



**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
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 17, 2016	2016_448155_0014	028564-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP

c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

COUNTRY LANE LONG TERM CARE RESIDENCE

R. R. #3, 317079 HWY 6 & 10 CHATSWORTH ON N0H 1G0

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

SHARON PERRY (155), DOROTHY GINTHER (568)

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): September 22, 23, 26, 27, and 28, 2016.

The following intake was completed within the Resident Quality Inspection (RQI): 035851-15 - follow-up to compliance order #001, inspection number 2015_253614_0021 related to registered nurse being on duty and present in the home at all times.

During the course of the inspection, the inspector(s) spoke with Executive Director, Long Term Care Consultant, Director of Care, Office Manager, Registered Nurse, Registered Practical Nurse, Registered Dietitian, Personal Support Workers, Resident Council representative, residents and families.

The inspectors also toured the home, observed medication administration, medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

**Continance Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Sufficient Staffing**

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

**4 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)**



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :



1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times unless there was an allowable exception to this requirement.

On September 23, 2016, an agency registered nurse was observed working during the day shift (0700-1500 hours).

Review of the registered staff schedule revealed that there were three vacant part time registered nurse positions. The Executive Director #101 shared that out of the three vacant part time lines they had created a full time position that would consist of two evening shifts and five day shifts every two weeks. This new full time registered nurse position was offered to an applicant and the registered nurse was to start on October 17, 2016. The Executive Director #101 shared that they were currently interviewing for a part time registered nurse to fill the remaining vacant line consisting of two evening shifts and four night shifts every two weeks.

A review of the registered staff schedule for the period of September 19 to September 27, 2016 revealed that an agency registered nurse worked the following:

- three out of twenty-three day shifts (13 per cent)
- six out of twenty-three evening shifts (26 per cent)
- two out of twenty-three night shifts (9 per cent)

The Executive Director #101 shared that an agency registered nurse worked when a registered nurse who was an employee of the home was not available.

This was previously issued on December 18, 2015, inspection number 2015_253614_0021, as compliance order #001 and Director's referral #001; January 20, 2015, inspection number 2015_325568_0003 as compliance order #001; and August 14, 2014, inspection number 2014_325568_0008 as compliance order #001.

The scope of this area of non-compliance was isolated, despite Ministry of Health action non-compliance continues, and the severity was determined to be a level 2 with the potential for risk of harm. [s. 8. (3)]



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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :



1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

During stage one of this inspection, resident #002 reported that they were concerned with the way they were treated and the way another resident was treated during care by an identified staff member.

Record review revealed a Complaint Investigation Form.

On September 28, 2016 during an interview with the Executive Director (ED) #101 they said they had followed up with the staff member involved in the alleged incident. The ED #101 shared that the staff member did not feel that they had been rough with the resident. When asked if the home had submitted a Critical Incident to the Director regarding this incident of suspected abuse, the ED #101 said they had not.

The licensee failed to ensure that a person, who had reasonable grounds to suspect that abuse of resident by a staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.



**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the
following weight changes are assessed using an interdisciplinary approach, and
that actions are taken and outcomes are evaluated:**

- 1. A change of 5 per cent of body weight, or more, over one month.**
- 2. A change of 7.5 per cent of body weight, or more, over three months.**
- 3. A change of 10 per cent of body weight, or more, over 6 months.**
- 4. Any other weight change that compromises the resident's health status. O.
Reg. 79/10, s. 69.**

Findings/Faits saillants :



1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

3. A change of 10 per cent of body weight, or more, over 6 months.

During stage one of this inspection, record review revealed that resident #011 had a significant weight loss.

Record review revealed that resident #011 lost more than ten per cent of body weight over six months.

During an interview with the Registered Dietitian #106 they shared that when there was a significant weight change the registered staff were to complete a referral to the Registered Dietitian in Point Click Care for assessment.

On September 27, 2016, record review for resident #011 revealed that there was no assessment that included an evaluation of the resident's weight after resident #011 had a greater than ten per cent weight loss in six months.

The Extendicare, Resident Care, Weight Change Program, policy # RESI-05-02-07 effective November 2013 stated that registered staff reviewed weights to determine whether weight change was significant:

- a) a change of 5 per cent or more over one month
- b) a change of 7.5 per cent or more over three months
- c) a change of 10 per cent over six months or
- d) any other weight change that compromises the resident's health status.

For all significant weight changes as outlined above, a referral must be made to the Registered Dietitian/Dietary Manager/designate.

The Registered Dietitian #106 shared during an interview that there was no assessment that included an evaluation of resident #011's weight as they did not receive a referral for the significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]



Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

3. A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

- 1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
- 2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
- 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
- 4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
- 5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
- 6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
- 7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
- 8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
- 9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
- 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
- 11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

Findings/Faits saillants :



1. The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Record review revealed a Complaint Investigation Form that identified an incident which took place. Resident #002 reported that they were concerned with the way they were treated and the way another resident was treated during care by an identified staff member.

On September 28, 2016 during an interview with the Executive Director (ED) #101 they said that the PSW was an agency staff working in the home. The ED stated that prior to performing their duties the agency staff were to complete an orientation which included review of the home's policy entitled Zero Tolerance Resident Abuse, Resident Rights and Commitment to Residents. ED #101 was unable to provide documentation that the PSW had completed the required training on the home's policy to promote zero tolerance of abuse and neglect prior to working in the home.

The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

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 no staff performs their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 24th day of October, 2016

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

Original report signed by the inspector.



**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) : SHARON PERRY (155), DOROTHY GINTHER (568)

Inspection No. /

No de l'inspection : 2016_448155_0014

Log No. /

Registre no: 028564-16

Type of Inspection /

Genre

d'inspection:

Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Oct 17, 2016

Licensee /

Titulaire de permis :

CVH (No.2) LP
c/o Southbridge Care Homes, 766 Hespeler Road, Suite
301, CAMBRIDGE, ON, N3H-5L8

LTC Home /

Foyer de SLD :

COUNTRY LANE LONG TERM CARE RESIDENCE
R. R. #3, 317079 HWY 6 & 10, CHATSWORTH, ON,
N0H-1G0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur :

Mary Lynne Kennedy-McGregor

To CVH (No.2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:



**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

**Ministère 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

Order # /
Ordre no : 001 **Order Type /**
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre 2015_253614_0021, CO #001;
existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times.

Grounds / Motifs :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times unless there was an allowable exception to this requirement.

On September 23, 2016, an agency registered nurse was observed working during the day shift (0700-1500 hours).

Review of the registered staff schedule revealed that there were three vacant part time registered nurse positions. The Executive Director #101 shared that out of the three vacant part time lines they had created a full time position that would consist of two evening shifts and five day shifts every two weeks. This new full time registered nurse position was offered to an applicant and the registered nurse was to start on October 17, 2016. The Executive Director #101 shared that they were currently interviewing for a part time registered nurse to fill the remaining vacant line consisting of two evening shifts and four night shifts every two weeks.



**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*

**Ministère 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*

A review of the registered staff schedule for the period of September 19 to September 27, 2016 revealed that an agency registered nurse worked the following:

- three out of twenty-three day shifts (13 per cent)
- six out of twenty-three evening shifts (26 per cent)
- two out of twenty-three night shifts (9 per cent)

The Executive Director #101 shared that an agency registered nurse worked when a registered nurse who was an employee of the home was not available.

This was previously issued on December 18, 2015, inspection number 2015_253614_0021, as compliance order #001 and Director's referral #001; January 20, 2015, inspection number 2015_325568_0003 as compliance order #001; and August 14, 2014, inspection number 2014_325568_0008 as compliance order #001.

The scope of this area of non-compliance was isolated, despite Ministry of Health action non-compliance continues, and the severity was determined to be a level 2 with the potential for risk of harm. (155)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jan 09, 2017



**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

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



**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*

**Ministère 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*

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.



**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*

**Ministère 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*

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, 11^e 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.



**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*

**Ministère 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*

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 17th day of October, 2016

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** SHARON PERRY

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