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

Ottawa Service Area Office
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
May 11, 2015	2015_365194_0012	O-001655-15, 000881-14	Complaint

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East Bowmanville ON L1C 1P9

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

CHANTAL LAFRENIERE (194), MARIA FRANCIS-ALLEN (552)

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 20, 21, 22,23, 24,27, 28,29,30, May 01,04,05,06, 2015

Four complaint logs were completed concurrently during this inspection: Log # O-001655-15, #O-000881-14, #O-001319-14, #O-001214-14

PLEASE NOTE: A Written Notification and Compliance Order under s. 6(7) identified in report #2015_365194_0013 (Log#O-000745-14,#O-001689-15,#O-000749-14 and #O-000847-14) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Director of Resident and Family Services(DRFS),Residents, Registered Nurse (RN),Registered Practical Nurse(RPN)Environmental Service Manager (ESM),Dietary staff, Dietitian, and Personal Service Workers (PSW)

Also reviewed; Identified Resident's clinical health records, Cleaning schedules, licensee's internal investigation into identified resident fall, Tour of home areas and observation of Meal service, Deep cleaning of resident rooms, Air mattresses in the home and staff/resident provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 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 ensure that care set out in the plan of care provided to the residents as specified in the plans

Log #O-001655-15

An anonymous complaint directed that a fall had occurred involving Resident #28. The plan of care for Resident #28 indicates that weight bearing has become unreliable and now requires the use of a sit to stand lift for all transfers for safety. Two staff to provide assistance with sit to stand lift.

A "Resident Transfer/Lift assessment" was completed for Resident #28 four day prior to the fall, indicating that the resident required a sit to stand lift for transfers.

A "Falls Risk Assessment" was completed for Resident #28 one day prior to the fall, indicating that the resident was
-unable to independently come to a standing position
-exhibited loss of balance while standing
-Decrease in muscle coordination

The licensee's internal incident report indicates on an identified date, the Charge Nurse was called to Resident #28's bathroom and found Resident on floor and PSW #149 standing beside the resident.

The investigation indicated that Resident #28 asked Staff #149 to be toileted and was reassured by Resident #28 that one staff was required for transfer. Staff #149 assisted Resident #28 to standing position, resident grabbed the handrail but before Staff #149 could manoeuvre the chairs around Resident #28 was unable to continue gripping the bar, and was assisted to the floor by staff #149.

During an interview DOC has indicated that Staff #149 transferred Resident #28 without assistance, resulting in an injury. The plan of care directed that the Resident was a two staff assist with transfer. (194)

Log #O-001319-14

Review of the clinical health records indicate Resident #024 has chewing problems and has decreased appetite, specifically at lunch and dinner time. An agreement completed between the resident's POA and the home indicates at lunch and dinner, the mechanically altered meal is to be served in a specific manner to increase food intake. This is also reflected in the resident's care plan

Two Dining services were observed at lunch time. On both occasions, the staff members supervising the resident during the meal time did not serve the meal in the specific manner outlined in the care plan.

Interview with Staff #099 explained the staff is expected to serve the meal in the specific manner outlined in the care plan in an attempt to increase the resident's food intake (552)

Log # 000745-14

The home submitted a Critical Incident Report indicating that on an identified date, the receptionist received a call from an off duty Personal Support Worker (PSW) indicating that Resident #015 was unaccompanied and at an establishment near the home. Three staff members escorted the resident back to the home with minimal encouragement. The report indicated the resident had been checked 40 minutes prior to elopement. the resident had been checked at 1600 hours.

Review of the clinical health records indicate the Resident #015 had an unsteady gait and ambulated with a walker but often needs cueing by staff to use it. Resident #015 had made five attempts to leave the home over a two month period in 2013 and three attempts one month prior to the incident. The resident had also been found outside of the building on two separate occasions in 2013. Staff were directed in the care plan to monitor the resident every 15 minutes for 24 hours following an outing, leave of absence or spouse visit.

Interview with Staff #101 and #102 explained the resident was to be monitored every 15 minutes due to exit seeking behaviors. Staff #102 further explained the resident's attempts to leave the home increase following visit for his/her spouse.

On the date of the incident, documentation indicated the resident was last checked at 1600 hours - there is no further evidence that the resident was being checked every 15 minutes between 1600 and 1640 hours when the resident was found outside the home.

Resident #015 has been discharged from the home.

During an interview the DOC agreed that it did not appear Resident #015 was being monitored every 15 minutes as outlined in the care plan.(552)

Log # O-001689-15

A critical incident report was received on an identified date for Resident #01 with a fall incident that resulted in transfer to hospital that occurred three days prior to the report submission. The CIR indicated the resident was returning unaccompanied from washroom using the wheelchair as an ambulation aid. The resident fell resulting in a transfer to hospital, was diagnosed with injury and died three days later.

Review of the written plan of care, in effect at the time of the fall, for Resident #01 indicated the resident's risk for falls is characterized by history of falls/injury, multiple risk factors related to: impaired balance, non-compliance with mobility aide use and identified medications. Interventions Included: use bed alarm when in bed, use chair alarm when in wheelchair and staff to offer assistance with toileting.

Review of the progress notes and the post fall assessment note indicated the resident's bed alarm was turned off when the resident got out of bed and went to the bathroom unassisted. The resident fell on the way back. The bed alarm was turned on to prevent another fall.

The bed alarm did not sound to alert staff when the resident self transferred and walked to the bathroom putting the resident at increased risk for falls and injury. (570)

Log # O-000749-14

A critical incident report was received on an identified date for a fall incident that causes an injury to Resident #03 for which the resident was taken to hospital resulting in a significant change in the resident's health status. The CIR indicated the resident was found on the floor. The resident sustained an injury and was sent to the hospital.

Review of the progress notes for Resident #03 over a seven month period indicated the resident was assessed at high risk of falling and sustained 5 falls during that time:

Review of the written plan of care for Resident #03, in effect at time of fall indicated the resident's risk for falls is characterized by history of falls/injury and multiple risk factors related to: self transferring, unsteady gait due to severe medical conditions. Interventions Included: staff to ensure pad alarm is working and floor mat is in place when in bed and chair alarm in place when up in wheelchair.

Review of the progress notes and the post fall assessment note indicated the resident's chair pad alarm was not activated at the time of incident and that loss of balance caused the fall and the resident sat on the floor.

The alarm did not sound to alert staff when the resident self transferred from chair putting the resident at increased risk for falls and injury. (570)

Log # O-000847-14

On an identified date RPN #155 reported that Resident #16 was found to be incontinent at the beginning of the shift. Resident #16 indicated ringing the call bell at the end of the previous shift and told PSW that care was needed. PSW staff did attend to Resident #16's call bell, but did not provide care for the resident. Resident #16 was told that the next shift would be in to provide care.

During an interview the DOC indicated PSW's #153 and #154 explained that it was at the end of the shift and the resident's call bell was answered and the resident was informed that the next shift was going to be right with the resident. The DOC indicated that the time between the call bell and the actual care being provided was probably about 20 min.

The plan of care for Resident #16 directs that the resident requires total assistance related to a medical condition and staff are to check every two hours for incontinence and provide incontinent care when needed. Staff are to cleanse with no rinse barrier after each incontinence episode and apply barrier every shift, and change brief when wet or soiled.(194) [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when an specialized mattress was implemented for Resident #37 with two full bed rails in place, that the bed system was evaluated to minimized the risk of entrapment for the resident.

Resident #37 was observed lying on a specialized mattress with two full rails in place. A 3"to 4" gap between the side of the specialized mattress and the full side rail on the right hand side was observed. RPN #123 informed the inspector that Resident #37 was recently placed on the specialized mattress. RPN #123 indicated that the resident was at high risk for falls and had a history of climbing out of bed. RPN #123 was asked, if the bed system had been evaluated/assessed for entrapment for this resident, RPN #123 was not aware if this had been completed.

During interview RN #140 indicated that no bed system assessment/evaluation had been completed, after the specialized mattress was initiated for Resident #37.

DOC indicated that the home does currently have an assessment/evaluation completed for the bed systems in the home. She indicated that when the specialized mattress for Resident #37 was applied no additional bed system assessment/evaluation related to entrapment was completed. [s. 15. (1)]

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 by ensuring that when bed rails are used,
a) Resident #37 is assessed and the bed system is evaluated to minimize risk to the resident
b)steps are taken to prevent Resident #37 from entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

Issued on this 29th day of May, 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) :	CHANTAL LAFRENIERE (194), MARIA FRANCIS-ALLEN (552)
Inspection No. / No de l'inspection :	2015_365194_0012
Log No. / Registre no:	O-001655-15, 000881-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 11, 2015
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	STRATHAVEN LIFECARE CENTRE 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the residents as specified in the plan

-The plan of care for Resident #24 as it relates to dietary interventions will be provided as specified in the plan
-The plan of care for Resident #03 as it relates to prevention of falls will be provided as specified in the plan
-The plan of care for Resident # 01 as it relates to continence care will be provided as specified in the plan
-The plan of care for Resident #28 as it relates to transfers will be provided a specified in the plan.

Grounds / Motifs :

1. Log #O-001655-15

An anonymous complaint directed that a fall had occurred involving Resident #28. The plan of care for Resident #28 indicates that weight bearing has become unreliable and now requires the use of a sit to stand lift for all transfers for safety. Two staff to provide assistance with sit to stand lift.

A "Resident Transfer/Lift assessment" was completed for Resident #28 four day prior to the fall, indicating that the resident required a sit to stand lift for transfers.

A "Falls Risk Assessment" was completed for Resident #28 one day prior to the fall, indicating that the resident was
-unable to independently come to a standing position
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-Decrease in muscle coordination

The licensee's internal incident report indicates on an identified date, the Charge Nurse was called to Resident #28's bathroom and found Resident on floor and PSW #149 standing beside the resident.

The investigation indicated that Resident #28 asked Staff #149 to be toileted and was reassured by Resident #28 that one staff was required for transfer. Staff #149 assisted Resident #28 to standing position, resident grabbed the handrail but before Staff #149 could manoeuvre the chairs around Resident #28 was unable to continue gripping the bar, and was assisted to the floor by staff #149.

During an interview DOC has indicated that Staff #149 transferred Resident #28 without assistance, resulting in an injury. The plan of care directed that the Resident was a two staff assist with transfer. (194)

Log #O-001319-14

Review of the clinical health records indicate Resident #024 has chewing problems and has decreased appetite, specifically at lunch and dinner time. An agreement completed between the resident's POA and the home indicates at lunch and dinner, the mechanically altered meal is to be served in a specific manner to increase food intake. This is also reflected in the resident's care plan

Two Dining services were observed at lunch time. On both occasions, the staff members supervising the resident during the meal time did not serve the meal in the specific manner outlined in the care plan.

Interview with Staff #099 explained the staff is expected to serve the meal in the specific manner outlined in the care plan in an attempt to increase the resident's food intake (552)

Log # 000745-14

The home submitted a Critical Incident Report indicating that on an identified date, the receptionist received a call from an off duty Personal Support Worker (PSW) indicating that Resident #015 was unaccompanied and at an establishment near the home. Three staff members escorted the resident back

to the home with minimal encouragement. The report indicated the resident had been checked 40 minutes prior to elopement. the resident had been checked at 1600 hours.

Review of the clinical health records indicate the Resident #015 had an unsteady gait and ambulated with a walker but often needs cueing by staff to use it. Resident #015 had made five attempts to leave the home over a two month period in 2013 and three attempts one month prior to the incident. The resident had also been found outside of the building on two separate occasions in 2013. Staff were directed in the care plan to monitor the resident every 15 minutes for 24 hours following an outing, leave of absence or spouse visit.

Interview with Staff #101 and #102 explained the resident was to be monitored every 15 minutes due to exit seeking behaviors. Staff #102 further explained the resident's attempts to leave the home increase following visit for his/her spouse.

On the date of the incident, documentation indicated the resident was last checked at 1600 hours - there is no further evidence that the resident was being checked every 15 minutes between 1600 and 1640 hours when the resident was found outside the home.

Resident #015 has been discharged from the home.

During an interview the DOC agreed that it did not appear Resident #015 was being monitored every 15 minutes as outlined in the care plan.(552)

Log # O-001689-15

A critical incident report was received on an identified date for Resident #01 with a fall incident that resulted in transfer to hospital that occurred three days prior to the report submission. The CIR indicated the resident was returning unaccompanied from washroom using the wheelchair as an ambulation aid. The resident fell resulting in a transfer to hospital, was diagnosed with injury and died three days later.

Review of the written plan of care, in effect at the time of the fall, for Resident #01 indicated the resident's risk for falls is characterized by history of falls/injury, multiple risk factors related to: impaired balance, non-compliance with mobility aide use and identified medications. Interventions Included: use bed alarm when

in bed, use chair alarm when in wheelchair and staff to offer assistance with toileting.

Review of the progress notes and the post fall assessment note indicated the resident's bed alarm was turned off when the resident got out of bed and went to the bathroom unassisted. The resident fell on the way back. The bed alarm was turned on to prevent another fall.

The bed alarm did not sound to alert staff when the resident self transferred and walked to the bathroom putting the resident at increased risk for falls and injury. (570)

Log # O-000749-14

A critical incident report was received on an identified date for a fall incident that causes an injury to Resident #03 for which the resident was taken to hospital resulting in a significant change in the resident's health status. The CIR indicated the resident was found on the floor. The resident sustained an injury and was sent to the hospital.

Review of the progress notes for Resident #03 over a seven month period indicated the resident was assessed at high risk of falling and sustained 5 falls during that time:

Review of the written plan of care for Resident #03, in effect at time of fall indicated the resident's risk for falls is characterized by history of falls/injury and multiple risk factors related to: self transferring, unsteady gait due to severe medical conditions. Interventions Included: staff to ensure pad alarm is working and floor mat is in place when in bed and chair alarm in place when up in wheelchair.

Review of the progress notes and the post fall assessment note indicated the resident's chair pad alarm was not activated at the time of incident and that loss of balance caused the fall and the resident sat on the floor.

The alarm did not sound to alert staff when the resident self transferred from chair putting the resident at increased risk for falls and injury. (570)

Log # O-000847-14

On an identified date RPN #155 reported that Resident #16 was found to be incontinent at the beginning of the shift. Resident #16 indicated ringing the call bell at the end of the previous shift and told PSW that care was needed. PSW staff did attend to Resident #16's call bell, but did not provide care for the resident. Resident #16 was told that the next shift would be in to provide care.

During an interview the DOC indicated PSW's #153 and #154 explained that it was at the end of the shift and the resident's call bell was answered and the resident was informed that the next shift was going to be right with the resident. The DOC indicated that the time between the call bell and the actual care being provided was probably about 20 min.

The plan of care for Resident #16 directs that the resident requires total assistance related to a medical condition and staff are to check every two hours for incontinence and provide incontinent care when needed. Staff are to cleanse with no rinse barrier after each incontinence episode and apply barrier every shift, and change brief when wet or soiled.(194) [s. 6. (7)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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 11th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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