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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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 11iém étage
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Téléphone: (905) 546-8294
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 19, 2017;	2017_539120_0020 (A1)	033338-16	Follow up

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

No amendments were required on the Public Report and Order. Amendments were made to both the Licensee Order Report (page 4) and Licensee Inspection Report (page 5) with respect to content related to the home's "Restraint & PASD Procedures in LTC" policy.

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 19 day of May 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 22, 2017

An inspection (2016-449619-0026) was previously conducted July 27 to August 19, 2016 and non-compliance identified related to bed safety and resident assessments. An order was issued on October 25, 2016. For this follow up inspection, the majority of the conditions laid out in the order have been complied with, however several components remain outstanding. See below for the details.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Kinesiologist, Registered Practical Nurses, Personal Support Workers and residents.

During the course of the inspection, the inspector toured three home areas and observed resident bed systems, reviewed resident clinical records, bed system entrapment audit results, bed safety policies and procedures and bed safety staff training and education materials.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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 :

The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection (2016-449619-0026) was previously conducted July 27 to August 19, 2016, and non-compliance was identified with this section related to resident clinical assessments for the safe use of one or more bed rails and any associated risk factors for injury, suspension or entrapment. An order with multiple conditions was issued on October 25, 2016, and all were addressed with the exception of two specific conditions. The first being the inclusion of questions related to a resident while sleeping for a specified period of time, to establish their habits, sleeping patterns, behaviours and other relevant risk factors before the application of bed rails. The second being the date that alternatives to bed rails were trialled before the application of bed rails and whether they were successful or not.

For this follow up inspection, five existing residents (#100 to #104) and two newly admitted residents were selected for review to determine whether they were assessed for bed rail use and associated safety risks. It was determined that an interdisciplinary team participated in the assessments of all of the residents reviewed, and that all forms identified in the home's policies and procedures were completed for each resident by two practical registered nurses (RPN). The residents each had an accurate written plan of care identifying the reason for bed rail use, the number of bed rails to be applied and when. However, when the policies and associated forms were reviewed, it was not clear what specific habits,

behaviours and sleeping patterns were considered risk factors associated with bed related injuries or entrapment.

The licensee's newest policy titled "Bed Entrapment & Bedrail Assessment" (Tab 06-02, published November 21, 2016) included a section related to resident bed safety assessments. The direction required that residents be assessed by a registered team before bed rails were applied and at any time with a change in condition and when a change in bed rail use was required. In addition, residents were to be assessed for potential risks associated with using bed rails through observation and input from an inter-professional team (which can include personal support workers, Kinesiologist, Physiotherapist, etc) working on multiple shifts. No additional information or details were provided regarding the observation component in the policy. The two RPNs who were involved in the assessments confirmed that each newly admitted resident was monitored and observed for a period of 72 hours before the application of bed rails. However, this information was not included in the home's policy or on any of the forms that were used to assess the resident.

The policy directed the team to use a form titled "Resident/Bedrail Assessment (RBA)" which included a check list (appendix C page 1) and a decision tree or an organizational flow diagram (appendix C page 2) in order to assess the resident. The check list (and comments text boxes beside each point) included potential bed safety risks to consider such as "sleeping patterns, awake and in bed - movement patterns, medical diagnosis, medications, toileting habits, safety habits, personal expressions around bed use, health status and environmental factors". The flow diagram was to be used to determine how the bed rails would be used, if considered a personal assistive services device (PASD) or a restraint. At the end of the organizational flow diagram, the assessor was to determine if the bed rails were considered a "high, medium or low" risk and to note the recommendations. It was not clear based on these forms what sleeping patterns and behaviours were considered a risk for bed related injuries, how long the resident was monitored for and by whom. Neither of the policies or any of the forms included a definition of the risk categories. Both RPNs reported that they did not use a developed guideline or list of criteria to determine which category best applied to the resident but instead used their own clinical judgement. Each had their own differing ideas of what was considered high, medium or low risk. Residents #100, #101 and #102 were each identified as low risk for bed entrapment and resident #104 was identified to have been both a low risk and at medium risk for bed entrapment.

The licensee's policy tilted "Restraint & PASD Procedures in LTC" (Tab 04-52, published November 3, 2016), included direction that the "team" consider and evaluate alternatives to the use of a physical device (bed rail) in collaboration with the resident and/or substitute decision maker (SDM) before considering the use of the device for the resident. The completed assessment was to be included in the resident's chart and was titled "Alternatives to PASD/Restraint Assessment (APRA)". The device could therefore be used if all of the criteria were met, alternatives considered and tried where appropriate. The policy did not include specific examples of any bed related safety risks associated with bed rail use under the title of "Risk Factors Involved". The APRA form included risk factors for consideration such as cognition, medical diagnosis, medication use, falls with injury, recent fracture, personal expressions, inappropriate mobility equipment and acute delirium. The APRA form included an area to document what alternatives were trialled and the outcome, but neither the form or the policy included the need to include a time frame for the alternatives to be trialled. The APRA form included some relevant alternatives to bed rails which included a raised edge mattress, bed alarms, medical, cognitive, environmental and functional approaches. The use of bolsters(soft rails) were not included as an alternative on any of the forms or in the policy. According to the two RPNs who were involved in the resident assessments, alternatives such as bolsters were trialled for some residents, however the forms for the selected residents reviewed did not include when the alternatives were trialled, for how long, whether they were effective and did not include bolsters as an option.

Personal support workers (PSWs), who were tasked at observing all residents, whether in bed or not, were required to document what they observed on a flow sheet titled "Personal Care Observation and Monitoring Form". It included moods and behaviours exhibited while the resident was awake. Only one behaviour was listed for monitoring on night shift labeled as "Insomnia". Another flow sheet used by PSWs was titled "Daily Observation Sheet" and was used for a 24-hour period to monitor residents who required additional monitoring if identified with a specific behaviour or condition. It included whether the resident was sleeping in bed, sleeping in a chair, awake, calm, unusually restless, searching or swearing, kicking, hitting etc. A PSW explained that if a resident was found in an unsafe situation, such as on the floor or in an unusual position, the RN would be notified. The observation sheet did not include behaviours or patterns of sleep associated with the potential of increasing bed related injuries such as involuntary body movements, sleeping on edge of the bed, sleeping with feet or arms through the bed rail or on the bed rail, sleeping with feet or head off the bed, etc. The role of

the PSW in observing the residents while sleeping and the forms they were to use were not included in the "Bed Entrapment & Bedrail Assessment" policy.

Although the licensee assessed each resident, the licensee did not fully comply with the order that was issued to amend their policies and associated forms to include questions related to a resident while sleeping for a specified period of time, to establish their habits, sleeping patterns, behaviours and other relevant risk factors before the application of bed rails and what alternatives to bed rails were trialled before the application of bed rails (if possible) and whether or not they were successful or not.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

Issued on this 19 day of May 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2017_539120_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 033338-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : May 19, 2017;(A1)

Licensee / Titulaire de permis : Schlegel Villages Inc
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

LTC Home / Foyer de SLD : THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JO-ANNA GURD

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

To Schlegel Villages 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)

Linked to Existing Order / Lien vers ordre existant: 2016_449619_0026, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

(A1)
The licensee shall complete the following:

1. Amend the home's existing "Resident/Bedrail Assessment " form and/or the Personal Care Observation and Monitoring Form to include:

A) Questions that can be answered by the PSWs, who have been tasked at observing the residents while in bed, that are specifically related to the resident while sleeping for sleep associated behaviours or conditions associated with the potential of increasing bed related injuries after the application of any bed rails; and

B) The most appropriate alternative for the resident, including the option of soft rails (adjustable bolsters), that was trialled prior to the application of one

or more bed rails (where possible) and document when the alternative(s) was trialled, who monitored the alternative and if effective during the specified trial time period; and

C) Define the meaning of "high, medium and low" risk categories identified on the organizational flow diagram form (appendix C) and provide clear written direction to assist the assessor(s) in determining which category the resident meets in relation to their risk factors and safe use of bed rails. The outcome needs to clearly identify what options or interventions are available to the resident and assessor when a resident meets a particular risk category.

2. Amend the "Restraint & PASD Procedures in LTC" (Tab 04-52) to include specific examples of bed related safety risks associated with bed rail use, specific bed rail alternatives and interventions to mitigate any identified bed related safety risks. Include the time frame required to trial an alternative to bed rails, who will monitor the alternative and how long the alternative was trialled.

3. Amend the "Bed Entrapment & Bedrail Assessment" policy (Tab 06-02) to include specific roles and responsibilities of team members involved in assessing residents for risks related to the use of one or more bed rails. Include the details of the process of assessing residents upon admission, when a change in the resident's condition has been identified and at an established frequency to monitor residents for risks associated with bed rail use on an on-going basis. The time frames for monitoring residents without bed rails, with bed rails and with alternatives in place shall be established. The policy shall include guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection (2016-449619-0026) was previously conducted July 27 to August 19,

2016, and non-compliance was identified with this section related to resident clinical assessments for the safe use of one or more bed rails and any associated risk factors for injury, suspension or entrapment. An order with multiple conditions was issued on October 25, 2016, and all were addressed with the exception of two specific conditions. The first being the inclusion of questions related to a resident while sleeping for a specified period of time, to establish their habits, sleeping patterns, behaviours and other relevant risk factors before the application of bed rails. The second being the date that alternatives to bed rails were trialled before the application of bed rails and whether they were successful or not.

For this follow up inspection, five existing residents (#100 to #104) and two newly admitted residents were selected for review to determine whether they were assessed for bed rail use and associated safety risks. It was determined that an interdisciplinary team participated in the assessments of all of the residents reviewed, and that all forms identified in the home's policies and procedures were completed for each resident by two practical registered nurses (RPN). The residents each had an accurate written plan of care identifying the reason for bed rail use, the number of bed rails to be applied and when. However, when the policies and associated forms were reviewed, it was not clear what specific habits, behaviours and sleeping patterns were considered risk factors associated with bed related injuries or entrapment.

The licensee's newest policy titled "Bed Entrapment & Bedrail Assessment" (Tab 06-02, published November 21, 2016) included a section related to resident bed safety assessments. The direction required that residents be assessed by a registered team before bed rails were applied and at any time with a change in condition and when a change in bed rail use was required. In addition, residents were to be assessed for potential risks associated with using bed rails through observation and input from an inter-professional team (which can include personal support workers, Kinesiologist, Physiotherapist, etc) working on multiple shifts. No additional information or details were provided regarding the observation component in the policy. The two RPNs who were involved in the assessments confirmed that each newly admitted resident was monitored and observed for a period of 72 hours before the application of bed rails. However, this information was not included in the home's policy or on any of the forms that were used to assess the resident.

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organizational flow diagram (appendix C page 2) in order to assess the resident. The check list (and comments text boxes beside each point) included potential bed safety risks to consider such as "sleeping patterns, awake and in bed - movement patterns, medical diagnosis, medications, toileting habits, safety habits, personal expressions around bed use, health status and environmental factors". The flow diagram was to be used to determine how the bed rails would be used, if considered a personal assistive services device (PASD) or a restraint. At the end of the organizational flow diagram, the assessor was to determine if the bed rails were considered a "high, medium or low" risk and to note the recommendations. It was not clear based on these forms what sleeping patterns and behaviours were considered a risk for bed related injuries, how long the resident was monitored for and by whom. Neither of the policies or any of the forms included a definition of the risk categories. Both RPNs reported that they did not use a developed guideline or list of criteria to determine which category best applied to the resident but instead used their own clinical judgement. Each had their own differing ideas of what was considered high, medium or low risk. Residents #100, #101 and #102 were each identified as low risk for bed entrapment and resident #104 was identified to have been both a low risk and at medium risk for bed entrapment.

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were trialled for some residents, however the forms for the selected residents reviewed did not include when the alternatives were trialled, for how long, whether they were effective and did not include bolsters as an option.

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Although the licensee assessed each resident, the licensee did not fully comply with the order that was issued to amend their policies and associated forms to include questions related to a resident while sleeping for a specified period of time, to establish their habits, sleeping patterns, behaviours and other relevant risk factors before the application of bed rails and what alternatives to bed rails were trialled before the application of bed rails (if possible) and whether or not they were successful or not.

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance is pattern, as more than one of the residents who used one or more bed rails was not assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and the history of non-compliance is on-going as an order was previously issued on October 25, 2016.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Aug 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 19 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

Service Area Office /
Bureau régional de services : Hamilton