Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2019	2019_671684_0040	018760-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Gabriel's Villa of Sudbury
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 21-22, 2019.

The following intake was inspected upon during this Critical Incident System Inspection:

One log related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, medication incidents, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

Inspector #684 reviewed a Critical Incident Report which was submitted to the Director, for a medication incident/adverse drug reaction; whereby resident #001 received a medication contrary to the prescribers orders.

Inspector #684 reviewed the home's investigation file and noted a Medication Incident Notification which was reported on a specified date in 2019. The Incident Description indicated the resident had a change in their status related to a certain medical condition. A Registered Practical Nurse (RPN) and Registered Nurse (RN) looked into the care the resident had received and noted a medication had been administered contrary to the prescribers orders.

Upon reviewing the resident's health care record for a specific medical indicator for resident #001, Inspector #684 noted that a medication was administered when the indicator was out of therapeutic range for a specified period of time in 2019. The medication was administered several times by multiple different registered staff, both RNs and RPNs.

Inspector #684 reviewed the physician orders for resident #001 for a specified period of time in 2019, specifically looking at the order for the medication which was administered. The order clearly stated specific perimeters when the medication was not to be given.

Inspector #684 reviewed the home's policy "The Medication Pass", last revised January 2018, Section 3, Policy 3-6. The policy stated "All medications administered are listed on the resident's medication administration record (MAR). Each resident received the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The right resident received the right medication (not expired) of the right does, at the right time, by the right route for the right reason and completed by the right documentation".

During an interview with RPN #101 they informed Inspector #684 that when a specific medical indicator was outside of the therapeutic range, staff would either hold the medication or call the physician. RPN #101 stated for resident #001 if their medical indicator was outside of the therapeutic range staff were to hold the medication as per the physician's order.

Inspector #684 interviewed RN #102 and asked, where would staff find directions on

what to do with certain medical indicators, RN #102 stated, it would be indicated on the electronic medication administration record (eMAR). Inspector #684 and RN #102 reviewed the eMAR for resident #001, for one specific medication. The RN stated that the medication which was administered on the specified dates and times should not have been administered, as the medical indicator results were out of the therapeutic range.

Inspector #684 interviewed the Assistant Director of Care (ADOC) and asked them to explain the process the registered staff were to follow when administering a certain medication. The ADOC stated, the medication was to be administered as per the eMAR, that certain medications have a medical indicator which was to be checked, and staff were to follow the eMAR and do checks, complete the independent double check system, review the order, check the medication was correct, right dose, obtain medical indicator result and do second check to ensure the right medication, and right dosage before signing off the independent double check. Inspector #684 and ADOC reviewed eMAR and medical indicator results from Point Click Care (PCC) for resident #001, as noted during the specified time frame in 2019. The eMAR indicated that the medication was administered to resident #001 on a number of different days. The ADOC confirmed that as per the physician's order the medication should not have been given to resident #001 with the medical indicator results outside of the specified therapeutic range.

Together, Inspector#684 and the Director of Care (DOC) reviewed the eMAR and medical indicator report for resident #001; the DOC acknowledged that on the dates identified the medical indicator was outside of the specified therapeutic range, and the medication should not have been given as per the physician's order. [s. 131. (2)]

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 has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, or procedure, that the plan, policy or procedure was complied with.

According to section (s.) 114. (2) of Ontario Regulation (O. Reg.) 79/10, every licensee of a long-term care home shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration of all drugs used in the home.

Specifically, the licensee had failed to comply with their policy titled "The Medication System- The Medication Pass", policy 3-6, last revised January 2018, which was part of the home's medication management system's written policies and procedures.

Inspector #684 reviewed the home's policy "Medication System- The Medication Pass", policy 3-6, last revised January 2018, which stated "Each resident receives the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The right resident received the right medication of the right dose, at the right time, by the right route..., for the right reason, and completed by the right documentation".

Inspector #684 reviewed a Critical Incident Report which was submitted to the Director, for a medication incident/adverse drug reaction for resident #001. Upon further review of the home's investigation file, Inspector #684 noted a list of residents in the home that were identified as receiving a specified medication, resident #002 and #003 were noted on this list.

1) Inspector #684 reviewed a medical indicator for resident #002, and identified on a

number of specified dates in 2019, a specified medication was administered to resident #002.

Upon further review of the medical indicator report and the eMAR, the Inspector identified that the specified medication was not administered on a number of different dates.

Inspector #684 reviewed the physician orders for resident #002 for a specific order in 2019. The order provided specific administration directions for the specified medication.

Inspector #684 and RPN #101 reviewed the medical indicator results as well as the eMAR for resident #002, they stated on a number of dates in 2019, the resident was given a medication when the medical indicator was out of the therapeutic range, and that they would not have given the medication.

Inspector #684 reviewed the eMAR and medical indicator results for resident #002 with RN #102. The RN stated they would not have administered the medication to resident #002 on the identified dates with the medical indicator being out of the therapeutic range.

Inspector #684 and the ADOC reviewed a specific eMAR and medical indicator results for resident #002. Upon review of the eMAR and medical indicator result documentation, the ADOC stated, "I would have questioned the medical indicator result as it was out of the normal range [for resident #002]. I think there should have been a clinical assessment and the medication should have been held when the medical indicator result was outside the therapeutic range". The ADOC stated “I would expect that if there was a clinical judgement made that there be a progress note”. The ADOC and Inspector #684 reviewed the PCC electronic progress notes for resident #002, and identified that there were no progress notes related to medication administration for the specified dates discussed.

During an interview between the DOC and Inspector #684, they reviewed the eMAR and medical indicator results for resident #002, the DOC stated, "I would most likely not give the the medication based on the medical indicator results and norms for this resident".

2) Inspector #684 reviewed the medical indicator report in PCC for resident #003, and identified on a specified date in 2019, the medical indicator result was out of the therapeutic range on that day and that the specified medication was administered to resident #003.

Upon further review of the medical indicator report from a specified period of time in 2019, Inspector #684 noted a specified medical indicator range for resident #003.

Inspector #684 reviewed the physician orders for resident #003 for a specific month in 2019, which gave specific orders for a specified medication.

Inspector #684 and RPN #101 reviewed the documented medical indicators for resident #003; RPN #101 stated they would not have given the medication with the recorded medical indicator results, as this was outside the prescribed parameter in the physician's order.

Inspector #684 reviewed the eMAR from a specific month in 2019, and the medical indicator results for resident #003 with RN #102, they stated they would not have administered the medication to resident #003 with the reported medical indicators.

Inspector #684 and the ADOC reviewed the eMAR and medical indicator results from a specified date in 2019, from PCC for resident #003. The ADOC stated, that clinical judgement should have been part of the practice, as it was a risk for resident #003 to receive their medication. Inspector #684 asked the ADOC if they were using clinical judgement should there have been a progress note written. The ADOC stated "Yes absolutely". The ADOC and Inspector #684 reviewed the PCC electronic progress notes and noted that there were no written progress notes related to the medication administration written on that day.

Inspector #684 and the DOC reviewed the eMAR and medical indicator report for resident #003; the DOC stated the medication that was given on a specified date in 2019, should not have been given. [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 where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, or procedure, that the plan, policy or procedure was complied with, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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.

Inspector #684 reviewed a Critical Incident Report which was submitted to the Director, for a medication incident/adverse drug reaction; where by resident #001, received a medication contrary to the prescribers orders.

Inspector #684 reviewed the physician orders for resident #001 from a specified time frame in 2019, specifically looking at one medication order. The order clearly stated specific perimeters when the medication was not to be given.

Upon reviewing the medical indicator results for resident #001, Inspector #684 noted that the medication was administered with medical indicator results outside the therapeutic range for the specified period of time. This medication was administered a several different times by multiple different registered staff, both RNs and RPNs. Please refer to WN #1.

During an interview with Inspector #684 the ADOC reviewed the eMAR and medical indicator results from PCC for resident #001, as noted from the specified time frame in 2019. The eMAR indicated that the medication was administered to resident #001 on all of the identified dates. The ADOC confirmed that as per the physician's order the medication should not have been given to resident #001 with the noted medical indicator results.

Together, Inspector#684 and the DOC reviewed the eMAR and medical indicator report for resident #001; the DOC acknowledged that on the dates identified the medication should not have been given as per MD order.

Inspector #684 reviewed the Medication Incident Summary report for a specified month in 2019, the report showed one medication incident for resident #001. [s. 135. (1)]

Issued on this 10th day of December, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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) :	SHELLEY MURPHY (684)
Inspection No. / No de l’inspection :	2019_671684_0040
Log No. / No de registre :	018760-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 3, 2019
Licensee / Titulaire de permis :	St. Joseph's Health Centre of Sudbury 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	St. Gabriel's Villa of Sudbury 4690 Municipal Road 15, Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Ray Ingriselli

To St. Joseph's Health Centre of Sudbury, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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

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. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The Licensee must be compliant with r. 131 (2) of the O. Reg 79/10.
Specifically, the licensee must:

A) Re-educate all registered staff on safe medication administration practices.

B) Educate all registered staff on medical indicator monitoring, focusing on what to do when medical indicators are not within the therapeutic range.

C) Complete medication incidents for all identified errors, upon completion of medication incident reports, review all medication incidents noting trends, risks, areas for improvement and re-evaluate quarterly.

E) Develop and conduct weekly audits to ensure accuracy of medication administration for each resident that receives the identified medication for the next three months. Maintain a record of the audits that are conducted.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #684 reviewed a Critical Incident Report which was submitted to the Director, for a medication incident/adverse drug reaction; whereby resident #001 received a medication contrary to the prescribers orders.

Inspector #684 reviewed the home's investigation file and noted a Medication Incident Notification which was reported on a specified date in 2019. The Incident Description indicated the resident had a change in their status related to

a certain medical condition. A Registered Practical Nurse (RPN) and Registered Nurse (RN) looked into the care the resident had received and noted a medication had been administered contrary to the prescribers orders.

Upon reviewing the resident's health care record for a specific medical indicator for resident #001, Inspector #684 noted that a medication was administered when the indicator was out of therapeutic range for a specified period of time in 2019. The medication was administered several times by multiple different registered staff, both RNs and RPNs.

Inspector #684 reviewed the physician orders for resident #001 for a specified period of time in 2019, specifically looking at the order for the medication which was administered.
The order clearly stated specific perimeters when the medication was not to be given.

Inspector #684 reviewed the home's policy "The Medication Pass", last revised January 2018, Section 3, Policy 3-6. The policy stated "All medications administered are listed on the resident's medication administration record (MAR). Each resident received the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The right resident received the right medication (not expired) of the right does, at the right time, by the right route for the right reason and completed by the right documentation".

During an interview with RPN #101 they informed Inspector #684 that when a specific medical indicator was outside of the therapeutic range, staff would either hold the medication or call the physician. RPN #101 stated for resident #001 if their medical indicator was outside of the therapeutic range staff were to hold the medication as per the physician's order.

Inspector #684 interviewed RN #102 and asked, where would staff find directions on what to do with certain medical indicators, RN #102 stated, it would be indicated on the electronic medication administration record (eMAR). Inspector #684 and RN #102 reviewed the eMAR for resident #001, for one specific medication. The RN stated that the medication which was administered on the specified dates and times should not have been administered, as the medical indicator results were out of the therapeutic range.

Inspector #684 interviewed the Assistant Director of Care (ADOC) and asked them to explain the process the registered staff were to follow when administering a certain medication. The ADOC stated, the medication was to be administered as per the eMAR, that certain medications have a medical indicator which was to be checked, and staff were to follow the eMAR and do checks, complete the independent double check system, review the order, check the medication was correct, right dose, obtain medical indicator result and do second check to ensure the right medication, and right dosage before signing off the independent double check. Inspector #684 and ADOC reviewed eMAR and medical indicator results from Point Click Care (PCC) for resident #001, as noted during the specified time frame in 2019. The eMAR indicated that the medication was administered to resident #001 on a number of different days. The ADOC confirmed that as per the physician's order the medication should not have been given to resident #001 with the medical indicator results outside of the specified therapeutic range.

Together, Inspector#684 and the Director of Care (DOC) reviewed the eMAR and medical indicator report for resident #001; the DOC acknowledged that on the dates identified the medical indicator was outside of the specified therapeutic range, and the medication should not have been given as per the physician's order.

The severity of this issue was determined to be a level three, as there was actual harm a risk or actual risk to residents of the home. The scope of the issues was a level one, as it affected 33 percent of the residents reviewed. The home had a level two compliance history, previous non compliance to a different subsection. (684)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 3rd day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shelley Murphy

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