hit their head. A neurological flow sheet was started, however, was not found to be completed for three identified shifts on identified consecutive dates in September, 2017, as confirmed with the Clinical Director of Nursing on October 30, 2017.

B) On an identified date in October, 2017, resident #004 sustained an unwitnessed fall. A neurological flow sheet was started, however, the resident sustained another unwitnessed fall the following day. The neurological flow sheet was continued as per direction from the physician however, it was not completed on two identified shifts in October, 2017, as confirmed with the Clinical Director of Nursing on October 30, 2017.

C) On an identified date in April, 2017, resident #002 sustained an unwitnessed fall. The neurological flow sheet was not started as confirmed with the DOC on November 1, 2017.

D) On an identified date in April, 2017, resident #002 sustained an unwitnessed fall. The neurological flow sheet was not started as confirmed with the DOC on November 1, 2017.

The home's program, "Post Fall Assessment Policy" identified that all residents would be assessed post falls to determine the extent and type of injury and to assess contributing factors that may have caused the fall using a tool specifically designed for this purpose. Interview with the Clinical Director of Nursing on October 31, 2017, confirmed that it was the expectation of the home that staff completed the Fall Assessment Tool after any fall had occurred and/or on a quarterly basis. A completed Fall Assessment Tool was not completed following the fall of resident #004 on an identified date in September, 2017, as confirmed with the Clinical Director of Nursing on October 30, 2017. [s. 8. (1) (a),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, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

The home's "Process for Quality Improvement Client Service Response Form (CSR) Complaint Investigation", last reviewed June 2014, directed staff that a CSR form was to be completed by any staff receiving a complaint or a concern.
A progress note from September 2016 by RPN #116, documented that the substitute decision maker (SDM) of resident #013 had concerns related to the care the resident was receiving and comments made by a staff member. The Administrator confirmed that they did not have a CSR on file or knowledge of the concerns that were raised to the RPN. An interview with RPN #116 on October 31, 2107, confirmed they remembered the concern but could not recall if they completed the CSR form but did confirm they notified the Admissions Co-ordinator regarding the concern. An interview with the Admissions Co-ordinator on October 31, 2017, confirmed that they do not remember the incident or receiving a CSR and confirmed that it would be the expectation that the staff member receiving the complaint complete a CSR. The licensee failed to ensure that the complaint process was followed. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #007 was noted to have an area of altered skin integrity on an identified date in October, 2017, which was being treated according to the Treatment Assessment Record (TAR's). Interview with the DOC on October 30, 2017, confirmed that the area of altered skin integrity was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment until after identified by the LTC Inspector. This was confirmed with the DOC on October 31, 2017. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug.

The DOC confirmed that if the required notification of a medication incident involving a resident was not documented on the Medication Incident Report (MIR) or in the resident's clinical record then the notification had not occurred by the Registered Staff.

Resident #012 had a designated Substitute Decision Maker (SDM) for both personal care and finances. On an identified date in July, 2017, staff documented on a MIR that the resident did not receive the correct dose of a medication. The MIR provided an opportunity for staff to document if they had notified the resident and/or the SDM and the physcian. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review of all medication incidents and adverse drug reactions that have occurred in the home and any changes and improvements identified in the review are implemented, and a written record is kept of everything provided for in clause (a) and (b).

A reviewed of the home's Professional Advisory Meeting Minutes for September 2017, identified that two medications errors occurred in the past quarter, however; there was no review of the specific medication incidents regarding the incident or any interventions, changes and improvements identified in the review to prevent future medication incidents and there was no written record kept. The Administrator confirmed that the above was completed informally and not documented. [s. 135. (3)]

Issued on this 1st day of February, 2018

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2017_695156_0005
Log No. / No de registre :	024589-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 19, 2017
Licensee / Titulaire de permis :	Rykka Care Centres LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	Wellington Park Care Centre 802 Hager Avenue, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Nevills

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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 :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that resident #002 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective in relation to falls prevention.

Grounds / Motifs :

1. This order is based on the application of the factors of severity (3), scope (1) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity actual harm for the identified resident, the scope of isolated and the licensee's history of non-compliance that included ongoing non compliance with a voluntary plans of corrective action (VPC) issued in March 2016, and February and March 2014.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

Resident #002 sustained an unwitnessed fall on an identified date in April, 2017. The resident lost their balance and was found lying on the floor.
The care plan for resident #002 in effect on this date in April, 2017 indicated that the resident was at risk for falls. Interventions were noted in the care plan to reduce the risks to the resident from falls.

The following day, in April, 2017, the resident sustained another unwitnessed fall. Staff heard a noise and found the resident had sustained a fall. The care plan had not been changed since the previous fall and the interventions remained the same; care set out in the plan has not been effective as the resident sustained the second fall.

The following day, in April, 2017 the resident sustained another unwitnessed fall. The resident was found on the floor, sustained an injury and was complaining of pain. Awhile later, the resident was transferred to hospital and treated.

The care plan and interventions in effect had not been changed since either of the previous two falls on the previous two days. The resident was not reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective as confirmed with the DOC on November 1, 2017.
[s. 6. (10) (c)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 19, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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