Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 20, 2022	2021_820130_0014	008910-21, 008985-21, 011454-21, 011619-21, 012748-21, 017266-21	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way Thorold ON L2V 4T7

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

Linhaven
403 Ontario Street St Catherines ON L2N 1L5

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

GILLIAN HUNTER (130), CATHY FEDIASH (214), ROSEANNE WESTERN (508)

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): December 20, 21, 22, 23, 24, January 4, 5, 7, 2021.

During this inspection the home was toured, residents were observed and interviewed, staff were interviewed, medication administration was observed, clinical records, investigation files and relevant policies and procedures were reviewed.

This inspection was conducted related to the following intakes:

Log # 008910-21, # 008985-21, # 017266-21 and # 011454-21 related to falls management and prevention;
Log # 011619-21, and # 012748-21 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate, Administrator, Director of Resident Care (DRC), Associated Director of Resident Care (ADOC), registered staff, personal support workers (PSWs), residents, families and visitors.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 :

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

In July 2021, a resident's laboratory report identified an abnormal level. The physician reviewed the laboratory report and wrote a new order on the report, which included a medical abbreviation symbol, indicating a change followed by the new dose of medication.

A nurse stated when they transcribed the order onto the physician order form, they had not transcribed the medical abbreviation symbol and only transcribed the new medication and the dose, as they were unaware of the meaning of the medical abbreviation symbol.

The new order was processed by the pharmacy and delivered to the home. The resident was administered and consumed both orders of the medication which was greater than times the prescribed dose. The resident was transferred and admitted to hospital for treatment resulting from the medication error.
The DRC confirmed drugs were not administered to the resident, as specified by the prescriber.

There was actual harm to the resident when drugs were not administered as specified by the prescriber.

Source: CI report, home's investigative notes and re-education materials, a resident's laboratory report, physician orders, progress notes, medication incident form, pharmacy's Incident Evaluation and Response notes, and interview with the DRC and other staff.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care for falls prevention for a resident was provided as specified in the plan.

In June, 2021, a resident was found in another resident's room, lying on their back, guarding an area and complaining of pain. The resident's mobility device was found in another room.

The resident was at risk for falls. Their plan of care at the time of the incident directed staff to ensure that the safety device was in place at specific times to prevent injury.

The post fall assessment that was completed after the fall in June 2021, identified that the safety device was not in place at the time of the incident.

Failure to ensure that the resident's safety device was in place, as specified in the plan, resulted in harm to the resident as they sustained a fall with injury.

Sources: CI report, post-fall assessment and interview with staff.

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 care set out in the plan of care for falls prevention is provided as specified in the plan, 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 ensure their policies, including the pharmacy policy, regarding medication incidents, was in compliance with and implemented in accordance with all applicable requirements under the Act.

In accordance with LTCH Act, 2007, s. 8 (1), and in reference to O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies developed for the medication management system to ensure accurate storage, administration and disposal of all drugs used in the home.

In accordance with LTCH Act, 2007, s. 8 (1), and in reference to O. Reg. 79/10, s. 135 (1) (b), the licensee was required to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (SDM), 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.

Specifically, the licensee's policy titled, "Medication Incident Reporting" and the pharmacy policy titled, "Reporting Medication Incidents", were not in compliance with and implemented in accordance with the requirements to ensure that every medication incident was reported to the person's identified in O. Reg. 79/10, s. 135 (1) (b).

The licensee's policy indicated the following:

a) Medication incidences must be reported to the resident, the SDM, if applicable, the DRC, the prescriber, the resident's attending physician and the pharmacy. The Medical

Director of the home will be notified on a quarterly basis of medication incidents and trends at PAC meetings.

b) RN/RPN will complete the Medication Incident Form provided by the pharmacy for both pharmacy and nursing related medication incidents.

The pharmacy's policy indicated the following:

a) All incidents regardless of origin are communicated to the pharmacy by providing a completed medication incident form.

b) The instructions to complete the medication incident form, located on the back of the form, are to ensure the health and safety of the resident and document immediate actions taken, which included, reporting to the resident/POA, Pharmacy Service Provider, Attending Physician, Director of Care, Prescriber, Medical Director, and RN (EC).

c) The home investigates the circumstances of the medication incident, completes all necessary documentation and reports findings to the Director of Care or designate, Medical Director, Prescriber, the resident's attending physician or RN in the extended class (EC) attending the resident.

The licensee's policy had not included the requirement to make notification to the RN (EC) attending the resident. The policy indicated the Medical Director would be notified on a quarterly basis, which had not aligned with the pharmacy's policy and medication incident form to document immediate actions taken that included reporting to the Medical Director.

The pharmacy's policy had not included the requirement to make notification to the resident and the resident's substitute decision maker, if any, despite the pharmacy's medication incident form requiring staff to document immediate actions and reporting to these persons.

Staff indicated the most recent PAC minutes had identified the Medical Director was invited to the meeting but had not indicated if the Medical Director attended. Staff confirmed the policies had not met the legislative requirements identified.

The requirement to notify all required persons when a medication incident occurs ensures that the legislation is complied with and provides for an interdisciplinary

approach to review trends and patterns with the goal to enhance the medication management system by reducing medication incidents and preventing harm to residents.

Sources: CI reports, licensee's policy, "Medication Incident Reporting" (policy PTH02-005, revised October 5, 2021), pharmacy policy, "Reporting Medication Incidents" (policy 7.3, revised March 2020), and interviews with the Associate Administrator and DRC. [s. 8. (1) (a)]

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 the licensee's policies, titled, "Medication Incident Reporting" and "Reporting Medication Incidents" regarding medication incidents, is in compliance with and implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure accurate acquisition of a resident's drugs.

In July 2021, a resident's laboratory report identified an abnormal level. The physician reviewed the laboratory report and wrote a new order on the report, which included a medical abbreviation symbol, indicating a change followed by the new dose of medication.

A nurse stated when they transcribed the order onto the physician order form, they had not transcribed the medical abbreviation symbol and only transcribed the new medication and the dose, as they were unaware of the meaning of the medical abbreviation symbol.

The new order was processed by the pharmacy and delivered to the home. The resident was administered and consumed both orders of the medication which was greater than times the prescribed dose. The resident was transferred and admitted to hospital for treatment resulting from the medication error.
The DRC confirmed drugs were not administered to the resident, as specified by the prescriber.

1. The pharmacy's policy, titled, "Ordering New Prescriptions Using PointClickCare" (PCC), indicated the following:

a) All new prescriber orders must be entered in PCC to populate the electronic Medication Administration Record (eMAR); this process may be completed by the nurse upon receipt of a new prescriber order or by CareRx Pharmacy upon receipt of a new prescriber order.

b) CareRx Pharmacy will verify nurse entered PCC medication orders upon receipt of prescriber orders when dispensing during regular business hours, when applicable.

The Associate Administrator, DRC and documentation indicated the new medication order had been entered into PCC by the pharmacy as it was during regular business hours.

Following this medication incident, the pharmacy conducted an "Incident Evaluation and Response". Analysis and corrective actions indicated pharmacy staff, who enter new orders, and referred to as inputters, should have reviewed the full list of the resident's medications prior to entering any new order. This would have allowed the inputter to identify existing, potentially duplicate orders and either discontinue or clarify them.

Secondly, the pharmacist should have reviewed the resident's full medication profile as part of checking any new order. In addition, the pharmacy's software system, "Kroll", flags any duplicate orders under the interactions section in the software. The software had flagged the resident's order, which should have alerted the pharmacist.

While the pharmacy's policy identified the pharmacy would verify orders entered by the nurse into PCC, their policy had not identified actions to be taken when the pharmacy enters orders into PCC.

2. Re-education had been provided to the staff members involved in the resident's medication incident. Documents provided, included the College of Nurses of Ontario (CNO), medication practice standard. The practice standard indicated that nurses accept orders that are clear, complete, and appropriate. This standard contained a decision tree for accepting orders, that prompted the nurse to ask if the order was clear and to consider if they understood the order. The standard indicated if the order was not clear to the nurse, they were not to perform any further actions and were to follow up with the prescriber.

The Associate Administrator, DRC, and ADRC confirmed it was an expectation that registered staff practiced in accordance with the CNO medication practice standard. They confirmed the licensee and the pharmacy did not have policy(s) or protocol(s) that contained this information, at the time of this inspection.

Sources: CI report, home's investigative notes and re-education materials, a laboratory report, physician orders, progress notes, medication incident form, pharmacy's Incident Evaluation and Response notes, pharmacy policy "Ordering New Prescriptions Using PointClickCare" (policy 9.3, revised July 2019), and interviews with a nurse and other staff.

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 written policies and protocols are developed for the medication management system to ensure accurate acquisition of a resident's drugs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that medication incidents involving residents were reported to the Medical Director, when the incidents occurred.

a) A medication incident report form indicated in June 2021, a resident received a higher than prescribed dose of medication, which caused an adverse reaction and resulted in a hospital admission.

The medication incident form indicated a check mark had not been in place that the Prescriber, Medical Director and RN (EC), had been notified. A review of progress notes indicated the Prescriber had been notified and staff confirmed the resident was not being attended to by the RN (EC), at the time of this incident.

b) Another medication incident report form indicated a resident was found to have a missing dose of their prescribed medication in August 2021. No harm occurred to the resident.

The medication incident form indicated a check mark had not been in place to confirm the Prescriber and Medical Director, had been notified. A review of progress notes indicated the Prescriber had been notified.

Staff confirmed the Medical Director had not been notified when these two medication incidents occurred.

The requirement to notify all required persons when a medication incident occurs ensures that the legislation is complied with and provides for an interdisciplinary approach to review trends and patterns with the goal to enhance the medication management system by reducing medication incidents and preventing harm to residents.

Sources: CI report, medication incidents and progress notes for residents, and interviews with the Associate Administrator and DRC.

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 medication incidents are reported to the Medical Director, when the incidents occur, to be implemented voluntarily.

Issued on this 21st day of January, 2022

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN HUNTER (130), CATHY FEDIASH (214), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2021_820130_0014
Log No. / No de registre :	008910-21, 008985-21, 011454-21, 011619-21, 012748-21, 017266-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 20, 2022
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, Thorold, ON, L2V-4T7
LTC Home / Foyer de SLD :	Linhaven 403 Ontario Street, St Catherines, ON, L2N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Perrodou

Ontario

Ministry of Long-Term Care

Ministère 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

To The Regional Municipality of Niagara, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 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 s. 131 (2) of O. Reg. 79/10.

Specifically, the licensee must:

1) Ensure that all staff who are responsible for transcribing orders receive the following education:

a) All medical abbreviations that are used in the transcription of orders.

b) The College of Nurses of Ontario (CNO), Medication practice standard including the decision tree titled, "Is the Order Clear, Complete and Appropriate?".

This education shall be documented and include the names of all staff, their designation, and date training was provided. Training records shall be retained.

2) Ensure the listing of all medical abbreviations that are used in the transcription of orders, is posted and readily available to all staff who are responsible for transcribing orders.

An order was made by taking the following factors into account:

Severity: Actual harm occurred to a resident, who was admitted to hospital and sustained a significant change in their health status.

Scope: This non-compliance was isolated as observation of medication administration to two other resident's had not resulted in non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 131 (2) and two Voluntary Plans of Correction (VPC) were issued to the home.

Grounds / Motifs :

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

In July 2021, a resident's laboratory report identified an abnormal level. The physician reviewed the laboratory report and wrote a new order on the report, which included a medical abbreviation symbol, indicating a change followed by the new dose of medication.

A nurse stated when they transcribed the order onto the physician order form, they had not transcribed the medical abbreviation symbol and only transcribed the new medication and the dose, as they were unaware of the meaning of the medical abbreviation symbol.

The new order was processed by the pharmacy and delivered to the home. The resident was administered and consumed both orders of the medication which was greater than times the prescribed dose. The resident was transferred and admitted to hospital for treatment resulting from the medication error.
The DRC confirmed drugs were not administered to the resident, as specified by the prescriber.

There was actual harm to the resident when drugs were not administered as specified by the prescriber.

Source: CI report, home's investigative notes and re-education materials, a resident's laboratory report, physician orders, progress notes, medication incident form, pharmacy's Incident Evaluation and Response notes, and interview with the DRC and other staff. (214)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 11, 2022

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 20th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Hunter

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