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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 6, 2013	2013_184124_0024	O-000942-13, O-001008-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

REACHVIEW VILLAGE
130 REACH STREET, UXBRIDGE, ON, L9P-1L3

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

LYNDA HAMILTON (124), PATRICIA POWERS (157)

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): October 28, 29, 30, 2013.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers, Consulting Pharmacist, Physiotherapy Assistant, Program Manager and Activity Aid.

During the course of the inspection, the inspector(s) completed walking tours of the home, observed staff-resident interactions, made general observations of resident care, reviewed resident health records, the home's Resident and Family Satisfaction Surveys and the home's policies and procedures,"PRN Medications - Administration and documentation" LTC-F-90 Effective February 2012, Revised August 2012 and "Pain Assessment and Symptom Management" LTC-E-80, Effective August 2007, Revised August 2012.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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 failed to comply with O.Reg. 79/10, s.134 (a) in that Resident #1's response to medication and the effectiveness of Resident #1's medication were not monitored and documented appropriate to the risk level of the drug.

Resident #1 has diagnoses of hypertension and arthritis.

Since admission, Resident #1 was prescribed and received Acetaminophen 650 mg two tablets (1300mg) by mouth every eight hours.

On a Physician Medication Review of a specified date, Resident #1 was prescribed Tylenol 325mg, one to two tablets by mouth every four hours as needed.

#S112, the Consulting Pharmacist for the home, reported that people can still safely take up to 4000mg of Acetaminophen in twenty-four hours.

Resident #1's Medication Administration Records indicate the following:

One specific month - 650 mg of PRN Acetaminophen was administered on seven different days and 1300mg of PRN Acetaminophen was administered on three other days.

In summary, on seven days Resident #1 was administered a total dose of 4550 mg of Acetaminophen (3900 mg from regularly prescribed dose and 650 mg PRN)and on three other days, Resident #1 was administered a total dose of 5200 mg of Acetaminophen (3900 mg from regularly prescribed dose and 1300 mg PRN).

The next month - 650 mg of PRN Acetaminophen was administered on nine days.

On these days, the resident was administered a total of 4550 mg of Acetaminophen

The third month - 650 mg of PRN Acetaminophen was administered on five days and 1300mg of PRN Acetaminophen on one day.

In summary, on five days, Resident #1 was administered a total of 4550 mg of Acetaminophen
and on one other day, the resident was administered a total of 5200 mg of Acetaminophen

There is no clinical documentation to indicate that the risk associated with the administration of this dose of Acetaminophen has been assessed or evaluated.

The Director of Care and one of the Registered Practical Nurses responsible for the administration of medication to Resident #1 confirmed that this risk has not been evaluated or discussed with Resident #1, the physician or family/Substitute Decision Maker. [s. 134. (a)]

2. There is no evidence in Resident #1's progress notes that the resident's response or the effectiveness of the following PRN medications were assessed:

On a specific date - Acetaminophen 650 mg for pain and medication for nausea
Three days later - Acetaminophen 650 mg for pain
Thirteen days later - Acetaminophen 650 mg for pain
Eighteen days later - Acetaminophen 650 mg for pain
Twenty-two days later - Acetaminophen 650 mg for pain
Thirty days later - medication for nausea
Thirty-eight days later - Acetaminophen 650 mg for pain
Forty days later - Acetaminophen 650 mg for pain

On October 29, 2013, an interview with the ADOC and a review of the home's policy ("PRN Medications - Administration and documentation" LTC-F-90 Effective February 2012, Revised August 2012) confirmed that the expectation is staff will document the effectiveness of administered PRN medication on the interdisciplinary progress notes. [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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to comply with the LTCHA 2007, s. 6. (2) in that Resident #1's plan of care is not based on an assessment of the resident and the needs of that resident.

Resident #1 was admitted with diagnoses of arthritis and was prescribed Acetaminophen 650 mg two tablets (1300mg) by mouth every eight hours.

Thirteen days after admission, a Pain Assessment Inventory was completed for Resident #1.

On October 30, 2013, the DOC and a RPN who administers medication to Resident #1 reported that the resident has pain daily.

Resident #1 received as needed doses of Acetaminophen 650 mg on thirteen occasions one month, nine occasions the next month, and seven occasions in the third month.

Despite the pain assessment at time of admission and experiencing ongoing pain, Resident #1's plan of care does not identify pain or include any interventions to address the resident's daily pain. [s. 6. (2)]

2. The licensee failed to comply with the LTCHA 2007, s.6. (7) in that Residents #1 and #5 did not receive care as specified in their plans of care.

On the Physician Medication Review Resident #1's physician ordered blood work monthly.

One month, Resident #1's blood work was completed as ordered by the physician.

The next month, Resident #1 did not have all of the blood work completed. The Assistant Director of Care confirmed that Resident #1's blood work was not completed. The ADOC made arrangements for the blood work to be completed two weeks later.

The home is currently implementing an audit system to track the completion of prescribed blood work. The fact that Resident #1 did not have blood work completed was identified by this system.

Resident #5 was admitted with diagnosis of Dementia.

The Admission Orders from the physician for Resident #5 indicated that blood work was to be completed.
Resident #5's lab reports indicated that all the blood work with the exception of one test was completed.
The ADOC and RN S#107 confirmed that Resident #5 did not have all blood work completed. [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 residents have blood work completed as set out in their plans of care, to be implemented voluntarily.

WN #3: 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 failed to comply with O.Reg 79/10 s.8 (1) in that the policy and procedure, "PRN Medications - Administration and Documentation" LTC - F - 90, Effective February 2012, Revised August 2012 and the policy and procedure, "Pain Assessment and Symptom Management" LTC-E-80, Effective August 2007, Revised August 2012 were not complied with.

O.Reg. 79/10, 114. (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

A review of policy "PRN Medications - Administration and Documentation" LTC - F - 90, Effective February 2012, Revised August 2012 directs the following:

"PRN medication orders will include the frequency with which the medication may be given, the route, dosage and the purpose intended (e.g. for sleep, pain, anxiety)"
The following PRN medication orders for Resident #1 fail to indicate the purpose intended:
September 26, 2012 - Acetaminophen 325 mg 1 to 2 tablets (325 - 650 mg) by mouth every 4 hours as needed
September 25, 2012 - Another medication by mouth every 6 hours as needed [s. 8. (1)]

2. "The nurse administering the PRN medication will assess the Resident prior to administration of the prescribed medication and the assessment will be documented"

The following PRN medications were administered without a documented assessment of Resident #1 prior to administration:
September 10, 2013 - Acetaminophen 650 mg for pain
September 10, 2013 - Medication for nausea
September 13, 2013 - Acetaminophen 650 mg for pain
September 26, 2013 - Acetaminophen 650 mg for pain
September 28, 2013 - Acetaminophen 650 mg for pain
October 2, 2013 - Acetaminophen 650 mg for pain
October 10, 2013 - Medication for nausea
October 18, 2013 - Acetaminophen 650 mg for pain
October 20, 2013 - Acetaminophen 650 mg for pain

Policy directs that "PRN medication that has been given regularly should be reported to Physician/Nurse Practitioner for reassessment if the medication is for routine scheduled use"
Resident #1 received PRN doses of Acetaminophen 650 mg on thirteen occasions in one specific month, nine occasions the next month, and seven occasions in the third month as well as being on a routine dose of Acetaminophen (1300 mg 3x a day)
There is no evidence that this was reported to the physician or that the physician was consulted related to the assessment of the resident's pain management needs. [s. 8. (1)]

3. The home's pain management program, described in the policy "Pain Assessment and Symptom Management" LTC-E-80, Effective August 2007, Revised August 2012 , provided by the Director of Care, directs the following:

"If pain is identified on admission, or the resident has a diagnosis which could result in pain, and/or is receiving regular pain medication, a pain monitoring tool will be initiated for a minimum of 72 hours"
Resident #1:
- has a diagnosis of arthritis
- was receiving regular pain medication on admission
- was identified to have pain on admission
There is no evidence that a pain monitoring tool was initiated for a minimum of 72 hours.

"If the resident complains of pain, a quick pain assessment on the resident will be completed using PQRST and documented." "The resident's pain will be measured using a standardized, evidence informed clinical tool"
Medication administration records indicate that Resident #1 complained of pain frequently. There is no evidence of the completion of a quick Pain Assessment Tool or that the resident's pain was measured using a standardized, evidence informed clinical tool.

"Initiate a pain monitoring tool when PRN medication is used for three consecutive days"
Tylenol 650 mg was administered to Resident #1 on three consecutive days on seven

different occasions.
There is no evidence that a pain monitoring tool was initiated. [s. 8. (1)]

4. "The resident's care plan will be updated to reflect pain management"

The plan of care for Resident #1 does not provide any identification or description of the resident's pain or provide interventions for the assessment and management of the resident's pain. [s. 8. (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 the home's policy and procedures related to pain management are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

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 failed to comply with O. Reg. 79/10, s. 52(1) 2 in that the strategies to manage pain were not provided for in the home's policy and procedure.

The home's pain management program, described in the policy "Pain Assessment and Symptom Management" LTC-E-80, Effective August 2007, Revised August 2012 , provided by the Director of Care, does not include non-pharmacological interventions, equipment, supplies, devices and assistive aids as strategies to manage pain. [s. 52. (1) 2.]

2. The licensee failed to comply with O. Reg. 79/10, s. 52(1) 3 in that the comfort measures were not provided for in the home's policy and procedure.

The home's pain management program, described in the policy "Pain Assessment and Symptom Management" LTC-E-80, Effective August 2007, Revised August 2012 , provided by the Director of Care, does not provide direction for comfort care measures to assist in the management of pain. [s. 52. (1) 3.]

3. The licensee failed to comply with O. Reg. 79/10, s. 52(2) in that Resident #1's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this process.

A pain assessment was completed at the time of admission. The assessment identified that Resident #1 experienced pain.
The resident has the following analgesics ordered:
Tylenol 1300 mg q6h
Tylenol 325 mg 1-2 tabs q 4h PRN

One specific month - 650 mg of PRN Acetaminophen was administered on seven different days and 1300mg of PRN Acetaminophen was administered on three other days.

In summary, on seven days Resident #1 was administered a total dose of 4550 mg of Acetaminophen (3900 mg from regularly prescribed dose and 650 mg PRN)

The next month - 650 mg of PRN Acetaminophen was administered on nine days.

On these days, the resident was administered a total of 4550 mg of Acetaminophen

The third month - 650 mg of PRN Acetaminophen was administered on five days and 1300mg of PRN Acetaminophen on one day.
On five days, Resident #1 was administered a total of 4550 mg of Acetaminophen.
On another day, the resident was administered a total of 5200 mg of Acetaminophen

There is no evidence that any further pain assessment using a clinically appropriate assessment tool was completed when Resident #1's pain was not relieved by initial interventions. [s. 52. (2)]

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 home's pain management program reflects non-pharmacological interventions and comfort measures to manage pain and that residents are assessed using a clinically appropriate assessment instrument when their pain is not relieved by initial interventions, to be implemented voluntarily.

Issued on this 19th day of November, 2013

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

Lynda Hamilton

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) :	LYNDA HAMILTON (124), PATRICIA POWERS (157)
Inspection No. / No de l'inspection :	2013_184124_0024
Log No. / Registre no:	O-000942-13, O-001008-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 6, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	REACHVIEW VILLAGE 130 REACH STREET, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BARBARA ANDREWS

To REVERA LONG TERM CARE INC., 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 Resident #1's response to medication and the effectiveness of Resident #1's medication are monitored and documented appropriate to the risk level of the drug.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg. 79/10, s.134 (a) in that Resident #1's response to medication and the effectiveness of Resident #1's medication were not monitored and documented appropriate to the risk level of the drug.

Resident #1 has diagnoses of hypertension and arthritis.

Since admission, Resident #1 was prescribed and received Acetaminophen 650 mg two tablets (1300mg) by mouth every eight hours.

On a Physician Medication Review of a specified date, Resident #1 was prescribed Tylenol 325mg, one to two tablets by mouth every four hours as needed.

#S112, the Consulting Pharmacist for the home, reported that people can still

safely take up to 4000mg of Acetaminophen in twenty-four hours.

Resident #1's Medication Administration Records indicate the following:

One specific month - 650 mg of PRN Acetaminophen was administered on seven different days and 1300mg of PRN Acetaminophen was administered on three other days.

In summary, on seven days Resident #1 was administered a total dose of 4550 mg of Acetaminophen (3900 mg from regularly prescribed dose and 650 mg PRN)and on three other days, Resident #1 was administered a total dose of 5200 mg of Acetaminophen (3900 mg from regularly prescribed dose and 1300 mg PRN).

The next month - 650 mg of PRN Acetaminophen was administered on nine days.

On these days, the resident was administered a total of 4550 mg of Acetaminophen

The third month - 650 mg of PRN Acetaminophen was administered on five days and 1300mg of PRN Acetaminophen on one day.

In summary, on five days, Resident #1 was administered a total of 4550 mg of Acetaminophen and on one other day, the resident was administered a total of 5200 mg of Acetaminophen

There is no clinical documentation to indicate that the risk associated with the administration of this dose of Acetaminophen has been assessed or evaluated.

The Director of Care and one of the Registered Practical Nurses responsible for the administration of medication to Resident #1 confirmed that this risk has not been evaluated or discussed with Resident #1, the physician or family/Substitute Decision Maker. [s. 134. (a)]

(157)

2. There is no evidence in Resident #1's progress notes that the resident's

response or the effectiveness of the following PRN medications were assessed:

On a specific date - Acetaminophen 650 mg for pain and medication for nausea
Three days later - Acetaminophen 650 mg for pain
Thirteen days later - Acetaminophen 650 mg for pain
Eighteen days later - Acetaminophen 650 mg for pain
Twenty-two days later - Acetaminophen 650 mg for pain
Thirty days later - medication for nausea
Thirty-eight days later - Acetaminophen 650 mg for pain
Forty days later - Acetaminophen 650 mg for pain

On October 29, 2013, an interview with the ADOC and a review of the home's policy ("PRN Medications - Administration and documentation" LTC-F-90 Effective February 2012, Revised August 2012) confirmed that the expectation is staff will document the effectiveness of administered PRN medication on the interdisciplinary progress notes. [s. 134. (a)] (157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 27, 2013

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

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Lynda Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

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