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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 24, 2013	2013_191107_0010	H-002171-12	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BAYWOODS PLACE
330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 10, 11, 12, 13, 2013

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Nutrition Manager (NM), registered nursing staff, front line nursing and dietary staff

During the course of the inspection, the inspector(s) Reviewed the clinical health records of identified residents, observed the lunch and breakfast meal services, reviewed relevant policies and procedures, toured the kitchen and storage areas

The following Inspection Protocols were used during this inspection:
Dining Observation

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 :

[LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for residents was not provided to the residents as specified in their plans of care.
A) Resident #001 was not provided care as specified in the plan at the lunch meal September 10, 2013. The resident had a plan that required additional food and assistive devices at meals. The resident was not offered the additional food (resident has had significant weight loss) and did not receive their assistive devices that would assist the resident in eating more independently. Staff confirmed the interventions were not provided to the resident as specified in the plan.
B) Care was not provided as specified in the plan at the breakfast meal September 12, 2013.
i) Resident #006 required a specialized menu, however, received an item which is restricted on their specialized menu. Staff did not identify the error until noted by the inspector.
ii) The plan of care for resident #009 identified a food allergy, however, the resident was provided the food item they were identified as having an allergy to. Staff did not identify the error until noted by the inspector.
iii) Prune juice was not provided to three identified residents (#007, #011, #012) who required it at the breakfast meal as per their plan of care (prune juice was available, however, a can opener was not available and residents were therefore not offered the juice)
iv) The plan of care for resident #010 required a special item to be added to their hot cereal, however, the required item was not available and the resident did not receive it with their cereal.
E) A special beverage was required at the breakfast meal for resident #008, however, it was not offered to the resident as per their plan of care

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. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 69]
Resident #001 had an 8.2% significant weight loss over one month, however, the weight change was not assessed by nursing or the Registered Dietitian. A weight warning note was triggered and a re-weigh was requested to confirm the significant weight loss, however, the re-weigh was not recorded in the computer as completed. An actual assessment of the significant weight loss had not occurred as of the date of this inspection and action had not been taken to address the weight loss. During observation in the dining room the resident did not receive the interventions previously identified on the resident's plan of care. The computer did not identify that a significant weight warning had triggered in the "weights and vitals" tab.

2. [O.Reg. 79/10, s. 69]
Resident #002 had a 7.9% significant weight loss over three months, and an additional significant weight loss of 5.2% the next month, however, a multidisciplinary assessment of the weight loss did not occur until the regularly scheduled quarterly review after the second significant weight loss. The significant weight loss over three months was not triggered by the computer and was missed for follow up, resulting in a delay in interventions. The resident also had a significant reduction in their intake during this time (4.3% of meals taken < 75%, 18.2% the next month, 76% the following month, 72% the subsequent month 75% the month the quarterly review was completed, as noted on food intake records) and progress notes identified reduced intake since the first month. The resident had a further 7.1% significant weight loss over the month following the quarterly review, however, there was no multidisciplinary assessment of the further weight loss. The Registered Dietitian initiated interventions at the quarterly review, however, follow up on the effectiveness of the interventions in relation to the further significant weight loss did not occur and the further significant weight loss was not assessed by the multidisciplinary team. The significant weight loss did not flag on the computer system and therefore did not trigger for staff until the subsequent month. The resident lost 19% of their body weight over a five month period.

3. [O.Reg. 79/10, s. 69]
Resident #003 had a 9.6% significant weight loss over one month, however, the weight change was not assessed by the multidisciplinary team. The significant weight loss did not appear to have flagged on the home's computer system and therefore, did not trigger for follow up by the team. During the month that the significant weight loss was identified, the Registered Dietitian saw the resident related to skin integrity,

however, an assessment of the resident's weight did not occur at that time and interventions were not revised on the resident's plan of care.

4. [O.Reg. 79/10, s. 69]
Resident #004 had a 12.1% significant weight loss over one month and a referral to the Registered Dietitian was initiated by nursing. Progress notes at the beginning of the month indicated that a re-weigh was completed confirming the significant weight loss and stated the resident continued to refuse a specific meal. A Dietitian saw the resident at the end of the month and a re-weigh, to confirm the significant weight loss, was requested. Action was not taken to address the weight loss at that time. The Nutrition Care committee also reviewed the resident's weight, however, action was not taken to address the significant weight loss. The resident continued to have further unplanned weight loss of approximately 1 kilogram (kg) per month over a four month period. A Registered Dietitian saw the resident seven times during and identified unexplained weight loss, however, the plan of care was not revised to address the weight loss. The Dietitian confirmed that the resident was not interviewed during the nutritional assessments over a three month period and the resident was not asked the reason for the weight loss. During interview with the inspector, the resident stated they were trying to lose weight and that they were skipping at least one meal daily, usually a particular meal. Several referrals to the Dietitian and progress notes identified the resident was consistently skipping a particular meal, however, "Point of Care" food intake records did not reflect consistently refused meals. Staff interview identified that the resident frequently refused a particular meal. An assessment of the discrepancies between intake records and staff observation did not occur and the resident was not consulted as part of the assessment process. The resident has lost 18% of their body weight in the past six months without revision to their plan of care.

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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
Not all residents were offered the planned menu items at meals.
A) At the lunch meal September 10, 2013 the planned menu identified seasoned peas and carrots, however, a stew mix (carrots, squash, and parsnip) was used for the minced and pureed menu. The change was not communicated to residents and residents were not sure what was in the mix when asked by the inspector. The Nutrition Manager stated that there wasn't enough peas so the cook used an alternative for the minced and pureed.
B) The planned renal menu for September 13, 2013 stated grape juice, fruit cocktail and cream of wheat cereal. These items were not available, resulting in errors at meal service. The Nutrition Manager stated that oatmeal was to be served to all residents, however, this was not reflected on the planned menu.
C) Residents were not offered pureed banana (as per the planned menu) at the breakfast meal September 13, 2013. The Dietary Aide stated that the bananas were available, however, missed in the refrigerator and not offered to residents requiring a pureed menu. Residents on a regular menu were offered bananas.
D) Pureed prunes were not available as required for the breakfast meal service.
E) The planned menu for the breakfast meal September 13, 2013 stated eggs and toast or toast and peanut butter, however, eggs, toast and yogurt were offered to all residents. [s. 71. (4)]

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 with ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Ontario

Ministry of Health and Long-Term Care

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (4)	CO #002	2012_191107_0002	107

Issued on this 25th day of September, 2013

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

Michelle Warrener

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) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2013_191107_0010
Log No. / Registre no:	H-002171-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 24, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAYWOODS PLACE 330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2012_191107_0002, CO #003;

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 prepare, submit and implement a plan that outlines how the home will ensure that the care set out in the plan of care for all residents related to meal services will be provided to resident as specified in their plans. The plan shall include monitoring, analysis, and evaluation activities.
The plan is to be submitted by October 8, 2013 to Michelle Warrener, Long-Term Care Homes inspector, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for residents was not provided to the residents as specified in their plans of care.
A) Resident #001 was not provided care as specified in the plan at the lunch meal September 10, 2013. The resident had a plan that required additional food and assistive devices at meals. The resident was not offered the additional food (resident has had significant weight loss) and did not receive their assistive devices that would assist the resident in eating more independently. Staff confirmed the interventions were not provided to the resident as specified in the plan.
B) Care was not provided as specified in the plan at the breakfast meal September 12, 2013.
i) Resident #006 required a specialized menu, however, received an item which is restricted on their specialized menu. Staff did not identify the error until noted by the inspector.
ii) The plan of care for resident #009 identified a food allergy, however, the resident was provided the food item they were identified as having an allergy to. Staff did not identify the error until noted by the inspector.
iii) Prune juice was not provided to three identified residents (#007, #011, #012) who required it at the breakfast meal as per their plan of care (prune juice was available, however, a can opener was not available and residents were therefore not offered the juice)
iv) The plan of care for resident #010 required a special item to be added to their hot cereal, however, the required item was not available and the resident did not receive it with their cereal.
E) A special beverage was required at the breakfast meal for resident #008, however, it was not offered to the resident as per their plan of care (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2013

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2012_191107_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepared, submit, and implement a plan that outlines how the home will ensure that:

1. Significant weight changes are flagged and identified
2. A clear system for re-weighs is in place so all staff are aware when a re-weigh is completed
3. Action is taken as required for significant and ongoing unplanned weight loss
4. Residents are consulted as part of the assessment and care planning process
5. Information entered into the Point of Care system is accurate in relation to food and fluid consumption

The plan shall be submitted by October 8, 2013 to Long-Term Care Home Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 69] Previously issued September 28, 2011 as CO; October 25, 2012 as a CO

Resident #004 had a 12.1% significant weight loss over one month and a referral to the Registered Dietitian was initiated by nursing. Progress notes at the beginning of the month indicated that a re-weigh was completed confirming the significant weight loss and stated the resident continued to refuse a specific

meal. A Dietitian saw the resident at the end of the month and a re-weigh, to confirm the significant weight loss, was requested. Action was not taken to address the weight loss at that time. The Nutrition Care committee also reviewed the resident's weight, however, action was not taken to address the significant weight loss. The resident continued to have further unplanned weight loss of approximately 1 kilogram (kg) per month over a four month period. A Registered Dietitian saw the resident seven times during and identified unexplained weight loss, however, the plan of care was not revised to address the weight loss. The Dietitian confirmed that the resident was not interviewed during the nutritional assessments over a three month period and the resident was not asked the reason for the weight loss. During interview with the inspector, the resident stated they were trying to lose weight and that they were skipping at least one meal daily, usually a particular meal. Several referrals to the Dietitian and progress notes identified the resident was consistently skipping a particular meal, however, "Point of Care" food intake records did not reflect consistently refused meals. Staff interview identified that the resident frequently refused a particular meal. An assessment of the discrepancies between intake records and staff observation did not occur and the resident was not consulted as part of the assessment process. The resident has lost 18% of their body weight in the past six months without revision to their plan of care. (107)

2. [O.Reg. 79/10, s. 69]
Resident #003 had a 9.6% significant weight loss over one month, however, the weight change was not assessed by the multidisciplinary team. The significant weight loss did not appear to have flagged on the home's computer system and therefore, did not trigger for follow up by the team. During the month that the significant weight loss was identified, the Registered Dietitian saw the resident related to skin integrity, however, an assessment of the resident's weight did not occur at that time and interventions were not revised on the resident's plan of care. (107)

3. [O.Reg. 79/10, s. 69]
Resident #002 had a 7.9% significant weight loss over three months, and an additional significant weight loss of 5.2% the next month, however, a multidisciplinary assessment of the weight loss did not occur until the regularly scheduled quarterly review after the second significant weight loss. The significant weight loss over three months was not triggered by the computer and was missed for follow up, resulting in a delay in interventions. The resident also

had a significant reduction in their intake during this time (4.3% of meals taken < 75%, 18.2% the next month, 76% the following month, 72% the subsequent month 75% the month the quarterly review was completed, as noted on food intake records) and progress notes identified reduced intake since the first month. The resident had a further 7.1% significant weight loss over the month following the quarterly review, however, there was no multidisciplinary assessment of the further weight loss. The Registered Dietitian initiated interventions at the quarterly review, however, follow up on the effectiveness of the interventions in relation to the further significant weight loss did not occur and the further significant weight loss was not assessed by the multidisciplinary team. The significant weight loss did not flag on the computer system and therefore did not trigger for staff until the subsequent month. The resident lost 19% of their body weight over a five month period. (107)

4. [O.Reg. 79/10, s. 69]
Resident #001 had an 8.2% significant weight loss over one month, however, the weight change was not assessed by nursing or the Registered Dietitian. A weight warning note was triggered and a re-weigh was requested to confirm the significant weight loss, however, the re-weigh was not recorded in the computer as completed. An actual assessment of the significant weight loss had not occurred as of the date of this inspection and action had not been taken to address the weight loss. During observation in the dining room the resident did not receive the interventions previously identified on the resident's plan of care. The computer did not identify that a significant weight warning had triggered in the "weights and vitals" tab. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

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 24th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Michelle McNally for

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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