Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2016	2016_253614_0001	035819-15	Resident Quality Inspection

Licensee/Titulaire de permis

EDEN HOUSE CARE FACILITY INC
R.R. #2 GUELPH ON N1H 6H8

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

EDEN HOUSE NURSING HOME
5016 Wellington County Road 29 R. R. #2 GUELPH ON N1H 6H8

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

CAROLYN MCLEOD (614), DOROTHY GINTHER (568), NUZHAT UDDIN (532)

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): January 5, 6, 7, 8, 11, 12, 13, 14 and 15, 2016

When in the home the inspectors toured the resident home areas, medication room (s) and storage area(s), observed dining service, medication administration, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control procedures, posting of required information, relevant policies and procedures as well as meeting minutes pertaining to the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RN-Best Practice, RN-RAI Coordinator, RPN-RAI Back Up, Life Enrichment Coordinator, Nutritional Manager, two Cooks, one Dietary Aide, three RPN's, one RN, fifteen PSW's, office administrator, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

6 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

Observations during the initial tour of the home on January 5, 2016, revealed that there was no communication and response system in the activity room across from the nursing station, in the dining room, and in the lounge across from the dining room.

During an interview with the Best Practice Registered Nurse #102 they confirmed that the activity room across from the nursing station, dining room, and lounge across from the dining room were all accessible by residents and there was no resident-staff communication response system installed in these areas. [s. 17. (1) (e)]

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into considerations all potential zones of entrapment.

During Stage one of the Resident Quality Inspection, eighteen out of forty resident beds (45 per cent) were observed with one or more bed rails in the up position.

On January 6, 2016, an identified resident's bed was observed with a three quarter bed rail up on the right side. A bed rail bolster pad positioned between the bed rail and the mattress was noted to have fallen below the bed rail. The bolster was not attached to the bed rail and a gap was observed between the bed rail and the mattress. On the same day, an identified resident was observed in bed with a three quarter bed rail up on the left. There was a gap noted between the bed rail and the mattress.

During observations on January 13, 2016, the following was observed:

a)An identified resident was in bed with a three quarter bed rail raised on the left side. The resident was lying on a therapeutic surface. A gap was noted between the bed rail and the mattress. There were no corner guards on the bed frame and the mattress was

noted to slide on the surface with pressure. This resulted in an increased gap between the mattress and the bed rail.

b)An identified resident's bed was observed with a three quarter bed rail up on the right side. A bed rail bolster pad was noted between the mattress and the bed rail but it had fallen below the bed rail. There were no corner guards on the bed frame and the mattress slid to the left side increasing the gap between the mattress and the bed rail.

c)An identified resident's bed was observed with a three quarter bed rail up on the left side. A gap was noted between the bed rail and the mattress. A bed rail bolster pad was noted between the mattress and the bed rail, but it was not secured to the bed rail and had shifted out of position. There were no corner guards on the bed frame and the mattress slid easily to the right side increasing the gap between the mattress and the bed rail.

d)An identified resident's bed was observed with a therapeutic surface and one three quarter bed rail up on the right side. A gap was noted between the bed rail and the mattress on the right side. The bed surface had no corner guards and the mattress slid easily to the left side increasing the gap between the mattress and the bed rail.

e)An identified resident's bed was observed with one quarter bed rail up on the left side and one quarter rotating bed rail in the assist position up on the right side. A folded bolster pad was noted between the bottom of the mattress and the foot board where there was a gap of more than five inches. There were no corner guards on the bed surface and the mattress slid to the right increasing the gap between the left bed rail and the mattress.

f)An identified resident's bed was observed with a three quarter bed rail up on the left. There was a gap noted between the bed rail and the mattress. There were no corner guards on the bed surface and the mattress slid easily to the right increasing the gap between the bed rail and the mattress.

g)An identified resident's bed was observed with a three quarter bed rail up on the left side. A gap was noted between the bed rail and the mattress. There were no corner guards on bed surface and the mattress easily slid to the right increasing the gap noted above.

Review of the home's Bed Entrapment Report, dated April 2015, revealed that thirty of

the fifty-nine beds (51 per cent) tested for entrapment had failed one or more of zones two, three, and four. The report identified that specific beds had failed entrapment testing for zones two, three and four. An identified resident's bed was reported to have passed testing for all zones of entrapment, however the report indicated that the resident had an assist bed rail and not a three quarter bed rail on one side as observed during this inspection. The report did not indicate what solutions had been suggested or implemented to mitigate risk for these bed systems.

The DOC #101 indicated that for those beds that had failed one or more of zones two, three or four during testing, they were advised by a consulting company to use a bolster pad between the bed rail and the mattress. When asked if the beds that had been identified as having one or more failed zones had been retested after the bolster pads were put in place, the DOC #101 indicated that this had not been done.

On January 14, 2015, at 1430 hours the Director of Care #101, and Personal Support Worker (PSW) #128 were shown the concern regarding risk of entrapment on an identified resident's bed. It was identified that there was a potential for entrapment between the bed rail and mattress (zone 3) and under the bed rail (zone 2). While there was a grey bolster pad on the bed system, it had shifted position and fallen below the bed rail. The DOC #101 and PSW #128 confirmed that the bolster was not in position and there was potential for entrapment in the identified zones.

The Director of Care #101 confirmed that the home did not own the cone and cylinder tool for entrapment testing and that they did not follow the best practice guidelines for reassessing beds when they made adjustments or changes to the bed system. The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (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 bed rails are used, that steps are taken to prevent
resident entrapment taking into consideration all zones of entrapment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs, tables at an appropriate height to meet the needs of all residents, and appropriate seating for staff that were assisting residents to eat.

On January 13, 2016, an identified resident was observed sitting in the dining room trying to eat their meal; the resident had a specific health issue. The dining table was observed positioned in a manner that the resident had difficulty seeing the location and contents of their plate.

The plan of care for the resident revealed that the resident required some assistance with eating.

In an interview on January 13, 2016, at 1300 hours, the resident confirmed that they were not sitting at a table that was appropriate for them.

The Nutritional Manager confirmed that they have not looked into adjustable table surface for residents with limited mobility or tables at an appropriate height to meet the needs of the residents. [s. 73. (1) 11.]

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 appropriate furnishings and equipment in the dining room meet the needs of all residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On January 13, 2016, at 1206 hours it was observed that the treatment cart with drugs and drug-related supplies was left opened and parked in front of the dining room. The Registered Nurse #112 was assisting other residents in the dining room with their meals and Inspector #532 was able to open all the drawers of the treatment cart. The treatment cart contained prescription creams.

On January 15, 2016, at 1400 hours the treatment cart was observed parked down a care area hallway unlocked and unattended.

On January 13, 2016, in an interview, the Registered Nurse #112 shared that the cart was not equipped with a locking system.

During interviews on January 14 and 15, 2016, with the DOC #101 it was confirmed that the treatment cart was the old medication cart and when the home had received a new cart from pharmacy, they used the old medication cart as the treatment cart. The DOC #101 also confirmed that the treatment cart was not secure and did not lock. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On January 12, 2016, it was observed that a destruction bin for controlled substances was stored inside a separate, stationary cupboard however, the cupboard was unlocked.

In an interview, the Registered Nurse #112 shared that the cupboard does not lock however, the destruction bin for controlled substance had a lock.

On January 14, 2016, the DOC #101 confirmed that the destruction bin for controlled substances had a lock, however, the bin was not stored in a separate, double-locked stationary cupboard. [s. 129. (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 medications are stored in a secure and locked area, to be implemented voluntarily.

WN #5: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident.

On January 12, 2016, at 1215 hours, an identified resident was observed sitting in the dining room with drugs sitting on the dining table, in front of the resident. There were other residents sitting at the same table.

On January 12, 2016, at 1219 hours, in an interview the Resident Assessment Instrument / Minimum Data Set (RAI /MDS) Coordinator #104 revealed that the resident preferred to open the package of medication themself and would not allow staff to give the drugs to them.

It was observed that the Registered Practical Nurse (RPN) # 122 was at the nurse's station while the resident had the medication sitting on the table.

On January 12, 2016, the RAI coordinator also confirmed that they were not aware if there was a Doctor's order and that the self-administration of drugs was approved by the prescriber.

Record review confirmed that the self-administration of drugs was not approved or ordered by the prescriber.

The Director of Care #101 confirmed that the self-administration of drugs was to be approved by the physician and it was not. [s. 131. (5)]

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 resident self administers medication unless approved by the prescriber, in consultation with the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the infection prevention and control program.

On January 13, 2016, at 1159 hours during dining observation it was observed that Personal Support Worker (PSW) #117 collected and removed dirty soup bowls from the table and returned back to the table to feed residents without performing hand hygiene. During the same dining observation it was observed that PSW #117 and #118 assisted and lifted a resident in their wheelchair and sat down to feed the resident.

PSW #117 continuously was observed getting up through the dining service to put away the dirty dishes; however, they were not observed to perform hand hygiene each time.

On January 13, 2016, it was confirmed with the Registered Practical Nurse #122 that when staff remove dirty dishes or assist with lifting residents, they were expected to perform hand hygiene as the hand sanitizer was available and mounted on the wall in the dining room.

Staff members failed to participate in the implementation of the infection prevention and control program when they touched dirty dishes and assisted residents with other tasks and did not perform hand hygiene. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 3rd day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLYN MCLEOD (614), DOROTHY GINTHER (568), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2016_253614_0001
Log No. / Registre no:	035819-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 1, 2016
Licensee / Titulaire de permis :	EDEN HOUSE CARE FACILITY INC R.R. #2, GUELPH, ON, N1H-6H8
LTC Home / Foyer de SLD :	EDEN HOUSE NURSING HOME 5016 Wellington County Road 29, R. R. #2, GUELPH, ON, N1H-6H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To EDEN HOUSE CARE FACILITY INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

Grounds / Motifs :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

Observations during the initial tour of the home on January 5, 2016, revealed that there was no communication and response system in the activity room across from the nursing station, in the dining room, and in the lounge across from the dining room.

During an interview with the RN-Best Practice #102, they confirmed that the activity room across from the nursing station, dining room, and lounge across from the dining room were all accessible by residents and there was no resident-staff communication response system installed in these areas.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2016

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
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
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 1st day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Carolyn McLeod

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