Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2015	2015_365194_0022	O-002197-15, 002198-15	Follow up

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 18, 21 and 22, 2015.

also inspected during the follow up inspection were the following Critical incident Inspections Log #O-002571-15, #O-002754-15 and #O-002214-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (acting DOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

Also reviewed during the inspection was clinical health records of identified residents, licensee's internal investigation into allegations of abuse, staff educational records and licensee's policy on abuse.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **2 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. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The following finding is related to Log #O-002197-15.

The licensee has failed to ensure that residents are not charged for goods and services that they are required to provide using funding from:

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by the LHIN under a service accountability agreement, and

ii. the Minister, under section 90 of the Act.

On May 22, 2015 the licensee was served a compliance order requesting that Residents #053, 054, 055, 056, 057 & 058 be reimbursed for the cost associated with purchase of seat belt covers, a charge not allowable under s. 245 of O. Reg 79/10.

In addition the compliance order instructed the licensee to identify other residents who may have paid similar charges in the past and to proceed with the reimbursement of the identified costs. According to the Administrator no action has been taken to reimburse other affected residents. [s. 245. 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. 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 following finding is related to Log # O-002198-15.

The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The licensee's "Abuse and Neglect (Resident) - Zero Tolerance" Policy # 14-18 was reviewed and directs:

Verbal Abuse of a resident in any form of communication within a resident's hearing that demonstrates disrespect, including, but not limited to: sarcasm, mocking, taunting, degradation

This type of abuse is reportable to the MOHLTC immediately as per the reporting requirements.

The following finding is related to Log #O-002754-15.

The licensee was informed on an identified date by a family member of an allegation of staff to resident verbal abuse. The allegation received indicated a Registered staff being verbally abusive towards Resident #01 two days earlier.

During an interview RPN #113 describes Resident #01's as exhibiting responsive behaviours at the time of the allegation. RPN #113 indicates that Resident #01 was being repetitive. A family member reported overhearing RPN #113 telling Resident #01 "well we can't all have everything we want can we".

The licensee's internal investigation confirmed that Resident #01 was verbally abused

The Licensee informed the Director of the allegations of staff to resident verbal abuse four days after being informed by a family member.

The following finding is related to Log #O-002571-15.

On an identified date during a Resident Council meeting Resident #02 brought forward an allegation of neglect by staff.

During an interview with Inspector #194, Resident #02 recalled the incident and indicated informing staff of requiring personal care. Resident #02 indicated being told to go the dining room by staff and that care could not be provided while staff was on break. Resident #02 also reported to the inspector that personal care had not been provided the previous day prior to a meal. A review of the personal care record on Point of Care

(POC) indicated that Resident #2 had been provided personal care as directed in the plan of care for the previous day.

During the licensee's investigation into the allegations of neglect, PSW's indicated that Resident #02 had been re approached once the staff returned from break and offered personal care and Resident #02 had refused. The inspector was informed that the licensee's investigation into the allegations of neglect resulted in no reasonable grounds to suspect that neglect had occurred as alleged by Resident #02.

During interview with Inspector #194, Acting Director of Care indicated that the Director had not been notified of the outcome of the neglect investigation. [s. 20. (1)]

2. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

There was an existing Order in place for LTCHA s. 20(1) at the time of this incident under report #2015_360111_0011 with a compliance date of August 01, 2015.

The following finding is related to Log #O-002214-15.

On an identified date PSW #114 and #115 witnessed PSW #116 being verbally abusive towards Resident #03 while providing care and did not immediately report the incident to their supervisor.

The licensee completed an investigation confirming verbal abuse of Resident #03. [s. 20. (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. 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 has failed to ensure that care set out in the plan of care for Resident #01 related to responsive behaviours were provided as specified in the plan.

The following finding is related to Log #O-002754-15.

A review of the plan of care for Resident #01 identifies the following:

Remove Resident #01 from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity.

Review of the licensee's internal investigation and interview with RPN #113 was completed. During an interview RPN #113 describes Resident #01's as exhibiting responsive behaviours at the time of the allegation. RPN #113 indicates that Resident #01 was being repetitive. A family member reported overhearing RPN #113 telling Resident #01 "well we can't all have everything we want can we".

During interview with inspector #194, RPN #113 reported being aware of the interventions for Resident #01's responsive behaviours but indicated that the interventions were not provided as specified. [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 by ensuring that the care set out in the plan of care for Resident #01 related to responsive behaviour will be provided as specified, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

The following finding is related to Log #O-002571-15.

On an identified date during a Resident Council meeting Resident #02 brought forward an allegation of neglect by staff.

During an interview with Inspector #194, Resident #02 recalled the incident and indicated informing staff of requiring personal care. Resident #02 indicated being told to go the dining room by staff and that care could not be provided while staff was on break. Resident #02 also reported to the inspector that personal care had not been provided the previous day prior to a meal. A review of the personal care record on Point of Care (POC) indicated that Resident #2 had been provided personal care as directed in the plan of care for the previous day.

During the licensee's investigation into the allegations of neglect, PSW's indicated that Resident #02 had been re approached once the staff returned from break and offered personal care and Resident #02 had refused. The inspector was informed that the licensee's investigation into the allegations of neglect resulted in no reasonable grounds to suspect that neglect had occurred as alleged by Resident #02.

During interview with Inspector #194, Acting Director of Care indicated that the Director had not been notified of the outcome of the neglect investigation. [s. 23. (2)]

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 by ensuring that results of allegation of abuse or neglect investigation are reported to the Director., to be implemented voluntarily.

WN #5: 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. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect or a resident occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director

The following finding is related to Log #O-002754-15.

The licensee was informed on an identified date by a family member of an allegation of staff to resident verbal abuse. The allegation received indicated a Registered staff being verbally abusive towards Resident #01 two days earlier.

During an interview RPN #113 describes Resident #01's as exhibiting responsive behaviours at the time of the allegation. RPN #113 indicates that Resident #01 was being repetitive. A family member reported overhearing RPN #113 telling Resident #01 "well we can't all have everything we want can we".

The licensee's internal investigation confirmed that Resident #01 was verbally abused.

The Licensee informed the Director of the allegations of staff to resident verbal abuse four days after being informed by a family member. [s. 24. (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 by ensuring that allegations of abuse/neglect are immediately report to the Director, to be implemented voluntarily.

Issued on this 12th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2015_365194_0022
Log No. / Registre no:	O-002197-15, 002198-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 13, 2015
Licensee / Titulaire de permis :	St. Joseph's at Fleming 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Gillespie

To St. Joseph's at Fleming, 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: 2015_360111_0011, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The Licensee shall establish a process to identify residents who were charged and have paid for seat belt covers and take reasonable steps to reimburse these residents or their lawful representatives for amounts owing.

Grounds / Motifs :

1. On May 22, 2015 the licensee was served a compliance order requesting that Residents #053, 054, 055, 056, 057 & 058 be reimbursed for the cost associated with purchase of seat belt covers, a charge not allowable under s. 245 of O. Reg 79/10.

In addition the compliance order instructed the licensee to identify other residents who may have paid similar charges in the past and to proceed with the reimbursement of the identified costs. According to the Administrator no action has been taken to reimburse other affected residents.

The decision for the reissue of this order was based on the licensee's compliance history. There is ongoing non compliance related to O. Reg. 79/10 s. 245. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_360111_0011, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The Licensee will ensure that

-Every alleged, suspected, or witnessed incident of staff to resident abuse and/or neglect is immediately reported and investigated.
-The Director is notified within 21 days of the results of every investigation into alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff
-the remaining 30% of staff are re-educated on what constitutes staff to resident abuse and/or neglect and reporting requirements

Grounds / Motifs :

1. The following finding is related to Log #O-002754-15.

The licensee was informed on an identified date by a family member of an allegation of staff to resident verbal abuse. The allegation received indicated a Registered staff being verbally abusive towards Resident #01 two days earlier.

During an interview RPN #113 describes Resident #01's as exhibiting responsive behaviours at the time of the allegation. RPN #113 indicates that Resident #01 was being repetitive. A family member reported overhearing RPN #113 telling Resident #01 "well we can't all have everything we want can we".

The licensee's internal investigation confirmed that Resident #01 was verbally

abused

The Licensee informed the Director of the allegations of staff to resident verbal abuse four days after being informed by a family member.

The following finding is related to Log #O-002571-15.

On an identified date during a Resident Council meeting Resident #02 brought forward an allegation of neglect by staff.

During an interview with Inspector #194, Resident #02 recalled the incident and indicated informing staff of requiring personal care. Resident #02 indicated being told to go the dining room by staff and that care could not be provided while staff was on break. Resident #02 also reported to the inspector that personal care had not been provided the previous day prior to a meal. A review of the personal care record on Point of Care (POC) indicated that Resident #2 had been provided personal care as directed in the plan of care for the previous day.

During the licensee's investigation into the allegations of neglect, PSW's indicated that Resident #2 had been re approached once the staff returned from break and offered personal care and Resident #2 had refused. The inspector was informed that the licensee's investigation into the allegations of neglect resulted in no reasonable grounds to suspect that neglect had occurred as alleged by Resident #02.

During interview with Inspector #194, Acting Director of Care indicated that the Director had not been notified of the outcome of the neglect investigation. [s. 20. (1)]
(194)

2. Re-education on what constitutes staff to resident abuse and/or neglect and reporting requirements has not been completed for all staff as required in Order #2 issued May 22, 2015. Inspector was informed that the home has purchased the surge learning software and the program was not up an running until June 26, 2015. The home provided reports indicating that 30% of staff have not been re-educated at the time of the inspection.

This order will be reissued based on the ongoing non compliance related the inability to identify and report incidents of abuse/neglect within the legislative time lines, putting residents at potential risk for injury. During the inspection two Critical incidents related to abuse were inspected and found to be non compliant related to legislative requirements. Re-education requirements for staff have not been completed as directed in Order #2 issued May 22, 2015
(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

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 13th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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