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

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291 King Street, 4th Floor
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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
Oct 24, 2013	2013_202165_0017	L-000799-13 L-000793-13	Critical Incident System

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

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

CIS #000021-13; CIS #000019-13; CIS #000020-13; CIS #000025-13; CIS #000024-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Nursing (ADON), Personal Support Workers (PSW), Registered staff, family members, residents

During the course of the inspection, the inspector(s) reviewed policy and procedures, education records, clinical health record

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not protect residents from abuse by anyone.
A) Staff reported that in September 2013, an identified PSW was yelling at resident #001 for using their call bell. The resident reported that the PSW yelled at them, stated they should not have used the call bell and that they had six to eight other residents that needed their help. The resident reported that they asked the PSW to stop yelling but they continued to scream at them. The resident stated that they have never been yelled at before, they were really upset and felt that the PSW was very rude to them. The resident also stated that the PSW made them feel nervous. Staff working that evening reported that they found the resident crying after the incident. During an interview with the PSW, they confirmed that they had raised their voice toward the resident when answering the call bell. The PSW confirmed that they told the resident that they ring their call bell all the time, that they had six to eight other residents and that they should not have used their call bell despite needing assistance. The staff told the inspector that the resident rang their call bell every five minutes and that the resident should understand when I explain to them that I have other people.
B) Resident #002 reported that the same PSW yelled at them but was not able to recount specific statements. Staff reported that in September 2013, the PSW was observed rushing and being rough with the resident. The resident was observed crying by Registered staff and indicated that the PSW had been mean and rude. The PSW stated that they work fast, if they don't rush they don't finish their work and they may have been rough when assisting the resident. The staff member confirmed that they raised their voice toward the resident and that the resident was crying during this process but stated the resident was always crying.
C) One resident interviewed stated that the staff member was very, very rough and wouldn't have them touch them. Another resident stated that the staff member was rude, rushes residents and did not listen to residents. Two other residents identified that they did not want this staff member to provide personal care including bathing.
D) Several staff reported that the PSW had used foul language, raised their voice, had been very angry towards residents and as a result of the PSW's actions have made some residents cry. Some staff have reported that they do not feel residents were safe when the PSW was working. During an interview with the PSW they confirmed that they work fast, if they do not rush they do not finish as they have many tasks and they do not have time to spend talking about nothing to residents.
E)In September 2013, three separate incidents of alleged verbal abuse involving the same PSW occurred on the same scheduled shift. Immediate action was not taken by

staff of the home after the first incident occurred and allowed the PSW to continue working their shift. As a result, two more incidents occurred. The PSW worked their next scheduled shift and another incident of verbal abuse occurred. The PSW was disciplined by the home.
In October 2013, an alleged physical abuse involving the same PSW occurred. It was reported to staff of the home the following day however; immediate action was not taken by staff of the home. The PSW finished their shift and worked their next scheduled shift the following day. The PSW received discipline from the home.[s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur should immediately report the suspicion and the information upon which it is based to the Director.
A) In October 2013, a resident reported to a staff member of an incident of alleged physical abuse they witnessed the previous day. The staff member did not report it immediately and left a written note for the home's administrator the day after they became aware. The home did not report the incident to the Director until two days after it was reported to the staff member.
B) In September 2013, a resident reported to a staff member of an incident of alleged verbal abuse that occurred the previous day. The staff member left a written note for the home's ADON however; this was not retrieved for two days and therefore, the Director was not notified immediately.
C) In September 2013, a staff member reported to the home of an incident of alleged verbal abuse that occurred three days prior. The staff member did not report the incident immediately and as a result, the Director was not notified immediately.
D) In September 2013, a staff member reported to the home of an incident of alleged verbal abuse that occurred the previous day. The following day, another staff member reported a separate incident of alleged verbal abuse involving the same resident. The ADON confirmed that there were two separate incidents although they were not reported as separate incidents. The Director was not notified until two days after becoming aware of the first incident. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the right for residents to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity were fully respected and promoted.

A) In September 2013, staff entered resident #005's room to get them up for the morning. PSW staff reported that the resident did not want to get up at this time however; they proceeded to get the resident up despite the resident's wishes to stay in bed. The Administrator indicated that residents have the right to choose if they wish to remain in bed and the expectation was for staff to respect the resident's individual choice. The resident requested staff assistance to be toileted however; a PSW staff stated no, that it was not safe and denied the resident assistance to be toileted. PSW staff confirmed that registered staff did not indicate that it was unsafe to toilet the resident. PSW staff interviewed confirmed that alternative measures to ensure safety were not initiated so that the resident could be toileted. It was reported that the resident was usually toileted before breakfast however; the resident was not toileted for three and a half hours later, once the resident had reported the incident after breakfast. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the right for residents to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity are fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
A) The sleep/rest plan of care for resident #005 indicated the resident preferred to get up between 0700 and 0800 hours. In September 2013, staff confirmed that they got the resident up at least 40 minutes early despite the resident verbalizing they did not want to get up at this time. The Administrator confirmed that staff were to get residents up based on their plans of care and resident's choice.
B) The toileting plan of care for resident #005 indicated the resident required total dependence for toileting, was able to verbalize when they required to be toileted and staff were to toilet at the resident's request. In September 2013, staff confirmed that after they got the resident up they did not provide assistance to toilet the resident when the resident requested. The plan of care also indicated that the resident used bedpans/urinals however; these were not offered as alternatives to toileting. [s. 6. (7)]

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 the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and did not ensure that the policy was complied with.
A) The home's "Abuse and Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy and procedure indicated under number one of mandatory reporting, that all cases of suspected or actual abuse must be reported immediately in written form to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call.
i) In September 2013, staff were aware of an incident of suspected verbal abuse however; this was not immediately reported to the management staff. The home's management indicated they were not aware until three days later.
ii) In September 2013, it was reported to a staff member by a resident of suspected verbal abuse that occurred the previous day however; this was not immediately reported to management staff. A written note was left for the ADON however; they did not return to work until two days later.
iii) In October 2013, it was reported to a staff member by a resident of suspected physical abuse. A written note was left for the Administrator the following day after becoming aware of the incident however; it was not retrieved and the Director was not notified until two days after staff became aware of the incident.[s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy was complied with, to be implemented voluntarily.

Issued on this 31st day of October, 2013

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

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

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) :	TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2013_202165_0017
Log No. / Registre no:	L-000799-13 L-000793-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 24, 2013
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ARTHUR NURSING HOME 215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA CANADA

To CARESSANT-CARE NURSING AND RETIREMENT 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee of the long term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. Previously issued as CO December 9, 2011.
1. The licensee of the long term care home did not protect residents from abuse by anyone.
A) Staff reported that in September 2013, an identified PSW was yelling at resident #001 for using their call bell. The resident reported that the PSW yelled at them, stated they should not have used the call bell and that they had six to eight other residents that needed their help. The resident reported that they asked the PSW to stop yelling but they continued to scream at them. The resident stated that they have never been yelled at before, they were really upset and felt that the PSW was very rude to them. The resident also stated that the PSW made them feel nervous. Staff working that evening reported that they found the resident crying after the incident. During an interview with the PSW, they confirmed that they had raised their voice toward the resident when answering the call bell. The PSW confirmed that they told the resident that they ring their call bell all the time, that they had six to eight other residents and that they should not have used their call bell despite needing assistance. The staff told the inspector that the resident rang their call bell every five minutes and that the resident should understand when I explain to them that I have other people.
B) Resident #002 reported that the same PSW yelled at them but was not able to recount specific statements. Staff reported that in September 2013, the PSW was observed rushing and being rough with the resident. The resident was

observed crying by Registered staff and indicated that the PSW had been mean and rude. The PSW stated that they work fast, if they don't rush they don't finish their work and they may have been rough when assisting the resident. The staff member confirmed that they raised their voice toward the resident and that the resident was crying during this process but stated the resident was always crying.
C) One resident interviewed stated that the staff member was very, very rough and wouldn't have them touch them. Another resident stated that the staff member was rude, rushes residents and did not listen to residents. Two other residents identified that they did not want this staff member to provide personal care including bathing.
D) Several staff reported that the PSW had used foul language, raised their voice, had been very angry towards residents and as a result of the PSW's actions have made some residents cry. Some staff have reported that they do not feel residents were safe when the PSW was working. During an interview with the PSW they confirmed that they work fast, if they do not rush they do not finish as they have many tasks and they do not have time to spend talking about nothing to residents.
E)In September 2013, three separate incidents of alleged verbal abuse involving the same PSW occurred on the same scheduled shift. Immediate action was not taken by staff of the home after the first incident occurred and allowed the PSW to continue working their shift. As a result, two more incidents occurred. The PSW worked their next scheduled shift and another incident of verbal abuse occurred. The PSW was disciplined by the home.
In October 2013, an alleged physical abuse involving the same PSW occurred. It was reported to staff of the home the following day however; immediate action was not taken by staff of the home. The PSW finished their shift and worked their next scheduled shift the following day. The PSW received discipline from the home. [s. 19. (1)] (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 2013

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

A person who has reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. Previously issued as WN June 8, 2012 and issued as VPC December 12, 2012.
1. A person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur should immediately report the suspicion and the information upon which it is based to the Director.
A) In October 2013, a resident reported to a staff member of an incident of alleged physical abuse they witnessed the previous day. The staff member did not report it immediately and left a written note for the home's administrator the day after they became aware. The home did not report the incident to the Director until two days after it was reported to the staff member.
B) In September 2013, a resident reported to a staff member of an incident of alleged verbal abuse that occurred the previous day. The staff member left a written note for the home's ADON, however, this was not retrieved for two days and therefore, the Director was not notified immediately.
C) In September 2013, a staff member reported to the home of an incident of alleged verbal abuse that occurred three days prior. The staff member did not report the incident immediately and as a result, the Director was not notified immediately.
D) In September 2013, a staff member reported to the home of an incident of alleged verbal abuse that occurred the previous day. The following day, another staff member reported a separate incident of alleged verbal abuse involving the same resident. The ADON confirmed that there were two separate incidents although they were not reported as separate incidents. The Director was not notified until two days after becoming aware of the first incident. [s. 24. (1)] (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 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 October, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : TAMMY SZYMANOWSKI

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