Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 26, 27, 28, Oct 4, 5, 2012	2012_054133_0040	Critical Incident

Licensee/Titulaire de permis

CHARTWELL MASTER CARE LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH, P.O. BOX 429, LANCASTER, ON, K0C-1N0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Assistant Director of Care, the maintenance worker and a resident.

During the course of the inspection, the inspector(s) inspected all resident accessible windows and doors that lead to the outside of the home and reviewed a residents health care record.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s.8, s.5 in that the home is not a safe and secure environment for all of its residents. Resident #001 has eloped from the home through a bedroom window on three occasions and the home has failed to secure all bedroom windows in response to this pattern of elopement.

All windows in resident bedrooms are double paned sliding windows. All windows have been equipped with hardware on the lower inner track that serves as a window lock, to prevent the window from sliding fully open. The hardware is of a style that requires a hex key, also known as an Allen key, to apply and/or remove them.

On a day in April 2012, resident #001 eloped for the first time through their bedroom window. The Administrator explained to the inspector that the resident used a knife to remove the lower window lock. Resident #001 was then able to fully open the window, remove the screen and exit the building.

In follow up to resident #001's first elopement though a window, the home's maintenance worker applied a different style of window lock to the inner lower window track in an effort to hinder resident #001's ability to remove the hardware. The maintenance worker also applied the original style of lower window lock to the outer window track.

On a day in April 2012, eleven days after the first elopement, resident #001 eloped a second time through their bedroom window. The Administrator and maintenance worker explained to the inspector that resident #001 lifted their window pane up and out of the track and then removed the screen in order to exit the building.

In follow up to resident #001's second elopement through a window, the home's maintenance worker applied hardware to the upper area of resident #001's inner window (upper window lock) in order to prevent the window from being lifted up and out. As well, resident #001 was moved to a new bedroom which faces a secure outdoor space. In the new room, an upper window lock was applied. The original style of lower lock was in place on the window in the new bedroom and was not replaced with the new style of lower window lock which is more complicated and difficult to remove.

On a day in May 2012, an outside consultant assessed resident #001. The consultant took note that 2 locks (lower and upper) had been applied to resident #001's window and raised the concern that resident #001 could climb out of other resident's windows. The Administrator explained to the inspector that they did not feel that resident #001 would go out through other resident's windows and therefore they did not apply the intervention of installing upper window locks on all windows.

On a day in August 2012, staff discovered that resident #001 had removed the lower window lock on their bedroom window and had partially removed the window screen. The lower window lock was the same style of hardware that resident #001 had removed from their previous bedroom window during their 1st elopement on a day in April 2012. The knife that was used by resident #001 to remove the lower window lock was found by staff the following day in resident #001's bedroom.

In follow up to this event, the home's maintenance worker reapplied the lower window lock that resident #001 had removed. The more complicated lower window lock which is more difficult to remove was not applied. The inspector noted this style of lower window lock was still in place in resident #001's bedroom at the time of the inspection.

The day following the above described event, in August 2012, resident #001 eloped through a bedroom window for the third time. The Administrator explained that resident #001 eloped through the window in the bedroom across from theirs, which does not face a secure outdoor area. As with elopement #2, resident #001 lifted the window pane up and out of the track.

In follow up to resident #001's third elopement through a window, the home's maintenance worker installed an upper window lock and the more complicated style of lower window lock to the window that resident #001 eloped through.

During the Critical Incident inspection, on September 27th 2012, the maintenance worker explained to the inspector that while the upper window locks and the more complicated style of lower window locks had been ordered and received, there was no process in place to install the hardware to all resident's windows. The maintenance worker explained that

if the upper window locks are applied to all windows, they would have to be manually removed twice a year in order to allow for window cleaning and this would be an inconvenience for staff by adding extra work.

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. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.9. (1) 1.ii in that not all resident accessible doors that lead to the outside of the home are equipped with a door access control system.

The resident accessible exit door in the dining room is not equipped with a door access control system. This door leads to an unsecured outside area. There is a bolt lock mechanism on the door. The lock is engaged and disengaged by turning the knob on the mechanism one way or another. This mechanism does not prevent unauthorized exiting from the home.
2. The licensee has failed to comply with O. Reg. 79/10, s.9.(1)1 iii in that not all resident accessible doors that lead to the outside of the home are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident staff communication and response system, or, is connected to an audio visual enunciator that is connected to the nurses's station nearest to the door and has a manual reset switch at each door.

There are four doors that are accessible to residents and that lead to unsecured outside areas, that are not equipped with an alarm that allows calls to be cancelled only at the point of activation. These are: front door, South unit exit, activity room exit and the North unit exit. These doors are equipped with alarms that sound when the door is open and then the alarm is cancelled when the door is closed. This is part of the home's new call bell system that was installed in 2011. There is an older alarm system on all doors, which only allows alarms to be cancelled at the door, however this system has been disengaged.

There is one door that is accessible to residents and that leads to an unsecured outside area, the dining room exit door, that is not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident staff communication and response system, or, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 16 in that not every window that opens to the outdoors and is accessible to residents is restricted to open no more than 15 centimetres (6 inches).

The inspector observed and measured resident's windows in all but two bedrooms. The resident's windows are double pane sliding windows. All windows had hardware installed on the lower inner window tract to prevent them from fully opening. The inspector found that three windows could be opened more than 15 centimetres. The inspector informed the maintenance worker of these findings, who speculated that the hardware had become loosened and moved due to pressure from the windows being opened. The maintenance worker later informed the inspector that he had repositioned the hardware in the noted bedrooms. The inspector verified that these windows were now restricted to open no more than 15 centimetres.

Issued on this 15th day of October, 2012

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

Jessica Lapensée

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2012_054133_0040
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Sep 26, 27, 28, Oct 4, 5, 2012
Licensee / Titulaire de permis :	CHARTWELL MASTER CARE LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE 105 MILITARY ROAD NORTH, P.O. BOX 429, LANCASTER, ON, K0C-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISE CARDINAL

To CHARTWELL MASTER CARE LP, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee will ensure the home is a safe and secure environment for its residents by securing all resident accessible windows in order to prevent residents from eloping from those windows. The licensee will install upper window locks on all resident accessible windows in order to prevent them from being removed from the window tracks by residents. The licensee will also install a style of lower window lock that can not be readily removed by a resident with a knife or other such devices that are easily accessed by residents in the home.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, s.8, s.5 in that the home is not a safe and secure environment for all of its residents. Resident #001 has eloped from the home through a bedroom window on three occasions and the home has failed to secure all bedroom windows in response to this pattern of elopement.

All windows in resident bedrooms are double paned sliding windows. All windows have been equipped with hardware on the lower inner track that serves as a window lock, to prevent the window from sliding fully open. The hardware is of a style that requires a hex key, also known as an Allen key, to apply and/or remove them.

On a day in April 2012, resident #001 eloped for the first time through their bedroom window. The Administrator explained to the inspector that the resident used a knife to remove the lower window lock. Resident #001 was then able to fully open the window, remove the screen and exit the building.

In follow up to resident #001's first elopement though a window, the home's maintenance worker applied a different style of window lock to the inner lower window track in an effort to hinder resident #001's ability to remove the hardware. The maintenance worker also applied the original style of lower window lock to the outer window track.

On a day in April 2012, resident #001 eloped a second time through their bedroom window. The Administrator and maintenance worker explained to the inspector that resident #001 lifted the window pane up and out of the track and then removed the screen in order to exit.

In follow up to resident #001's second elopement through a window, the home's maintenance worker applied hardware to the upper area of resident #001's inner window (upper window lock) in order to prevent the window from being lifted up and out. As well, resident #001 was moved to a new bedroom which faces a secure outdoor space. In the new room, an upper window lock was applied. The original style of lower lock was in place on the window in the new bedroom and was not replaced with the new style of lower window lock which is more complicated and difficult to remove.

On a day in May 2012, an outside consultant assessed resident #001. The consultant took note that 2 locks (upper and lower) had been applied to resident #001's window and raised the concern that resident #001 could climb out of other resident's windows. The Administrator explained to the inspector that they did not feel that

resident #001 would go out through other resident's windows and therefore they did not apply the intervention of installing upper window locks on all windows.

On a day in August 2012 staff discovered that resident #001 had removed the lower window lock on their bedroom window and had partially removed the window screen. The lower window lock was the same style of hardware that resident #001 had removed from their previous bedroom window during their 1st elopement on a day in April 2012. The knife that was used by resident #001 to remove the lower window lock was found by staff the following day in resident #001's bedroom.

In follow up to this event, the home's maintenance worker reapplied the lower window that resident #001 had removed. The more complicated lower window lock which is more difficult to remove was not applied. The inspector noted this style of lower window lock was still in place in resident #001's bedroom at the time of the inspection.

The day following the above described event, in August 2012, resident #001 eloped through a bedroom window for the third time. The Administrator explained that resident #001 eloped through the window in the bedroom across from theirs, which does not face a secure outdoor area. As with elopement #2, resident #001 lifted the window pane up and out of the track.

In follow up to resident #001's third elopement through a window, the home's maintenance worker installed an upper window lock and the more complicated style of lower window lock to the window that resident #001 eloped through.

During the Critical Incident inspection, on September 27th 2012, the maintenance worker explained to the inspector that while the upper window locks and the more complicated style of lower window locks had been ordered and received, there was no process in place to install the hardware to all resident's windows. The maintenance worker explained that if the upper window locks are applied to all windows, they would have to be manually removed twice a year in order to allow for window cleaning and this would be an inconvenience for staff by adding extra work. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 12, 2012

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii. equipped with a door access control system that is kept on at all times, and
   iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee will ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are equipped with a door access control system that is on at all times. The licensee will also ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident staff communication and response system, or, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s.9.(1)1 iii in that not all resident accessible doors that lead to the outside of the home are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident staff communication and response system, or, is connected to an audio visual enunciator that is connected to the nurses's station nearest to the door and has a manual reset switch at each door.

There are four doors that are accessible to residents and that lead to unsecured outside areas, that are not equipped with an alarm that allows calls to be cancelled only at the point of activation. These are: front door, South unit exit, activity room exit and the North unit exit. These doors are equipped with alarms that sound when the door is open and then the alarm is cancelled when the door is closed. This is part of the home's new call bell system that was installed in 2011. There is an older alarm system on all doors, which only allows alarms to be cancelled at the door, however this system has been disengaged.

There is one door that is accessible to residents and that leads to an unsecured outside area, the dining room exit door, that is not with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident staff communication and response system, or, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. (133)

2. The licensee has failed to comply with O. Reg. 79/10, s.9. (1) 1.ii in that not all resident accessible doors that lead to the outside of the home are equipped with a door access control system.

The resident accessible exit door in the dining room is not equipped with a door access control system. This door leads to an unsecured outside area. There is a bolt lock mechanism on the door. The lock is engaged and disengaged by turning the knob on the mechanism one way or another. This mechanism does not prevent unauthorized exiting from the home. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2012

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.

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

Ministère 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

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
Toronto ON M5S 2B1
Télécopieur: (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
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 5th day of October, 2012

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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