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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
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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 |
|---|---|---|---|
| Feb 8, 2016 | 2016_302600_0001 | 35876-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

TENDERCARE NURSING HOMES LIMITED
212 Queen Street East, Suite 202 Sault Ste Marie ON P6A 5X8

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

TENDERCARE LIVING CENTRE
1020 McNICOLL AVENUE SCARBOROUGH ON M1W 2J6

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

GORDANA KRSTEVSKA (600), SOFIA DASILVA (567), SUSAN SEMEREDY (501)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): January 4, 5, 6, 7, 8, 11, 12, 13, and 14, 2016.**

**The following critical incidents were inspected concurrently with the RQI: Intake log number 003390-14 and 008684-14.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Social Worker (SW), Registered Dietitian (RD), Dietary Manager (DM), Physiotherapists (PT), Environmental Service Manager (ESM), Substitute Decision Makers (SDMs), family members, volunteers, registered staff, Personal Support Workers (PSWs), Health Care Aids (HCA), residents and President of Residents' Council.**

**During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service; medication administration; staff and resident interactions and provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, Residents' Council and residents' family meetings minutes, relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Recreation and Social Activities**
**Residents' Council**
**Safe and Secure Home**

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

- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: 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 has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of the critical incident submitted indicated on a specified date resident #040 had an incident while he/she was receiving care by PSW #118. The PSW also was involved in the incident with the resident. After the incident, the resident complained of discomfort to an identified body part. The resident was taken to the hospital on a specified date, and diagnosed with an injury. He/she had a procedure on a specified date, and a few hours later the resident passed away.

Review of the resident's written plan of care, indicated resident #040 had impaired physical condition and was at high risk. He/she was able to stand up with assistance by one staff and would follow direction with cuing.

Progress notes review revealed resident #040 had an incident on the identified date, while being provided care by PSW #118 who was also involved in the incident. After the fall the registered staff member was called to assess the resident and he/she found the resident had been transferred to the wheelchair. The progress note review indicated PSW #118 had transferred the resident to the chair.

Interview with PSW #118 revealed on an identified date, he/she assisted resident #040 with the care. During the process the resident had an incident together with PSW #118. The PSW confirmed after the accident, he/she stood up, grabbed the resident under both arms, lifted him/her and transferred to the wheelchair. After the PSW set resident on the wheelchair, he/she called the registered staff to assess the resident.

Further, the PSW confirmed transferring the resident to the wheelchair was not a safe technique for transferring the resident who just had an incident. Instead PSW #118 should have waited for the registered staff member to assess the resident and ensure the proper technique for transferring was used. PSW acknowledged he/she could have injured the resident or self during this transfer.

Interview with the DOC confirmed it was not a safe transfer and the PSW should not have transferred the resident after the incident.

The scope of the non-compliance is isolated to resident #040. However due to the severity of actual harm to the resident, a compliance order is warranted. [s. 36.]

***Additional Required Actions:***

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

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**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).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date observation revealed resident #005 was served a tray for lunch in his/her room which included identified food as part of the entrée. The resident did not eat most of his/her entrée.

Review of the most recent plan of care revealed resident #005 was at high nutritional risk related to weight loss and poor intake. The plan of care stated that the resident prefers different food over identified food that was served to him/her at lunch.

Interview with PSW #113 and dietary aide #112 revealed neither had consulted the resident's plan of care prior to providing resident #005 with his/her lunch entrée. Interview with the Dietary Manager revealed that the staff should have followed the home's practice of informing the registered staff that the resident needed a tray in his/her room so that a meal ticket could have been completed which should have included the resident's preferences. The Dietary Manager confirmed in this case there was a

breakdown in procedure that resulted in the resident not receiving his/her preference as specified in the plan of care. [s. 6. (7)]

2. Review of the critical incident submitted on an identified date indicated on a specified date resident #040 had an incident while he/she was receiving care by PSW #118. The PSW also was involved in the incident with the resident. After the incident, the resident complained of discomfort to an identified body part. The resident was taken to the hospital on a specified date, and diagnosed with an injury in the identified body part. He/she had a procedure on a specified date, and a few hours later the resident passed away.

Review of the MDS assessment from specified date indicated resident #040 required two staff extensive assistance with in the care process: to transfer the resident to/from the toilet, to adjust clothing, do peri-care and change incontinent products. Resident has been identified to be at high risk for incident.

Review of the progress notes from an identified date indicated the resident had an incident while PSW #118 assisted him/her with providing care. The resident knees buckled during the care, causing both staff and resident to get involved in the incident. Resident had been complaining of pain in an identified body part and the home had ordered a diagnostic procedure. The following day resident had been sent to hospital and he/she passed away few hours after an intervention.

Interview with PSW #118 confirmed on identified date he/she provided care to resident #040 without assistance of another staff member. During the process of care, when he/she was to apply a product to the resident, the resident's knees buckled, he/she lost the balance and both had incident. The PSW also confirmed that he/she had an incident and kept self aware of residents' conditions and changes by reading the written plan of care. This time he/she did not follow the plan of care because he/she did not have time to review it.

Interview with the DOC confirmed the staff is expected to review and follow direction from the written plan of care when they provide care to the residents. This staff did not provide care to resident #040 as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of the resident #012's MDS assessment from an identified date, revealed the resident had a memory problem, modified independence for daily decision making, and needed extensive assistance for locomotion on and off the unit. Further review of the MDS assessment revealed resident #012 was not able to perform the test for balance without physical help and his/her primary mode of mobility was a wheelchair wheeled by others.

Review of the resident post incident assessment record indicated on a specified date resident #012 had incident when he/she lost his/her balance. Review of the resident's written plan of care revealed: resident#012 had been identified as a high risk for the identified incident. The goal for prevention of the incident, last reviewed several months before the incident occurred, revealed the resident was to have safe assistance with some of the ADL's.
courage resident to sit in view of staff, revised an identified date,

Review of the written plan of care indicated the written plan of care was not updated after the incident, when resident #012's needs changed.

Interview with the DOC confirmed the resident #012's written plan of care was not revised and updated after the resident had an incident and his/her needs had changed. [s. 6. (10) (b)]

***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 the care set out in the plan of care is provided to residents as specified in the plan, to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, its furnishings and equipment are kept clean and sanitary.

On a specified date observation during the lunch meal revealed dirty plastic table card holders on many resident tables. On an identified date, review of the cleaning schedule posted in the dining room servery revealed that cleaning and sanitizing of plastic table card holders had not been signed off as being cleaned the previous week on a specified date, as scheduled, for tables with identified numbers. Interview with the Dietary Manager revealed card holders for those tables were not clean and did not appear as though they had been cleaned according to the schedule. The Dietary Manager confirmed that because residents touch these card holders often, they should be kept clean and sanitary in order to prevent the transmission of infectious diseases. [s. 15. (2) (a)]

2. The license has failed to ensure that the home, its furnishings and equipment were maintained in a safe condition and in a good state of repair.

On an identified date, observation in the third floor servery area revealed that there were two plastic lipped plates that had plastic coming off the middle of the plate. Interview with the Dietary Manager revealed that these plates should be taken out of circulation as they were not in a good state of repair as plastic pieces could come off onto the food and be ingested by the residents. [s. 15. (2) (c)]

***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 the home, its furnishings and equipment are kept clean and sanitary***
***to ensure that the home, its furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's right to communicate in confidence is fully respected and promoted without interference.

Resident #011's plan of care review revealed the resident resided in a room with two beds. He/she shared the room with the resident who needed total assistance for all activities of daily livings(ADLs), therefore the staff was present in the room very often.

Interview with resident #011 revealed that whenever he/she was talking on the phone, the staff would enter the room and regardless that he/she was on the phone, they continue to work on their task, either to provide care to the other resident or to clean the room.

Interview with RN #114 and PSW #115 indicated that when they go in residents' rooms to provide care or treatment, they close the privacy curtains to provide the privacy of the resident who receives the care, but had not considered the privacy to the resident who was on the phone. The RN #114 confirmed the resident who was talking on the phone, was not provided privacy while communicated.

Interview with the DOC confirmed that staff is expected to provide privacy to the residents either by closing the curtains when providing care, closing the door, or allow the resident to have privacy when resident is on the phone or when residents have visitors. For this resident the staff did not provide privacy when they still remained in the room while the resident was on the phone. [s. 3. (1) 14.]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of housekeeping of the Act, that procedures are developed and implemented for cleaning and disinfection of the following in accordance with the manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Observation of resident #008's assistive device on an identified date revealed that one of the side of the resident's assistive device was dirty.

Interview with RN # 125 confirmed that the resident's assistive device is to be cleaned at night according to a schedule and when necessary. The RN confirmed that the aid was dirty and that she would request that night staff clean it and leave a message in the communication book. [s. 87. (2) (b)]

**Issued on this 24th day of February, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**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) :** | GORDANA KRSTEVSKA (600), SOFIA DASILVA (567), SUSAN SEMEREDY (501) |
| **Inspection No. / No de l'inspection :** | 2016_302600_0001 |
| **Log No. / Registre no:** | 35876-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Feb 8, 2016 |
| **Licensee / Titulaire de permis :** | TENDERCARE NURSING HOMES LIMITED<br>212 Queen Street East, Suite 202, Sault Ste Marie, ON, P6A-5X8 |
| **LTC Home / Foyer de SLD :** | TENDERCARE LIVING CENTRE<br>1020 McNICOLL AVENUE, SCARBOROUGH, ON, M1W-2J6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | FRANCIS MARTIS |

To TENDERCARE NURSING HOMES LIMITED, 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) (b)

**Pursuant to / Aux termes de :**

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.

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that staff uses safe transferring techniques when assisting resident #01, and other residents.

This plan should include methods for monitoring front line staff, to ensure that they comply with the home's transfer and lifts policies, and with residents' individual plans of care.

The plan shall be submitted via email to Gordana.Krstevska@ontario.ca by February 19, 2016.

**Grounds / Motifs :**

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

Review of the critical incident submitted indicated on a specified date resident #040 had an incident while he/she was receiving care by PSW #118. The PSW also was involved in the incident with the resident. After the incident, the resident complained of discomfort to an identified body part. The resident was taken to the hospital on a specified date, and diagnosed with an injury. He/she had a procedure on a specified date, and a few hours later the resident passed away.

Review of the resident's written plan of care, indicated resident #040 had impaired physical condition and was at high risk. He/she was able to stand up with assistance by one staff and would follow direction with cuing.

Progress notes review revealed resident #040 had an incident on the identified

date, while being provided care by PSW #118 who was also involved in the incident. After the fall the registered staff member was called to assess the resident and he/she found the resident had been transferred to the wheelchair. The progress note review indicated PSW #118 had transferred the resident to the chair.

Interview with PSW #118 revealed on an identified date, he/she assisted resident #040 with the care. During the process the resident had an incident together with PSW #118. The PSW confirmed after the accident, he/she stood up, grabbed the resident under both arms, lifted him/her and transferred to the wheelchair. After the PSW set resident on the wheelchair, he/she called the registered staff to assess the resident.

Further, the PSW confirmed transferring the resident to the wheelchair was not a safe technique for transferring the resident who just had an incident. Instead PSW #118 should have waited for the registered staff member to assess the resident and ensure the proper technique for transferring was used. PSW acknowledged he/she could have injured the resident or self during this transfer.

Interview with the DOC confirmed it was not a safe transfer and the PSW should not have transferred the resident after the incident.

The scope of the non-compliance is isolated to resident #040. However due to the severity of actual harm to the resident, a compliance order is warranted. (600)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 19, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
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 8th day of February, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Gordana Krstevska

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office