Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 05, 2014;	2014_225126_0029 (A1)	O-000838-14, #O-001165-14	Critical Incident System

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On December 2, 2014, the Director of Care requested an extension to ensure compliance to January 2, 2015.

Issued on this 5 day of December 2014 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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Dec 05, 2014;	2014_225126_0029 (A1)	O-000838-14, #O-001165-14	Critical Incident System

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DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 31 and November 3, 2014

During this inspection the following Log were completed Log #:O-000838-14, #O-001165-14

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care, several registered and non-registered nursing staff, the Environmental Manager.

During the course of the inspection, the inspector(s) reviewed the resident health care record and observed care and services given to residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

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

- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #901	2014_225126_0029	126

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 110. (1) 1 whereby physical device were not applied in accordance with the manufacture's instruction.

On a specific day in September 2014, it was reported to the Director via the Critical Incident Report under O.Reg 79/10 s. 107 (3)(4) "Incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the president's health status". Resident # 25 was found by staff to have slid down the wheelchair with the seat belt to his/her neck.

On November 3, 2014, Inspector # 126 interviewed Personal Support Worker (PSW) S# 003 regarding the above incident. S# 003 indicated that Resident # 25 was very agitated on the day of the incident and sat the Resident in a wheelchair with a front seat belt buckle. Resident # 25 was confused and agitated and was unable to remove the seat belt. The front seat belt was applied loose, between 6-8 inches from the Resident abdomen. S# 003 indicated that the belt was not snugged to the resident as she assumed that the belt was not a restraint and there were no orders. S# 003 also indicated that in this home the Velcro belt with alarm or the front seat belt with a buckle are applied for a precaution to prevent falls.

Resident # 025 health care record was reviewed for a specific period between August and September, 2014. Several notes in the progress notes were documented indicating that Resident # 25 was agitated and was sliding down the w/c.

The Annual Resident Quality Inspection was conducted on October Oct 20-31,2014. During the course of that inspection it was observed by Inspector #126 and # 148 that two residents had Velcro belts that were applied loosely and could not undo the belt. Several Registered Nursing staff indicated that these belts were applied for safety to prevent falls. Registered and Non -Registered Nursing staff were applying front seat belt (clip, buckle and Velcro) on several resident and were not considering these belts as restraint.[s. 110. (1) 1.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S. O. 2007, chap 8, s. 31 (1) whereby Resident # 025 was restrained by a physical device and was not included in the plan of care.

On a specific day in September 2014, it was reported to the Director via the Critical Incident Report under O. Reg 79/10 s. 107 (3)(4) "Incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the president's health status". On a specific day in September 2014, Resident # 25 was found by staff to have slid down the wheelchair (w/c) with the seat belt to his/her neck.

On November 3rd and 4th , 2014, Inspector # 126 interviewed Personal Support Services (PSW) S# 100 & S#101, they indicated that Resident # 25 had a seat belt when sitting in the w/c. Both PSWs indicated that the seatbelt was applied loosely as a safety measure to prevent the Resident from falling and that it was not a restraint. On three specific day in August and on two specific days in September 2014, Resident # 25 was confused and agitated. Several registered and non-registered nursing staff indicated that Resident # 25 could not undo the seatbelt when Resident # 25 was agitated and confused. It was documented in the progress notes on those

days that Resident's # 25 was observed sliding down the w/c and the seatbelt continued to be applied.

Resident # 025 health care record was reviewed for a specific period between August and September, 2014. Several notes in the progress notes were documented indicating that Resident # 025 was agitated and was sliding down the w/c.

In September 2014, Resident # 25's seatbelt was not considered a restraint by the nursing staff; therefore in reviewing the health care record the application of the seatbelt was not included in the plan of care.

On November 3, 2014, Inspector # 126 interviewed Personal Support Services (PSW) S# 100 and S# 101. Both PSWs were working on a specific day in September 2014 on the day shift. S# 100 assisted Resident # 25 to get up before lunch, sat the Resident in a "portable" w/c and applied the front closure seat belt. S# 101 indicated that the "portable" w/c with front closure seat belt was used for Resident # 25 when he/she was agitated. Both PSWs indicated that the seatbelt was applied loosely as a safety measures to prevent Resident # 25 from falling.

Further review of the health care record indicated that there was no physician order or assessment for the application of the restraint including alternatives to the restraint and the least restrictive of such reasonable methods that would be effective to address risk. A general consent to the use of all types of restraints and PASD's was obtained from the Resident substitute decision maker, however the consent was not a consent specific for the use of the front closure seat belt as a restraint for Resident #25 in September 2014.

On November 3, 2014, an immediate order was served to the home related to O. Reg 79/10, s. 110. (1) 1. "Staff apply the physical device in accordance with any manufacturer's instructions". The home was ordered to ensure that, as per the home requirements, the Velcro seat belts shall only be applied on resident that can undo the belts easily and that front closure seat belts were not applied loosely on residents, if utilized as a restraint. By the end of the day on November 3, 2014, the home complied with the order.

The Resident Quality Inspection was conducted on October Oct 20-24 and October 27 -31, 2014. During the course of that inspection it was observed by Inspector #126 and # 148 that two residents had Velcro belts that were applied loosely and could not undo their belt. Several Registered Nursing staff indicated that these belts were applied for

safety to prevent falls. Registered and non-registered nursing staff were applying front seat belt (clip, buckle and Velcro) on several residents and were not considering these as restraints. [s. 31. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

Issued on this 5 day of December 2014 (A1)

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

Health System Accountability and Performance Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDA HARKINS (126) - (A1)

Inspection No. / No de l'inspection : 2014_225126_0029 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-000838-14, #O-001165-14 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Dec 05, 2014;(A1)

Licensee / Titulaire de permis :
DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970,
WINCHESTER, ON, K0C-2K0

LTC Home / Foyer de SLD :
DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970,
WINCHESTER, ON, K0C-2K0

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Joanne Sidorchuk

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To DUNDAS MANOR LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that staff apply physical devices (Velcro belt and front buckle seat belt) in accordance with any manufacturer's instructions by 16:00 today.

As per the home requirements, the Velcro belts shall only be applied to resident that can undo the belt easily.
The front buckle seat belts shall not been applied loosely on residents if utilized as a restraint.

Grounds / Motifs :

1. 1. The licensee has failed to comply with O. Reg 79/10, s. 110. (1) 1 whereby physical device were not applied in accordance with the manufacture's instruction.

On a specific day in September 2014, it was reported to the Director via the Critical Incident Report under O.Reg 79/10 s. 107 (3)(4) "Incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the president's health status". Resident # 25 was found by staff to have slid down the wheelchair with the seat belt to his/her neck.

On November 3, 2014, Inspector # 126 interviewed Personal Support Worker (PSW) S# 003 regarding the above incident. S# 003 indicated that Resident # 25 was very agitated on the day of the incident and sat the Resident in a wheelchair with a front seat belt buckle. Resident # 25 was confused and agitated and was unable to remove the seat belt. The front seat belt was applied loose, between 6-8 inches from the Resident abdomen. S# 003 indicated that the belt was not snugged to the resident as he/she assumed that the belt was not a restraint and there were no orders. S# 003 also indicated that in this home the Velcro belt with alarm or the front seat belt with a buckle are applied for a precaution to prevent falls.

Resident # 25 health care record was reviewed for a specific period between August and September, 2014. Several notes in the progress notes were documented indicating that Resident # 25 was agitated and was sliding down the w/c.

The Annual Resident Quality Inspection was conducted on October Oct 20-31,2014. During the course of that inspection it was observed by Inspector #126 and # 148 that two residents had Velcro belts that were applied loosely and could not undo the belt. Several Registered Nursing staff indicated that these belts were applied for safety to prevent falls. Registered and Non -Registered Nursing staff were applying front seat belt (clip, buckle and Velcro) on several resident and were not considering these belts as restraint.[s. 110. (1) 1.] (126)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Nov 03, 2014

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

The licensee shall ensure that all residents restrained by a physical device is included in the resident's plan of care only if all of the following are satisfied:

There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address risk.

The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address risk.

A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with

authority to give that consent.

The device is used in accordance with any requirements provided for in the regulations;

The resident is monitored while restrained, in accordance with the requirements provided for in the regulations;

The resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;

The resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;

The resident is restrained only for as long as is necessary to address risk.

The method of restraining used is discontinued if, as a result of the reassessment of the resident's condition

Grounds / Motifs :

1. 1. The licensee has failed to comply with LTCHA 2007, S. O. 2007, chap 8, s. 31 (1) whereby Resident # 025 was restrained by a physical device and was not included in the plan of care.

On a specific day in September 2014, it was reported to the Director via the Critical Incident Report under O. Reg 79/10 s. 107 (3)(4) "Incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the president's health status". On a specific day in September 2014, Resident # 25 was found by staff to have slid down the wheelchair (w/c) with the seat belt to his/her neck.

On November 3rd and 4th , 2014, Inspector # 126 interviewed Personal Support Services (PSW) S# 100 & S#101, they indicated that Resident # 25 had a seat belt when sitting in the w/c. Both PSWs indicated that the seatbelt was applied loosely as a safety measure to prevent the Resident from falling and that it was not a restraint.

On three specific day in August and on two specific days in September 2014, Resident # 25 was confused and agitated. Several registered and non-registered nursing staff indicated that Resident # 25 could not undo the seatbelt when Resident # 25 was agitated and confused. It was documented in the progress notes on those days that Resident's # 25 was observed sliding down the w/c and the seatbelt continued to be applied.

Resident # 25 health care record was reviewed for a specific period between August and September, 2014. Several notes in the progress notes were documented indicating that Resident # 25 was agitated and was sliding down the w/c.

In September 2014, Resident # 25's seatbelt was not considered a restraint by the nursing staff; therefore in reviewing the health care record the application of the seatbelt was not included in the plan of care.

On November 3, 2014, Inspector # 126 interviewed Personal Support Services (PSW) S# 100 and S# 101. Both PSWs were working on a specific day in September 2014 on the day shift. S# 100 assisted Resident # 25 to get up before lunch, sat the Resident in a "portable" w/c and applied the front closure seat belt. S# 101 indicated that the "portable" w/c with front closure seat belt was used for Resident # 25 when he/she was agitated. Both PSWs indicated that the seatbelt was applied loosely as a safety measures to prevent Resident # 25 from falling.

Further review of the health care record indicated that there was no physician order or assessment for the application of the restraint including alternatives to the restraint and the least restrictive of such reasonable methods that would be effective to address risk. A general consent to the use of all types of restraints and PASD's was obtained from the Resident substitute decision maker, however the consent was not a consent specific for the use of the front closure seat belt as a restraint for Resident #25 in September 2014.

On November 3, 2014, an immediate order was served to the home related to O. Reg 79/10, s. 110. (1) 1. "Staff apply the physical device in accordance with any manufacturer's instructions". The home was ordered to ensure that, as per the home requirements, the Velcro seat belts shall only be applied on resident that can undo the belts easily and that front closure seat belts were not applied loosely on residents, if utilized as a restraint. By the end of the day on November 3, 2014, the home complied with the order.

The Resident Quality Inspection was conducted on October Oct 20-24 and October 27-31, 2014. During the course of that inspection it was observed by Inspector #126 and # 148 that two residents had Velcro belts that were applied loosely and could not undo their belt. Several Registered Nursing staff indicated that these belts were applied for safety to prevent falls. Registered and non-registered nursing staff were applying front seat belt (clip, buckle and Velcro) on several residents and were not considering these as restraints. [s. 31. (1)] (126)

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

Jan 02, 2015(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
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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 5 day of December 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

Service Area Office /
Bureau régional de services : Ottawa