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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
May 11, 2017	2017_565612_0008	005919-17	Complaint

Licensee/Titulaire de permis

The Board of Management for the District of Manitoulin
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 3-7, 2017.

This Complaint Inspection is related to one complaint submitted to the Director related to staff to resident abuse.

A Critical Incident Inspection #2017_565612_0009 was conducted concurrently to this inspection. Findings of non-compliance for LTCHA, s. 20 (1) from that inspection were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, policies, procedures, programs, and staff personnel files.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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 :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse

and neglect of residents was complied with.

A complaint was received by the Director alleging that Personal Support Worker (PSW) #104 and #105 had been verbally and emotionally abusive towards resident #007 and #008 a few weeks prior.

Inspector #612 reviewed a Critical Incident (CI) report submitted to the Director on a specific date in March, 2017, which stated that the home had received a report that PSW #104 and #105 had been verbally and emotionally abusive towards resident #007 and #008. The CI stated that a report was received the same day the CI report was submitted to the Director. The CI further stated that there were two instances involving PSW #104 and resident #007 and one instance between PSW #105 and resident #008.

Inspector #612 interviewed PSW #103 on April 5, 2017. They stated that they did not recall the exact dates of the incidents, but that the incidents had occurred a few weeks prior to PSW #103 reporting them to the Director of Care (DOC). PSW #103 stated that they should have reported immediately, however, did not. They stated that there were three incidents they had reported to the DOC:
- The first incident occurred in a specific location and PSW #103 and PSW #104 were present. Resident #007 was exhibiting responsive behaviours. PSW #103 reported that PSW #104 verbally abused resident #007 while providing care.
- The second incident was in another location, resident #007, PSW #103 and PSW #104 were present. PSW #103 and PSW #104 were preparing the resident to perform specific care.They called Registered Nurse (RN) #118 into the specific location and the RN commented on how the resident was positioned. PSW #103 reported that PSW #104 made a comment which they stated was verbally abusive towards resident #007.
- The third incident was in a specific location and resident #008, PSW #103 and #105 were present. PSW #105 had resident #008 up in specific lift when PSW #103 entered to provide assistance. When the PSW #103 asked PSW #105 why the resident was in the specific lift, PSW #105 made an inappropriate comment. PSW #103 had reported the information to RN #110, however, RN #110 misinterpreted the comment, thinking that PSW #105 was directing the comment towards them (RN #110).

Inspector #612 interviewed RN #118 in regards to the incident which occurred in a specific location with resident #007. They stated that they did recall the comment, but that the incident had happened a while before they were interviewed by the home. They stated that they felt the comment was made in poor taste but they were not sure that the comment was abusive, but it "crossed a line". They stated that they did not report it to the

DOC or Administrator when it had occurred.

Inspector #612 interviewed RN #110. They stated that they recalled the day when PSW #103 had told them about the comment made towards resident #008, however, they thought that PSW #105 was directing it towards them (RN #110) and they dismissed it, therefore, they did not report it to the DOC or Administrator.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated January 2016 which stated that all employees or persons who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate or most senior Supervisor on shift at that time. It further stated that the person reporting the suspected abuse would follow the home's reporting/ provincial requirements to ensure the information was provided to the home's Administrator/ designate immediately.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program", last updated January 2016. The policy stated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. The policy indicated the following forms of abuse which included, but were not limited to verbal, emotional, physical, sexual and financial. Emotional abuse was defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization, that were performed by anyone other than a resident. Verbal abuse was 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, which was made by anyone other than a resident.

Inspector #612 interviewed the DOC and Administrator on April 6, 2017. They stated that the incidents were unacceptable and abuse of any kind was not tolerated in the home. They stated that PSW #104 and #105 had received discipline as a result of the home's investigation. They stated that PSW #103 had reported the three incidents to them weeks after they had occurred. The DOC and Administrator stated that the expectation was that any allegations, suspicion or witnessed abuse should have been immediately reported to them so that they could notify the Director and commence an immediate investigation. [s. 20. (1)]

2. Inspector #612 reviewed a CI report which was received by the Director on a specific day in September, 2016. The CI report indicated that on a specific shift in September, 2016, PSW #104 reported to RN #110 who then reported to the DOC allegations of neglect by PSW #106. The CI report further stated that care was not provided to numerous residents and that their care needs were neglected with respect to their physical needs and cleanliness, including mouth care was not provided, and that continence care was not provided, including maintaining clean and dry bedding. The residents involved were resident #001, #009, #010, #011, #012, #013 and #014.

Inspector #612 reviewed the home's investigation notes provided by the DOC. The notes indicated that RN #110 and PSW #104 reported specific personal care tasks that were not provided to resident #001, #009, #010, #011, #012, #013 and #014 during the specific shift in September, 2016.

Inspector #612 reviewed the resident's care plans in place at the time of the incident in September, 2016. All resident's care plans identified specific personal care tasks that they required and identified the level of assistance and the frequency that the assistance was required.

Inspector #612 interviewed PSW #104 on April 6, 2017. The PSW reported that there had been prior incidents when coming on shift after PSW #106 that residents were found without personal care having been provided, however, this was the first time that there were so many residents involved. They stated that they recalled reporting the previous incidents that residents were found without personal care having been provided, but they did not recall who they had reported it to or the previous dates that it had occurred. PSW #104 specifically recalled that resident #009 was experiencing a specific health issue at the time of the incident in September, 2016, and that there were specific interventions in their care plan to prevent their condition from worsening.

Inspector #612 reviewed resident #009's care plan in place at the time of the incident. The care plan indicated specific interventions related to the residents personal care needs and related to their specific condition.

Inspector #612 reviewed resident #009's specific assessment, completed on a specific date in September, 2016, which indicated that the resident had a specific condition. There was an assessment completed the day after the personal care was not provided and the condition had worsened.

Inspector #612 interviewed RN #110 who stated that they had received the report from PSW #104 that numerous residents were found on that specific shift in September, 2016, without personal care having been provided. They stated that they were very concerned and, therefore, they had reported it to the DOC. They stated that in the past there had been occasional reports of a resident being found without personal care having been provided, however, in this case there were so many residents involved that they felt it constituted neglect.

Inspector #612 reviewed the investigation notes and found a letter to PSW #106 from the DOC and Administrator which stated that they had determined that PSW #106 was neglectful of the residents on the specific shift in September, 2016 and PSW #106 was disciplined.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program", last updated January 2016. The policy stated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Neglect was defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents. Examples provided in the policy included neglecting the resident's physical needs with respect to cleanliness, such as neglecting to provide grooming, bathing, or teeth and nail care and refusing to provide assistance to the bathroom when the resident requested or required assistance.

Inspector #612 interviewed the DOC and Administrator on April 6, 2017. They confirmed that through interviews with staff members, they determined that the care was not provided to the residents. They also stated that for resident #009, the specific condition had worsened. The DOC and Administrator stated that PSW #106 was disciplined as a result of neglecting to provide care to the residents during the specific shift in September, 2016. They also stated that the expectation was that staff followed the home's zero tolerance of abuse and neglect policy. [s. 20. (1)]

Additional Required Actions:

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

Issued on this 12th day of May, 2017

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) :	SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2017_565612_0008
Log No. / Registre no:	005919-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 11, 2017
Licensee / Titulaire de permis :	The Board of Management for the District of Manitoulin 70 Robinson Street, Postal Bag 460, LITTLE CURRENT, ON, P0P-1K0
LTC Home / Foyer de SLD :	MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED 70 ROBINSON STREET, POSTAL BAG460, LITTLE CURRENT, ON, P0P-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Bond

To The Board of Management for the District of Manitoulin, 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 :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the home's policy to promote zero tolerance of abuse and neglect is complied with by all staff, and that all residents are protected from further abuse by PSW #104, #105 and #106.

Grounds / Motifs :

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

Inspector #612 reviewed a CI report which was received by the Director on a specific day in September, 2016. The CI report indicated that on a specific shift in September, 2016, Personal Support Worker (PSW) #104 reported to Registered Nurse (RN) #110 who then reported to the Director of Care (DOC) allegations of neglect by PSW #106. The CI report further stated that care was not provided to numerous residents and that their care needs were neglected with respect to their physical needs and cleanliness, including mouth care was not provided, and that continence care was not provided, including maintaining clean and dry bedding. The residents involved were resident #001, #009, #010, #011, #012, #013 and #014.

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Inspector #612 reviewed the resident's care plans in place at the time of the

incident in September, 2016. All resident's care plans identified specific personal care tasks that they required and identified the level of assistance and the frequency that the assistance was required.

Inspector #612 interviewed PSW #104 on April 6, 2017. The PSW reported that there had been prior incidents when coming on shift after PSW #106 that residents were found without personal care having been provided, however, this was the first time that there were so many residents involved. They stated that they recalled reporting the previous incidents that residents were found without personal care having been provided, but they did not recall who they had reported it to or the previous dates that it had occurred. PSW #104 specifically recalled that resident #009 was experiencing a specific condition at the time of the incident in September, 2016, and that there were specific interventions in their care plan to prevent their condition from worsening.

Inspector #612 reviewed resident #009's care plan in place at the time of the incident. The care plan indicated specific interventions related to the residents personal care needs and related to their specific condition.

Inspector #612 reviewed resident #009's specific assessment, completed on a specific date in September, 2016, which indicated that the resident had a specific condition. There was an assessment completed the day after the personal care was not provided and the condition had worsened.

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Inspector #612 reviewed the investigation notes and found a letter to PSW #106 from the DOC and Administrator which stated that they had determined that PSW #106 was neglectful of the residents on the specific shift in September, 2016 and PSW #106 was disciplined.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program", last updated January 2016. The policy stated that

Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Neglect was defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents. Examples provided in the policy included neglecting the resident's physical needs with respect to cleanliness, such as neglecting to provide grooming, bathing, or teeth and nail care and refusing to provide assistance to the bathroom when the resident requested or required assistance.

Inspector #612 interviewed the DOC and Administrator on April 6, 2017. They confirmed that through interviews with staff members, they determined that the care was not provided to the residents. They also stated that for resident #009, their specific condition had worsened. The DOC and Administrator stated that PSW #106 was disciplined as a result of neglecting to provide care to the residents during the specific shift in September, 2016. They also stated that the expectation was that staff followed the home's zero tolerance of abuse and neglect policy. (612)

2. A complaint was received by the Director alleging that PSW #104 and #105 had been verbally and emotionally abusive towards resident #007 and #008 a few weeks prior.

Inspector #612 reviewed a Critical Incident (CI) report submitted to the Director on a specific date in March, 2017, which stated that the home had received a report that PSW #104 and #105 had been verbally and emotionally abusive towards resident #007 and #008. The CI stated that a report was received the same day the CI report was submitted to the Director. The CI further stated that there were two instances involving PSW #104 and resident #007 and one instance between PSW #105 and resident #008.

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reported that PSW #104 verbally abused resident #007 while providing care.
- The second incident was in another location, resident #007, PSW #103 and PSW #104 were present. PSW #103 and PSW #104 were preparing the resident to perform specific care.They called RN #118 into the specific location and the RN commented on how the resident was positioned. PSW #103 reported that PSW #104 made a comment which they stated was verbally abusive towards resident #007.
- The third incident was in a specific location and resident #008, PSW #103 and #105 were present. PSW #105 had resident #008 up in specific lift when PSW #103 entered to provide assistance. When the PSW #103 asked PSW #105 why the resident was in the specific lift, PSW #105 made an inappropriate comment. PSW #103 had reported the information to RN #110, however, RN #110 misinterpreted the comment, thinking that PSW #105 was directing the comment towards them (RN #110).

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Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated January 2016 which stated that all employees or persons who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate or most senior Supervisor on shift at that time. It further stated that the person reporting the suspected abuse would follow the home's reporting/ provincial requirements to ensure the information was provided to the home's Administrator/ designate immediately.

Inspector #612 reviewed the home's policy titled, "Zero Tolerance of Resident

Abuse and Neglect Program", last updated January 2016. The policy stated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. The policy indicated the following forms of abuse which included, but were not limited to verbal, emotional, physical, sexual and financial. Emotional abuse was defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization, that were performed by anyone other than a resident. Verbal abuse was 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, which was made by anyone other than a resident.

Inspector #612 interviewed the DOC and Administrator on April 6, 2017. They stated that the incidents were unacceptable and abuse of any kind was not tolerated in the home. They stated that PSW #104 and #105 had received discipline as a result of the home's investigation. They stated that PSW #103 had reported the three incidents to them weeks after they had occurred. The DOC and Administrator stated that the expectation was that any allegations, suspicion or witnessed abuse should have been immediately reported to them so that they could notify the Director and commence an immediate investigation.

The decision to issued this compliance order was based on the severity, scope and compliance history. The severity was determined to be actual harm to the residents, the scope was isolated and the compliance history included a VPC issued during the 2016 RQI #2016_336620_0024 and a VPC issued during CIS inspection #2015_380593_0011. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2017

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 11th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Charette

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