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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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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
Jun 14, 2016	2016_396103_0018	030476-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF HASTINGS
1M Manor Lane Box #758 BANCROFT ON K0L 1C0

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

HASTINGS CENTENNIAL MANOR
1 MANOR LANE P.O. BOX 758 BANCROFT ON K0L 1C0

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

DARLENE MURPHY (103)

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): June 1-3, 6-9, 13, 2016

030476-15 (resident fall), 031505-15 (alleged resident to resident abuse), 033332-15 (alleged staff to resident abuse), 033368-15 (alleged resident to resident abuse), 033388-15 (resident fall), 033615-15 (alleged staff to resident abuse), 000107-16 (alleged resident to resident abuse), 005117-16 (environmental- loss of services), 008136-16 (alleged staff to resident abuse), 015130-16 (resident injury resulting in significant change of condition).

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Physiotherapy Aide (PTA), Maintenance worker, Environmental Manager, Assistant Director of Care (ADOC), and the Administrator.

During the course of the inspection, the inspector conducted a full walking tour of the home, reviewed the home's abuse policy and education records, made resident observations related to care and reviewed home temperatures and maintenance records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The following finding relates to Log #000107-16:

1. The licensee has failed to ensure residents are protected from abuse.

The home submitted a critical incident report on an identified date to report an alleged resident to resident abuse involving resident #008 and resident #006. Resident #006 sustained an injury as a result of the incident.

A geriatric psychiatry referral was made for resident #008 following the incident and the home's physician initiated medication changes to assist in the modification of the resident's behaviours.

This inspector reviewed resident #008's resident health care record for an identified period of time. An identified number of behaviours involving resident #008 and co-residents were found.

PSW staff, housekeeping staff and registered staff working both day and evening shifts was interviewed. The staff were found to be knowledgeable of resident #008's behavioural care plan but indicated the strategies were not always effective. Staff reported concerns in regards to the safety of co-residents when resident #008 was left unattended or unsupervised.

O. Reg 79/10, s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident. None of the identified incidents were reported to the MOHLTC.

The Assistant Director of Care (ADOC) was interviewed and stated she was unaware of the identified incidents or of resident #008's ongoing responsive behaviours. She indicated many of the incidents appeared to be reportable as an alleged resident to resident abuse and was unsure why they had not been reported or investigated in accordance with the home's zero tolerance of abuse policy.

The decision to issue an order related to these findings was based on the following:

The home's compliance history for the past three years was reviewed. A Written Notification (WN) and a Voluntary Plan of Correction (VPC) was issued on April 22,

2015, under LTCHA, 2007, s. 19 (Duty to Protect),
A WN and VPC was issued on October 27, 2014, under LTCHA, 2007, s. 19 (Duty to Protect),
A WN was issued on April 22, 2014 under LTCHA, 2007, s. 24 (Reporting certain matters to the Director).

The scope of this non compliance affects all residents that reside in the identified unit and the severity is actual harm as residents have been harmed by resident #008.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The following finding relates to Log #033332-15:

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #011 to ensure the assessments were integrated, consistent with and complemented each other.

On an identified date, resident #011 was being assisted by a PSW in a wheelchair. During the transfer, the resident was witnessed sustaining a potential injury and loudly yelling. Following the incident, two PSW's inspected the resident for injuries, but failed to notify the registered staff. Later that same day, the resident was observed to have bruising to the identified area and the resident was reporting pain.

The following day, the registered staff spoke with the PSW staff working the previous day. The PSW had failed to report the incident to the registered staff such that an assessment could be completed and to ensure oncoming staff could monitor the area for injury and pain. The resident was later diagnosed with an injury.

Discussion was held with the Administrator and she indicated the PSW staff had documented the incident in her notes, but had failed to report the incident to the registered staff. The Administrator stated the PSW's are required to report all potential injuries to the registered staff to facilitate the completion of an assessment. [s. 6. (4) (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 non-registered staff report all potential resident injuries to the registered staff such that an assessment can be completed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The following finding relates to Log #033332-15:

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #011.

As outlined in WN #2, resident #011 was witnessed sustaining a potential injury and loudly yelling while being transferred in a wheelchair by a PSW. The resident was later diagnosed with an identified injury.

The Administrator was interviewed and indicated staff are expected to ensure all transfers are done in a safe manner. She stated the home has discussed the issue of transporting residents in wheelchairs without foot pedals and the potential risks that is associated with this type of transfer. The Administrator indicated it would be her expectation that staff transfer these residents such that they are ensuring the residents remain safely in the chair, and at such a speed that the staff can appropriately react if needed to prevent resident injury. [s. 36.]

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 all staff use safe transferring techniques when assisting residents in wheelchairs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The following finding relates to Log #000107-16:

1. The licensee has failed to ensure resident #006 was assessed post fall.

As outlined in WN #1, resident #006 sustained an identified injury as a result of an altercation with resident #008. The post fall documentation was reviewed by this inspector. There was no documentation to support a post fall assessment had been completed. [s. 49. (2)]

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 a documented post fall assessment is completed using a clinically appropriate assessment instrument specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The following finding relates to Log #000107-16:

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

As outlined in WN #1, resident #008 was involved in a number of incidents. The home's abuse policy, F-20, last revised on May 1, 2015 was reviewed and indicated under "IV. Overview of Investigation and Reporting of Abuse and Neglect", that LTCHA, s. 24 (1) requires a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

In addition, the home's abuse policy defines physical abuse under "Section Five" as the use of physical force by a resident that causes physical injury to another resident.

PSW staff members were interviewed and indicated several residents had expressed fear of resident #008 and others had received injuries as a result of resident #008's behaviours. RN #110 was interviewed and indicated she only notified the MOHLTC of one incident involving resident #008 and that in hind sight she realized that was not in accordance with the home's abuse policy. [s. 20. (1)]

This non compliance resulted in the issuing of a Compliance order as outlined in WN #1.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The following findings relate to Log #033368-15 and #008136-16

1. The licensee has failed to ensure that the Director (MOHLTC) was informed of the results of an investigation into an alleged abuse.

On an identified date, the home submitted a critical incident report (CIS) to report an alleged resident to resident abuse. The home investigated the incident but, to date of this inspection, did not amend the report to reflect the outcome of the investigation. [s. 23. (2)]

2. On another identified date, the home submitted a CIS to report an alleged staff to resident abuse involving resident #009. The CIS, to date of this inspection, failed to reflect the results of the home's investigation into the allegation. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The following finding relates to Log #000107-16:

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions as a result of resident #008's aggressive behaviours.

As outlined in WN #1, resident #008 has been involved in numerous incidents since an identified date. The staff have been utilizing the strategies outlined in the behavioural care plan, but report the resident continues to put co-residents at risk of injury. [s. 54. (a)]

This non compliance resulted in the issuing of a Compliance order as outlined in WN #1.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The following findings relate to Log #030476-15 and #033332-15:

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of incidents that caused injuries that resulted in a significant change in resident's #001's and #011's health condition and for which the residents were taken to hospital.

On an identified date, resident #001 sustained a fall beside the bed. The resident was sent to hospital, diagnosed with an identified injury and returned to the home later that same day.

The MOHLTC was notified of the incident for the first time by means of a critical incident that was submitted three business days after the occurrence. [s. 107. (3) 4.]

2. On an identified date, resident #011 sustained a fall that resulted in an identified injury. The resident returned to the home later the same day. The home notified the MOHLTC of the significant change in condition for the first time eight days later by submitting a CIS. [s. 107. (3) 4.]

Issued on this 17th day of June, 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

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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2016_396103_0018
Log No. / Registre no:	030476-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 14, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF HASTINGS 1M Manor Lane, Box #758, BANCROFT, ON, K0L-1C0
LTC Home / Foyer de SLD :	HASTINGS CENTENNIAL MANOR 1 MANOR LANE, P.O. BOX 758, BANCROFT, ON, K0L-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kathy Plunkett

To THE CORPORATION OF THE COUNTY OF HASTINGS, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from abuse.

The licensee shall ensure the plan includes:

1) the development of a comprehensive, documented clinical assessment that clearly delineates resident #008's care needs in relation to responsive behaviours and the strategies required to prevent, minimize or respond to the responsive behaviours to ensure the safety of all co-residents,

2) how the home will implement the above strategies and who will be responsible for monitoring the effectiveness of the strategies,

3) the development and implementation of a monitoring process to ensure reporting of alleged, suspected or witnessed incidents of abuse is done in accordance with the home's zero tolerance of abuse policy.

4)the monitoring system should identify who will over see it and what consequences will be taken when staff do not adhere to the home's abuse policy.

The plan shall be submitted by fax at 613-569-9670 and sent Attention:Inspector Darlene Murphy on or before June 28, 2016.

Grounds / Motifs :

1. The following finding relates to Log #000107-16:

1. The licensee has failed to ensure residents are protected from abuse.

The home submitted a critical incident report on an identified date to report an alleged resident to resident abuse involving resident #008 and resident #006. Resident #006 sustained an injury as a result of the incident.

A geriatric psychiatry referral was made for resident #008 following the incident and the home's physician initiated medication changes to assist in the modification of the resident's behaviours.

This inspector reviewed resident #008's resident health care record for an identified period of time. An identified number of behaviours involving resident #008 and co-residents were found.

PSW staff, housekeeping staff and registered staff working both day and evening shifts was interviewed. The staff were found to be knowledgeable of resident #008's behavioural care plan but indicated the strategies were not always effective. Staff reported concerns in regards to the safety of co-residents when resident #008 was left unattended or unsupervised.

O. Reg 79/10, s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident. None of the identified incidents were reported to the MOHLTC.

The Assistant Director of Care (ADOC) was interviewed and stated she was unaware of the identified incidents or of resident #008's ongoing responsive behaviours. She indicated many of the incidents appeared to be reportable as an alleged resident to resident abuse and was unsure why they had not been reported or investigated in accordance with the home's zero tolerance of abuse policy.

The decision to issue an order related to these findings was based on the following:

The home's compliance history for the past three years was reviewed. A Written Notification (WN) and a Voluntary Plan of Correction (VPC) was issued on April 22, 2015, under LTCHA, 2007, s. 19 (Duty to Protect),
A WN and VPC was issued on October 27, 2014, under LTCHA, 2007, s. 19

(Duty to Protect),
A WN was issued on April 22, 2014 under LTCHA, 2007, s. 24 (Reporting certain matters to the Director).

The scope of this non compliance affects all residents that reside in the identified unit and the severity is actual harm as residents have been harmed by resident #008.

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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.

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, 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
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 14th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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