



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 9, 2013	2013_207147_0020	H-000511- 13	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): September 24, 25, 26, 27 and 30, 2013

H-000511-13

H-000630-13

This inspection was conducted concurrently with complaint inspection H-002065-12, H-001875-12 and H-000270-13. Non-compliance related to r.8(1)b from H-001875-12 is included in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Personal Support Workers (PSW), Registered staff and residents.

During the course of the inspection, the inspector(s) reviewed resident clinical charts, home's internal investigation notes, staff personnel file and policy and procedure related to Falls Prevention, Skin and Wound, Prevention of Abuse and Private Care Giver.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Training and Orientation

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 failed to ensure that all residents are protected from abuse by anyone.

Resident #102 was not protected from abuse by a caregiver.

Interview with the DOC and the registered staff who reported the incident confirmed that in September 2013, they found the resident in the shower room with the caregiver with soaked pyjamas, in tears and asking for assistance. According to assessment conducted by the registered staff, revealed that the resident had also sustained an injury while in the care of the caregiver.

Interview with the DOC confirmed that the resident had been receiving care by the caregiver since May 2013. However, the management team were not aware of this arrangement and therefore, did not put in place any strategies and interventions to minimize the risk of abuse by anyone in the home. [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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :



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1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A. According to the home's Private Caregivers policy (HRM A-80) last revised on April 30, 2010 and Specific Orientation - Private Caregiver (HRM B-35-40) last revised on November 9, 2010 stated the home is to ensure all private caregivers are to receive information and orientation about the home and pertinent policies, procedures, systems, processes and routines.

Interview with the DOC and the Administrator confirmed that resident #102 had been receiving care by a caregiver since May 2013. However, the home was not aware of this arrangement and had not provided the caregivers with any of the home's orientation which includes policies, procedures, systems, processes and routines related to Prevention of Abuse and Neglect.

B. According to the home's Abuse and Neglect Policy (RCS P-10) last revised on July 15, 2013, the registered staff are to contact the physician if a resident has been physically abused.

On September 15, 2012 resident #103 reported an allegation of physical abuse by a staff member to a family member, which was immediately reported to the home's management team.

Review of the resident's clinical records, progress notes and the physician's book confirmed that there were no documented evidence to substantiate that the registered staff called the physician related to this incident. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

- 1. The licensee failed to ensure that when a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.**

The home did not immediately report an incident of an suspected abuse of a resident to the Director. The home became aware of a suspected abuse of resident #102 by a caregiver in September 2013.

Interview with the DOC, the registered staff and review of the resident's clinical records confirmed that the registered staff documented that these allegation were reported to the DOC and Administrator, however the incident was not reported to the Director until the following day. [s. 24. (1)]



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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 when a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

There were no action taken with respect to resident #101, under the Skin Care and Wound Management Program, including documentation of reassessments and the resident's response to interventions.

Resident #101 sustained a skin tear as a result of an unsafe transfer technique by the staff.

The home's Skin Care and Wound Management Program - last revised on April 2010 related to treatment protocol for Skin Tears is to document skin tear and interventions. Review of the resident's clinical chart indicated that there were no further documentation related to the resident's skin tear or any further reassessments or resident's response to these interventions were documented. [s. 30. (2)]



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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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: 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 :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

in July 2013 resident #101 sustained a skin tear as a result of an unsafe transfer technique by the staff. Review of the resident's Plan of Care, Resident Assessment Protocol (RAP) since admission and interview with the staff confirmed that the resident required the assistance of a mechanical lift for all transfers. However, the staff utilized a different method of transferring the resident which was unsafe. Subsequently, during the transfer the resident sustained a skin tear and was then transferred to hospital for further assessment. [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 that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.



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Issued on this 22nd day of October, 2013

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

A handwritten signature in cursive script, appearing to read "J. M. M.", written in black ink on a white background.



**Ministry of Health and
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**Ministère de la Santé et
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Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

**Health System Accountability and Performance Division
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) : LALEH NEWELL (147)

Inspection No. /

No de l'inspection : 2013_207147_0020

Log No. /

Registre no: H-000511-13

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Oct 9, 2013

Licensee /

Titulaire de permis : RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

LTC Home /

Foyer de SLD : COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON,
L5B-1B5

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : NICOLE FISHER

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:



Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 that ensures that all resident are protected from abuse by anyone.

The plan is to be submitted by November 1, 2013 to Long-Term Care Homes Inspector

Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :

1. 1. The licensee failed to ensure that all residents are protected from abuse by anyone.

Resident #102 was not protected from abuse by a caregiver.

Interview with the DOC and the registered staff who reported the incident confirmed that in September 2013, they found the resident in the shower room with the caregiver with soaked pyjamas, in tears and asking for assistance.

According to assessment conducted by the registered staff, revealed that the resident had also sustained an injury while in the care of the caregiver.

Interview with the DOC confirmed that the resident had been receiving care by the caregiver since May 2013. However, the management team were not aware of this arrangement and therefore, did not put in place any strategies and interventions to minimize the risk of abuse by anyone in the home. (147)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2013



**Ministry of Health and
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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

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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 : 002

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that any plan, policy, protocol, procedure, strategy or system instituted related to Orientation of all private caregiver in the home providing direct care to any resident is complied with.

The plan is to be submitted by November 1, 2013 to Long-Term Care Homes Inspector

Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :



**Ministry of Health and
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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de soins de longue durée, L.O. 2007, chap. 8*

1. 1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A. According to the home's Private Caregivers policy (HRM A-80) last revised on April 30, 2010 and Specific Orientation - Private Caregiver (HRM B-35-40) last revised on November 9, 2010 stated the home is to ensure all private caregivers are to receive information and orientation about the home and pertinent policies, procedures, systems, processes and routines.

Interview with the DOC and the Administrator confirmed that resident #102 had been receiving care by a caregiver since May 2013. However, the home was not aware of this arrangement and had not provided the caregivers with any of the home's orientation which includes policies, procedures, systems, processes and routines related to Prevention of Abuse and Neglect.

B. According to the home's Abuse and Neglect Policy (RCS P-10) last revised on July 15, 2013, the registered staff are to contact the physician if a resident has been physically abused.

On September 15, 2012 resident #103 reported an allegation of physical abuse by a staff member to a family member, which was immediately reported to the home's management team.

Review of the resident's clinical records, progress notes and the physician's book confirmed that there were no documented evidence to substantiate that the registered staff called the physician related to this incident. (147)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2013



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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



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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.



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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, 11^e 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.



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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

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 9th day of October, 2013

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : LALEH NEWELL

Service Area Office /

Bureau régional de services : Hamilton Service Area Office