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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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Bureau régional de services de London
130 avenue Dufferin 4ème étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2017	2016_326569_0031	031056-16	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF OXFORD
300 Juliana Drive WOODSTOCK ON N4V 0A1

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

WOODINGFORD LODGE - INGERSOLL
325 THAMES STREET SOUTH INGERSOLL ON N5C 2T8

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

DONNA TIERNEY (569), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 29, 30, December 1, 2, 5, 2016.

During the course of the inspection, the inspector(s) spoke with the Acting Manager, the Manager of Woodingford Tillsonburg, the Administrator, the Manager of Resident Services, the Resident Assessment Instrument (RAI) Coordinator, a Registered Dietitian, the Nutrition Manager, a Pharmacist, the Administrative Assistant, four Registered Nurses, one Registered Practical Nurse, a Recreation Aide, six Personal Support Workers, a housekeeper, five family members, and over 20 residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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 O.Reg 79/10, s. 114. Medication management system

Findings/Faits saillants :

1. The licensee failed to ensure that the written policies and protocols that were developed for the medication management system ensured the accurate storage, destruction and disposal of all drugs used in the home, and that the written policies and protocols for the medication management system were based on evidence-based practice and were reviewed by the Director of Nursing and Personal Care and the Pharmacy provider.

The Medication Administration and Narcotics and Controlled Substance Task was completed as part of the Resident Quality Inspection (RQI).

Multiple observations of the medication carts over several days, verified that narcotics to be administered to residents were in a locked box in the side middle drawer that contained multiple resident blister packs. There was a separate plastic bin labelled "borrowed, wasted, held and discontinued" amongst the resident bins in the middle drawer within the medication cart that contained medications to be administered and the sharps container was on the side of the medication cart.

During an interview with a Registered Practical Nurse (RPN), they indicated that a partial dose of a narcotic, either an ampoule or partial tablet, that was not administered to a resident required another Registered Nurse (RN) to witness and co-sign on the Medication Administration Record (MAR) and the Surplus Medication Records that were kept in the binder on the medication cart. These unused narcotics were then disposed of by placement in the sharps container on the side of the medication cart.

Interview with two different RN's on different days, verified that narcotics, which included partial doses of ampoule's and tablets refused by residents, were placed in the sharps containers as a method of disposal and may be stored in the medication cart in either the bin marked discontinued medications or the narcotic box within the medication cart that contained narcotics for administration, until another registered staff was available to co-sign. One RN explained that often a single RN was working until shift change and RN's do not have a key to the locked cupboard with the locked box with mail slot that was the storage box for the medications to be destroyed by the Pharmacist.

Interview with another RN indicated that all narcotics for destruction which included partial tablets and liquid ampoule's, went into the locked box in the medication room for the Pharmacist to destroy. They explained that a liquid narcotic would keep in the medication cart until the next registered staff came on shift. Also an alternate RN stated that some narcotics were destroyed by two registered staff and placed in the sharps container and these narcotics were not destroyed by the pharmacy or manager and not recorded on the narcotic destruction log for destruction and record review by pharmacy and manager.

Record review of the Woodingford Policy, "Limited Narcotic/Controlled Drugs" # I 6.665 with a last reviewed date of June 14, 2016, indicated that "destruction occurs in the

presence of two nurses” and that a controlled medication removed from a container for administration but not administered which included unused partial tablets and unused portions of single dose ampoule's, must be “placed in the locked cupboard with the mail slot on each unit for destruction with the pharmacist or designate and Manager”.

Record review of the Woodingford Policy, “Drug Destruction” # I 6.645, with a date last reviewed of June 14, 2016, indicated that all drugs in containers that were not marked properly “will be stored in a safe and secure manner separate from current medications until the process of drug destruction occurs” and for controlled substances the criteria for destruction would be “stored in a double locked storage area outside of the medication cart until drug destruction occurs” and that “All medications will be destroyed in the presence of a minimum of two individuals, the Manager/Assistant Manager of Resident Services or delegate and the Pharmacist.” Additionally, a liquid controlled substance will be kept on the medication cart until the Manager/Assistant Manager of Resident Services or delegate and the Pharmacist is available to unlock the locked cupboard and place into the locked box.

Interview with the Manager verified that narcotics for destruction that have been kept in the medication cart should not be kept with other narcotics to be administered. The Manager agreed that narcotics placed in the discontinued bin in the medication cart would not be locked when the cart was in use or double locked when the cart was not in use, and further stated that this would happen a lot. The Manager also agreed that narcotics left on the counter in the medication room would not be double locked and further agreed that these practices did not meet legislative requirements and that the home's current policies were unclear. For example, the policy could be interpreted that two RN’s can "destroy narcotics". The Manager stated that the expectation was that registered staff were not to destroy narcotics but were to get the narcotics ready for Pharmacy to destroy.

The Manager also stated that there was not a policy that directed staff how to denature narcotics as staff should not be destroying any narcotics which included placement of narcotics into the sharps containers or garbage. The expectation was that all narcotics should be destroyed by the Manager and or designate and the Pharmacist, and the Manager agreed that some staff were not following the home's policy and that the home's policy contained parts that were not in compliance with the legislation. For example, narcotics for destruction are required to be double locked, stored and separated from medications to be administered, and all narcotics should be denatured to the extent that use would be improbable. The Manager agreed that policies #I 6.645 and #I 6.665

related to narcotic drug storage and destruction would be reviewed and revised and that all staff required re-education in practice and policy.

During an Interview with the Pharmacist, they verified that the Woodingford Policy # I 6.665, Limited Narcotic/Controlled Drugs, last reviewed June 14, 2016, had not been reviewed or evaluated by the Pharmacist at all and that some current practices of the registered staff related to narcotic storage and destruction for wasted or refused narcotics were not evidence-based or best practices. The Pharmacist agreed that the policies related to narcotic storage and destruction were unclear, contradictory and required revision and that staff education would be completed.

The licensee failed to ensure that the drug destruction and disposal policies and protocols were implemented for the medication management system that ensured the accurate storage, destruction and disposal of all narcotics used in the home, and that the drug destruction and disposal policies and protocols were in accordance with all applicable requirements under the Act.

The scope of this area of non-compliance was determined to be a level 3 which is wide-spread and the severity was determined to be a level 1 or minimal risk. The home had previous related non-compliance with this area of legislation. [s. 114.]

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 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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

An identified resident was observed to have a specific assistive device in place during stage one of the Resident Quality Inspection.

An interviewed Personal Support Worker (PSW) shared that the resident used the assistive device as a Personal Assistance Services Device (PASD) to facilitate activities of daily living (ADL).

The home's policy "Restraints Minimization: Use of Personal Assistance Service Devices (PASDs)" #I 6.090 with a date last reviewed of June 14, 2016, indicated that the use of a PASD must be approved by either a Physician, Registered Nurse or Registered Practical Nurse, an Occupational Therapist, or a Physiotherapist. It further outlined that the assessment included alternatives to the PASD were to be considered and trialled, and that the prescribing clinician was required to obtain informed consent from the resident and/or substitute decision-maker (SDM).

A record review of the identified resident's clinical record showed a written order for two other assistive devices as well as a signed consent. There was no order or consent found for the specific assistive device that was observed in place for this resident during the initial observation.

An "Interdisciplinary Assessment for the Use of a PASD" for the identified resident was found on the resident's clinical chart with a specified date. The PASD's that were assessed had not included the one the identified resident was observed in place during the initial observation. There was no order, assessment, or consent found for that specific PASD on the resident's electronic or hard copy chart. A look back of past PASD assessments for the identified resident that were completed on several past occasions, showed that these assessments also did not include the originally observed assistive device.

During an interview with an RN, they agreed that the identified resident used the observed assistive device as a PASD and acknowledged there was no PASD assessment on the resident's clinical chart, be it hard copy or electronic, as well as no order or signed consent. Both the RN, and the Manager of Woodingford Lodge

Tillsonburg agreed that there should be an order, an assessment, and signed consent for this identified resident's specific assistive device.

The licensee failed to comply with their policy Restraints Minimization: Use of Personal Assistance Service Devices (PASDs) for an identified resident's specific assistive device.

The scope of this issue was determined to be a level 1 or isolated, and the severity a level 1 which is minimum risk. The home had previous unrelated non-compliance with this area of legislation. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' Council was sought in the development and carrying out of the satisfaction survey.

Record review of the Residents' Council minutes from September 2015 to November 2016, failed to find any documentation that demonstrated that the home's satisfaction survey was reviewed by Residents' Council and their advice sought in the development and carrying out of the survey prior to its distribution.

In an interview on December 2, 2016 with the Administrative Assistant (AA), they shared that they transcribed the minutes for Residents' Council meetings. After review of those minutes for the previous 12 months, the AA acknowledged there was no documentation that supported that the home's satisfaction survey was reviewed by council prior to its distribution.

During an interview on December 5, 2016, with the licensee appointed assistant to Residents' Council, they acknowledged that the advice of Residents' Council was not sought in the development and carrying out of the most recent satisfaction survey.

The scope of this issue was determined to be a level 1 or isolated, and the severity a level 1 which is minimum risk. The home had previous unrelated non-compliance with this area of legislation. [s. 85. (3)]

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.

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

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) :	DONNA TIERNEY (569), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_326569_0031
Log No. / Registre no:	031056-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 7, 2017
Licensee / Titulaire de permis :	COUNTY OF OXFORD 300 Juliana Drive, WOODSTOCK, ON, N4V-0A1
LTC Home / Foyer de SLD :	WOODINGFORD LODGE - INGERSOLL 325 THAMES STREET SOUTH, INGERSOLL, ON, N5C-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Corrie Fransen

To COUNTY OF OXFORD, 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. 114. Medication management system

Order / Ordre :

1. The licensee must develop and implement written policies and protocols for the medication management system to ensure compliance with. O. Reg. 79/10, s. 114 to ensure the accurate storage, destruction and disposal of all narcotics used in the home.

2. The Licensee must ensure that the drug destruction and disposal policy includes the following:

That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

That drugs that are to be destroyed are destroyed in accordance with subsection (3). O. Reg. 79/10, s. 136 (2) including all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act.

That drugs must be destroyed by a team acting together and composed of, in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act

(Canada), one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a Physician or a Pharmacist.

3. The licensee must also ensure that all narcotics to be destroyed are altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

4. The licensee must educate all registered staff on all written policies and protocols for the medication management system related to storage, destruction and disposal of all narcotics used in the home.

5. The licensee must ensure that all written policies and protocols for the medication management system are reviewed by the Director of Nursing and Personal Care and the Pharmacy provider annually.

Grounds / Motifs :

1. The licensee failed to ensure that the written policies and protocols that were developed for the medication management system ensured the accurate storage, destruction and disposal of all drugs used in the home, and that the written policies and protocols for the medication management system were based on evidence-based practice and were reviewed by the Director of Nursing and Personal Care and the Pharmacy provider.

The Medication Administration and Narcotics and Controlled Substance Task was completed as part of the Resident Quality Inspection (RQI).

Multiple observations of the medication carts over several days, verified that narcotics to be administered to residents were in a locked box in the side middle drawer that contained multiple resident blister packs. There was a separate plastic bin labelled "borrowed, wasted, held and discontinued" amongst the resident bins in the middle drawer within the medication cart that contained medications to be administered and the sharps container was on the side of the medication cart.

During an interview with a Registered Practical Nurse (RPN), they indicated that a partial dose of a narcotic, either an ampoule or partial tablet, that was not administered to a resident required another Registered Nurse (RN) to witness and co-sign on the Medication Administration Record (MAR) and the Surplus Medication Records that were kept in the binder on the medication cart. These

unused narcotics were then disposed of by placement in the sharps container on the side of the medication cart.

Interview with two different RN's on different days, verified that narcotics, which included partial doses of ampoule's and tablets refused by residents, were placed in the sharps containers as a method of disposal and may be stored in the medication cart in either the bin marked discontinued medications or the narcotic box within the medication cart that contained narcotics for administration, until another registered staff was available to co-sign. One RN explained that often a single RN was working until shift change and RN's do not have a key to the locked cupboard with the locked box with mail slot that was the storage box for the medications to be destroyed by the Pharmacist.

Interview with another RN indicated that all narcotics for destruction which included partial tablets and liquid ampoule's, went into the locked box in the medication room for the Pharmacist to destroy. They explained that a liquid narcotic would keep in the medication cart until the next registered staff came on shift. Also an alternate RN stated that some narcotics were destroyed by two registered staff and placed in the sharps container and these narcotics were not destroyed by the pharmacy or manager and not recorded on the narcotic destruction log for destruction and record review by pharmacy and manager.

Record review of the Woodingford Policy, "Limited Narcotic/Controlled Drugs" # I 6.665 with a last reviewed date of June 14, 2016, indicated that "destruction occurs in the presence of two nurses" and that a controlled medication removed from a container for administration but not administered which included unused partial tablets and unused portions of single dose ampoule's, must be "placed in the locked cupboard with the mail slot on each unit for destruction with the pharmacist or designate and Manager".

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the medication cart until the Manager/Assistant Manager of Resident Services or delegate and the Pharmacist is available to unlock the locked cupboard and place into the locked box.

Interview with the Manager verified that narcotics for destruction that have been kept in the medication cart should not be kept with other narcotics to be administered. The Manager agreed that narcotics placed in the discontinued bin in the medication cart would not be locked when the cart was in use or double locked when the cart was not in use, and further stated that this would happen a lot. The Manager also agreed that narcotics left on the counter in the medication room would not be double locked and further agreed that these practices did not meet legislative requirements and that the home's current policies were unclear. For example, the policy could be interpreted that two RN's can "destroy narcotics". The Manager stated that the expectation was that registered staff were not to destroy narcotics but were to get the narcotics ready for Pharmacy to destroy.

The Manager also stated that there was not a policy that directed staff how to denature narcotics as staff should not be destroying any narcotics which included placement of narcotics into the sharps containers or garbage. The expectation was that all narcotics should be destroyed by the Manager and or designate and the Pharmacist, and the Manager agreed that some staff were not following the home's policy and that the home's policy contained parts that were not in compliance with the legislation. For example, narcotics for destruction are required to be double locked, stored and separated from medications to be administered, and all narcotics should be denatured to the extent that use would be improbable. The Manager agreed that policies #I 6.645 and #I 6.665 related to narcotic drug storage and destruction would be reviewed and revised and that all staff required re-education in practice and policy.

During an Interview with the Pharmacist, they verified that the Woodingford Policy # I 6.665, Limited Narcotic/Controlled Drugs, last reviewed June 14, 2016, had not been reviewed or evaluated by the Pharmacist at all and that some current practices of the registered staff related to narcotic storage and destruction for wasted or refused narcotics were not evidence-based or best practices. The Pharmacist agreed that the policies related to narcotic storage and destruction were unclear, contradictory and required revision and that staff education would be completed.

The licensee failed to ensure that the drug destruction and disposal policies and protocols were implemented for the medication management system that ensured the accurate storage, destruction and disposal of all narcotics used in the home, and that the drug destruction and disposal policies and protocols were in accordance with all applicable requirements under the Act.

The scope of this area of non-compliance was determined to be a level 3 which is wide-spread and the severity was determined to be a level 1 or minimal risk. The home had previous related non-compliance with this area of legislation. [s. 114.] (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 28, 2017

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
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 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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 7th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Donna Tierney

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