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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347 Preston St 4th Floor
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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
Jan 23, 2015	2015_396103_0009	O-000744-14	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 MANOR HOME FOR THE AGED
476 DUNDAS STREET WEST P.O. BOX 458 BELLEVILLE ON K8N 5B2

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): January 15, 16, 19, 20, 21, and 22, 2015

The following logs were included in this inspection: O-000744-14, O-001167-14, O-001226-14, O-001227-14 and O-001535-15.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Administrative Assistant, the Director of Nursing (DON), the Site Manager, and the Administrator.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 :

1. The licensee has failed to protect residents from abuse by failing to comply with the home's policy on zero tolerance of abuse.

On an identified date, Resident #2 was being assisted by two Personal Support Workers, S#103 and S#104. While providing care to this resident, a third PSW, S#102, entered the resident's room. S#103 and S#104 were both interviewed and stated Resident #2 became very agitated and began yelling at S#102 to leave the room. According to the staff, it was well known Resident #2 became agitated around S#102 and the staff member had been previously directed by management not to provide any care to this resident.

S#103 stated Resident #2 was visibly shaking and she was concerned the resident would fall. Neither staff member could recall why S#102 had entered the resident room, but both indicated they had not requested S#102's assistance. Staff stated they attempted to calm the resident, but S#102 continued to verbally taunt the resident.

According to O. Regs, 79/10 s. 2 (1), verbal abuse is defined as:
"any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth."

The home's zero abuse policy, F-20/F-20A, "Zero Tolerance of Abuse and Neglect Program and Appendices", states under "LTCHA Mandatory Reports", In accordance with LTCHA, s. 24 (1), a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the MOHLTC.

S#103 and S#104 both indicated they believed the incident to be abusive toward the resident, but neither staff member reported the allegation of staff to resident abuse to anyone until six days later. Both staff members confirmed they were aware of their mandatory obligation to report the allegation of abuse and were unsure why they did not immediately come forward to anyone. S#103 stated she did discuss the issue with another staff member, S#105 on an identified date and this staff member did report the allegation to the Director of Nursing at that time.

The DON initiated the investigation into the allegation of abuse immediately, however further delayed the reporting of the allegation to the MOHLTC until the after-hours pager was notified two days later.

Additionally, the home's zero abuse policy, under "Staff education", indicates employees

will receive education on the policy of Zero Tolerance of Abuse and Neglect during orientation and annually thereafter. S#104 did not receive abuse training including mandatory reporting in 2014.

S#102 was terminated by the home following the home's investigation. [s. 19. (1)]

2. On an identified date, Resident #1 alleged a staff member had yelled at them while administering the resident's morning medications. The home initiated an investigation into the allegation of abuse. Nine days later, the home submitted a critical incident report (CIR) to advise the MOHLTC of the allegation of verbal abuse and additional concerns raised by Resident #1.

The DON was interviewed and confirmed the MOHLTC was notified for the first time by means of the critical incident report. The DON also indicated the home did not notify the resident's Substitute Decision Maker (SDM) or any other person identified by the resident of the allegation of abuse because the resident is their own POA. The DON indicated there was no discussion with the resident to determine if the resident wanted someone notified.

Additionally the home did not notify the resident or the Director (MOHLTC) of the outcome of the investigation. According to the DON, the home investigated and the allegation was unfounded.

During an interview with Resident #1, the resident confirmed they were not made aware of the outcome of the investigation into the allegation of abuse and was not asked if they wanted the SDM or anyone notified of the incident.

The home's "Zero Tolerance of Abuse policy, F-20/F-20A" indicates under, "Investigation and Reporting":
-the home will notify the resident's SDM, if any, and any other person the resident specifies:
Immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that has the potential to be detrimental to the resident's health and well-being; and

Within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The policy also states:

The DON/delegate shall make a report to the MOHLTC Director with the results of every investigation conducted under this policy and any action the home takes in response to any incident of resident abuse or neglect and

Registered staff must notify the resident and the resident's SDM, if any, and any other person requested by the resident of the results of the investigation immediately upon the completion of the investigation.

The home failed to immediately report the allegation of abuse to the MOHLTC and did not have discussion with this capable resident to determine if they wanted anyone notified of this incident. Additionally the home failed to update the resident and the MOHLTC of the outcome of the investigation into this allegation of staff to resident abuse. [s. 19. (1)]

3. On an identified date, S#113 and S#114 were providing care to Resident #5 who has a cognitive impairment. According to S#113, during the provision of care, the resident became agitated and injured S#114. S#113 stated S#114 reacted by slapping the resident in the face.

S#113 did not come forward with the allegation of physical abuse until approximately 1.5 hours later when she advised the RN. The RN immediately initiated an investigation into the allegation and assessed the resident. The police were notified at that time as well as the DON and the ADON.

The home failed to notify the MOHLTC of the allegation of abuse until three days later when a critical incident report was submitted. Additionally, the resident's SDM was not notified until three days after the alleged incident.

The critical incident report outlined the allegation of staff to resident abuse and indicated further information related to the investigation would follow. To date of this inspection, no information related to the outcome of the investigation had been provided to the Director.

In accordance with the legislated requirements of abuse reporting and the home's Zero Tolerance of Abuse Policy, the staff member failed to immediately report the alleged abuse to the staff member in charge. The home failed to immediately report the alleged

staff to resident abuse immediately to the MOHLTC upon being made aware of the allegation.

Additionally, Resident #5's SDM was not notified of the alleged staff to resident abuse until three days following the alleged incident and the Director (MOHLTC) was not provided with information related to the outcome of the home's investigation into the allegation.

A thorough police and home investigation was conducted into the allegation of abuse and the allegation was determined unfounded. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 6 (7) whereby care was not provided to a resident as specified in the plan.

On an identified date during the night shift, Resident #3 was assisted to the bathroom by S#102 and requested assistance with the adjustment of clothing before and after toileting. S#102 refused to assist the resident and advised the resident they were capable of performing this independently.

Resident #3's plan of care, in effect at the time of this incident, was reviewed. Under toileting the care plan stated:
-resident will ask for and receive the necessary assistance,
-one person constant supervision and extensive assist for safety, ie. Adjust clothing, peri care.

The staff member failed to provide care to the resident as specified in the plan of care. The home investigated and the staff member was disciplined. [s. 6. (7)]

2. The licensee has failed to comply with LTCHA, 2007, s. 6 (7) whereby care was not provided to the resident as specified in the plan.

Resident #1 is a cognitively well resident that is independent with most aspects of care. Resident #1 reports several instances whereby staff have not provided care in accordance with the resident's specified wishes and finds the lack of communication to be unacceptable. The resident health care record was reviewed including Medication Administration Records, the resident care plan and progress notes.

On an identified date, the physician wrote an order which stated, may leave meds at bedside for resident to take later. The electronic Medication Administration record (eMAR) and the resident care plan indicated the same. Additionally, there were instructions on the eMAR's to indicate a specified pill needed to be crushed and that the bedtime pills were not to be delivered before 2130 hr.

On the following dates, the registered staff failed to provide care to the resident as specified in the plan:

On October 7, 8, 22 and 24-the resident's bedtime medications were delivered prior to 2130 hr,
On October 23 and 31- the registered staff member was unaware of the physician's order to leave the medications at the bedside for the resident to take later,
On November 2, 4, 6, 14, 16, 18, 19, 29 and 30-the resident's bedtime medications were delivered prior to 2130 hr,
On November 5-the registered staff member was unaware the resident self administered the medications,
On November 6-the registered staff member delivered the resident's specified pill not crushed,
On December 3, 11 and 26-the registered staff member delivered the resident's bedtime medications prior to 2130 hr,
On December 13- the registered staff was unaware the resident self administered medications,
On December 19-staff delivered the specified pill uncrushed, and
On January 20, 2015-staff attempted to provide the resident with a specified treatment.

According to Resident #1 and confirmed by an entry in the resident progress notes, the resident had requested the specified treatment be placed on hold five days earlier.

Resident #1 has repeatedly voiced concerns to staff in regards to the inconsistency of their medication delivery. Staff are failing to provide care to Resident #1 as specified in the plan of care. [s. 6. (7)]

Issued on this 26th day of January, 2015

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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2015_396103_0009
Log No. / Registre no:	O-000744-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 23, 2015
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 MANOR HOME FOR THE AGED 476 DUNDAS STREET WEST, P.O. BOX 458, BELLEVILLE, ON, K8N-5B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CLAUDETTE DIGNARD-REMILLARD

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

Order # / Ordre no : 001

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

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 is hereby ordered to ensure the home's abuse policy, "Zero Tolerance of Abuse and Neglect", F-20 and F-20A is followed for every alleged, suspected or witnessed incident of resident abuse or neglect.

The licensee shall ensure a monthly monitoring system is in place to audit the home's reporting of and investigation into each incident of alleged resident abuse or neglect to determine compliance with the abuse policy.

The licensee will develop and implement a system to address and re-educate, if deemed appropriate, staff and managers when the abuse policy is not complied with.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by failing to comply with the home's policy on zero tolerance of abuse.

On an identified date, Resident #2 was being assisted by two Personal Support Workers, S#103 and S#104. While providing care to this resident, a third PSW, S#102, entered the resident's room. S#103 and S#104 were both interviewed and stated Resident #2 became very agitated and began yelling at S#102 to leave the room. According to the staff, it was well known Resident #2 became agitated around S#102 and the staff member had been previously directed by management not to provide any care to this resident.

S#103 stated Resident #2 was visibly shaking and she was concerned the resident would fall. Neither staff member could recall why S#102 had entered the resident room, but both indicated they had not requested S#102's

assistance. Staff stated they attempted to calm the resident, but S#102 continued to verbally taunt the resident.

According to O. Regs, 79/10 s. 2 (1), verbal abuse is defined as:
"any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth."

The home's zero abuse policy, F-20/F-20A, "Zero Tolerance of Abuse and Neglect Program and Appendices", states under "LTCHA Mandatory Reports", In accordance with LTCHA, s. 24 (1), a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the MOHLTC.

S#103 and S#104 both indicated they believed the incident to be abusive toward the resident, but neither staff member reported the allegation of staff to resident abuse to anyone until six days later. Both staff members confirmed they were aware of their mandatory obligation to report the allegation of abuse and were unsure why they did not immediately come forward to anyone. S#103 stated she did discuss the issue with another staff member, S#105 on an identified date and this staff member did report the allegation to the Director of Nursing at that time.

The DON initiated the investigation into the allegation of abuse immediately, however further delayed the reporting of the allegation to the MOHLTC until the after-hours pager was notified two days later.

Additionally, the home's zero abuse policy, under "Staff education", indicates employees will receive education on the policy of Zero Tolerance of Abuse and Neglect during orientation and annually thereafter. S#104 did not receive abuse training including mandatory reporting in 2014.

S#102 was terminated by the home following the home's investigation. [s. 19. (1)]

2. On an identified date, Resident #1 alleged a staff member had yelled at them while administering the resident's morning medications. The home initiated an investigation into the allegation of abuse. Nine days later, the home submitted a

critical incident report (CIR) to advise the MOHLTC of the allegation of verbal abuse and additional concerns raised by Resident #1.

The DON was interviewed and confirmed the MOHLTC was notified for the first time by means of the critical incident report. The DON also indicated the home did not notify the resident's Substitute Decision Maker (SDM) or any other person identified by the resident of the allegation of abuse because the resident is their own POA. The DON indicated there was no discussion with the resident to determine if the resident wanted someone notified.

Additionally the home did not notify the resident or the Director (MOHLTC) of the outcome of the investigation. According to the DON, the home investigated and the allegation was unfounded.

During an interview with Resident #1, the resident confirmed they were not made aware of the outcome of the investigation into the allegation of abuse and was not asked if they wanted the SDM or anyone notified of the incident.

The home's "Zero Tolerance of Abuse policy, F-20/F-20A" indicates under, "Investigation and Reporting":
-the home will notify the resident's SDM, if any, and any other person the resident specifies:
Immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that has the potential to be detrimental to the resident's health and well-being; and

Within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The policy also states:

The DON/delegate shall make a report to the MOHLTC Director with the results of every investigation conducted under this policy and any action the home takes in response to any incident of resident abuse or neglect and

Registered staff must notify the resident and the resident's SDM, if any, and any other person requested by the resident of the results of the investigation immediately upon the completion of the investigation.

The home failed to immediately report the allegation of abuse to the MOHLTC and did not have discussion with this capable resident to determine if they wanted anyone notified of this incident. Additionally the home failed to update the resident and the MOHLTC of the outcome of the investigation into this allegation of staff to resident abuse. [s. 19. (1)]

3. On an identified date, S#113 and S#114 were providing care to Resident #5 who has a cognitive impairment. According to S#113, during the provision of care, the resident became agitated and injured S#114. S#113 stated S#114 reacted by slapping the resident in the face.

S#113 did not come forward with the allegation of physical abuse until approximately 1.5 hours later when she advised the RN. The RN immediately initiated an investigation into the allegation and assessed the resident. The police were notified at that time as well as the DON and the ADON.

The home failed to notify the MOHLTC of the allegation of abuse until three days later when a critical incident report was submitted. Additionally, the resident's SDM was not notified until three days after the alleged incident.

The critical incident report outlined the allegation of staff to resident abuse and indicated further information related to the investigation would follow. To date of this inspection, no information related to the outcome of the investigation had been provided to the Director.

In accordance with the legislated requirements of abuse reporting and the home's Zero Tolerance of Abuse Policy, the staff member failed to immediately report the alleged abuse to the staff member in charge. The home failed to immediately report the alleged staff to resident abuse immediately to the MOHLTC upon being made aware of the allegation.

Additionally, Resident #5's SDM was not notified of the alleged staff to resident abuse until three days following the alleged incident and the Director (MOHLTC) was not provided with information related to the outcome of the home's investigation into the allegation.

A thorough police and home investigation was conducted into the allegation of abuse and the allegation was determined unfounded. [s. 19. (1)]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

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 23rd day of January, 2015

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