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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
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159 rue Cedar Bureau 403
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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
Jun 23, 2017	2017_624196_0007	004558-17, 004566-17, 004572-17, 004574-17, 004575-17	Follow up

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

This inspection was conducted on the following date(s): May 1 - 5, 2017

Follow up to Compliance Orders: two intakes related to resident plans of care; one intake related to responsive behaviours; one intake related to required programs and one intake related to mandatory reporting.

Complaint inspection #2017_624196_0008 was inspected concurrently. As a result, findings of non-compliance related to LTCHA 2007, S.O.2007,c.8, s.6.(4) identified during the complaint inspection are issued in this Follow Up inspection report.

During the inspection, the Inspectors conducted a walk through of resident care areas, observed staff to resident interactions, observed the provision of care and services to residents, reviewed various home policies and procedures, and reviewed several resident health care records.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Operations Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinator, Physician's Assistant (PA), Registered Dietitian (RD), Food Services Supervisor/Environmental Manager, residents and family members.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #006	2016_395613_0019	621
O.Reg 79/10 s. 30. (1)	CO #005	2016_395613_0019	196
O.Reg 79/10 s. 53. (4)	CO #004	2016_395613_0019	621
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2016_395613_0019	196

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident, so that assessments were integrated and were consistent with and complemented each other.

Inspector #621 reviewed a complaint submitted to the Director in the spring 2017, regarding concerns about the care provided to resident #001.

The Inspector reviewed resident #001's care plan, last revised spring 2017, which identified this resident required a specific nutritional restriction and had a specific nutritional requirement. Additionally, the Inspector reviewed resident #001's records for a one month period which identified that on six particular days, the resident had not met the specific requirement with registered nursing staff initialing the daily record to confirm that they had reviewed the records.

During interviews, Personal Support Worker (PSW) #111 and Registered Nurse (RN) #112, reported to Inspector #621 that resident #001 was not on a specific nutritional restriction and had a specific nutritional requirement according to this resident's care plan. Additionally, RN #112 identified to the Inspector that as part of monitoring, PSW staff on the night shift were responsible to document the previous days nutritional intakes for each resident, compare it to the resident's goal, circle in red any nutritional intake totals that were less than the determined goal, and report this information to the registered nursing staff for further assessment.

Inspector #621 reviewed the home's policy entitled "Nutrition & Hydration Monitoring, RC-256", last revised May 2016, which indicated that:
- the PSW staff were to record food and fluids throughout each shift and report any change in intakes to registered staff;
- the Night shift PSW staff were to total all fluids once in a 24 hour period, to identify with a red circle any amounts less then specified on resident's care plan;
- the Registered staff were to document resident care needs regarding food and fluids in the individualized resident record and cross reference this information to the PSW flow sheets and look back reports; and
- the Registered staff were to refer to the RD any intake concerns that occurred over a 72-hour period and to assess for signs and symptoms of dehydration.

Inspector #621 conducted an interview with PSW #111 and RN #112 and they confirmed to the Inspector that resident #001 had a nutritional intake which was less than their goal for 11 out of 18 days, prior to an occurrence in spring 2017. Additionally, RN #112 verified that nutritional intakes for six days prior to the occurrence, were not circled in red when the daily nutritional intake was less than goal over a period of three consecutive days. Further, RN #112 identified that there was no documentation to indicate that PSW staff had alerted registered nursing staff of the low nutritional intakes, or that registered staff who had been signing off on the daily intake record, were completing further assessment on any low intakes, or referring any low intake trends of three consecutive days or more to the RD.

During an interview with the Inspector, RD #113 reported that they completed nutrition assessments quarterly on all residents, and sooner if there was a referral sent by the registered nursing staff. RD #113 identified that they had not received a referral or communication concerning resident #001 for a potential medical condition related to nutritional intakes until a specific date in spring 2017.

During an interview with Physician's Assistant (PA) #101, they reported to Inspector #621 that a specific nutritional restriction was prescribed for resident #001 in fall of 2016, for a medical condition which had since resolved. PA #101 identified that they were not aware that this restriction was still ordered for this resident, and expected that registered nursing staff would have reviewed this resident's plan of care and brought this issue forward to them for reassessment.

During an interview, the Operations Manager confirmed to the Inspector, that it was their expectation that staff collaborated with respect to the changing care needs of residents, and ensured resident assessments were integrated and consistent.

A Written Notification has been issued for this finding related to CO #001 from Inspection #2016_395613_0019, as the non-compliance had been identified prior to the compliance date of April 28, 2017. [s. 6. (4) (a)]

2. Compliance Order #001 from inspection #2016_395613_0019, due on April 28, 2017, ordered the licensee to develop, submit and implement a plan that included the following:
1. A process to ensure that all physician's orders are followed and when there is a change in a resident's wounds that the Physician (Medical Director) is notified.
2. A process to ensure that staff and others involved in the different aspects of care of residents #005, #010 and #014 and all other residents, collaborate with other members

of the care team, including the Medical Director and Physician Assistant to maintain effective communication regarding the status of resident's wounds, so that their assessments are integrated and are consistent with and complement each other.
3. A process to ensure that the home maintains effective communication between the Wound Care Specialist, Physician, Medical Director, Physician Assistant, Nurse Practitioner or any other resources who are part of the interdisciplinary team for each resident.

The licensee had developed and submitted a plan to achieve compliance with this legislation. While the home completed #1 and #3, Inspector #196 determined that #2 had not been fully implemented, so that staff and others maintained effective communication regarding the status of a resident's altered skin integrity, and that their assessments were integrated and were consistent and complemented each other.

During the inspection, Inspector #196 reviewed the health care records of resident #010 for information regarding altered skin integrity.

The assessment document from a particular date in 2017, completed by RPN #116, identified a specific treatment to resident #010's area of altered skin integrity. The progress notes on this same date, completed by RPN #116, identified that treatment was provided to resident #010's altered skin integrity and that an assessment was completed and that the protocol was added to the Treatment Administration Record (TAR).

The licensee policy titled "Skin and Wound Care - #NP-010", dated February 2017, indicated treatment for a specific type of altered skin integrity.

The current TAR was reviewed and identified that treatment for the altered skin integrity was as per the Medical Directive for a specific type of altered skin integrity.

The Inspector conducted an interview with PA #101, regarding the altered skin integrity needs of resident #010. They reported that they had given a verbal order for treatment of the resident's altered skin integrity on a date in 2017, during their rounds, and made a written order on the following date, which provided the details of the treatment was to be the same as had been order by Physician #114 for another area of the resident's body.

Inspector #196 reviewed Physician #114's orders, dated the fall of 2016, which identified the treatment for the other area of the body to be a specific treatment for altered skin integrity.

An interview was conducted with the Interim Administrator and they confirmed to the Inspector that the treatment ordered by PA #101 for resident #010 on a date in 2017, had not been included in the current TAR, as of the date during the inspection. They went on to confirm that RPN #107 had followed the correct and current orders as noted in the treatment binder on a particular date during the inspection, yet had documented on the TAR as having completed the specific treatment that had been previously ordered. They further reported that the TAR had not been updated with the new order when first received and the previous order should have been discontinued on the TAR at that same time, but that through the new audit process it would have been discovered the following week. [s. 6. (4) (a)]

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. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, had been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

On a date during the inspection, when reviewing resident #008's care needs with PSW #102, it was reported that a type of medication had been applied to an area of the resident's body. In addition, they reported that the medication had been brought into the home and it was located in the resident's bedside drawer.

Inspector #196 observed that resident #008 had a type of medication at their bedside that had been supplied by someone other than the pharmacy service provider, for the residents' use. At that same time, it was determined that this medication had not been prescribed for use by the physician.

After being brought forward to RN #108, the Physician's Assistant (PA) #101, wrote a physician's order for this specific type of medication.

Inspector interviewed RPN #107 regarding resident #008's specific type of medication. They reported that someone other than the pharmacy service provider had brought it in for the resident and then proceeded to show the Inspector the unlabeled medication that was in the medication cart.

The licensee's policy titled "Provision of Medications - PHM - 029" last revised June 15, 2015, identified "In order to optimize patient safety and care, all medications taken by residents of Cedarwood Lodge will be provided by Shaw's Pharmacy - Med-I-Well Services. The only exception will be for those products which Shaw's Pharmacy - Med-I-Well Services are unable to procure." In addition, the policy read "In accordance with the LTCH Act and Regulations, Shaw's Pharmacy - Med-I-Well Services will provide all medications acquired, received or stored by residents at Cedarwood Lodge."

Inspector #196 conducted a telephone interview with Pharmacist #117, at Shaw's Pharmacy - Med-I-Well Services. They confirmed that this specific type of medication was an over the counter medication, and can be procured through them, providing there was a physician's order and the resident was willing to cover it's cost. [s. 122. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies, that was secure and locked.

On a date, during the inspection, Inspector #196 observed an unlocked treatment cart in an unlocked room on the resident care unit. Within the cart were several prescription labeled medications for residents.

Specifically, there was a container with prescription labelled medication for resident #001, two containers with prescription labelled medication for resident #015 and a container of prescription labelled medication for resident #016.

An interview was conducted with RN # 112 who confirmed to the Inspector that the treatment cart was to be kept locked.

The licensee's policy titled "Safe Storage of Medications - PHM-032" approval date April 1, 2015, was reviewed. The policy stated "For the safety of both the residents and employees as well as in keeping with LTC Act, all medications will be stored in a locked manner and all Narcotics will be stored in a double lock manner." [s. 129. (1) (a) (ii)]

Issued on this 6th day of July, 2017

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2017_624196_0007
Log No. / Registre no:	004558-17, 004566-17, 004572-17, 004574-17, 004575-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 23, 2017
Licensee / Titulaire de permis :	AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC. 130 ELM STREET, SUDBURY, ON, P3C-1T6
LTC Home / Foyer de SLD :	CEDARWOOD LODGE 860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Crystal Morettin

To AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_395613_0019, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that staff and others involved in the different aspects of care of resident #010, and all other residents, collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident, so that assessments were integrated and were consistent with and complemented each other.

Compliance Order #001 from inspection #2016_395613_0019, due on April 28, 2017, ordered the licensee to develop, submit and implement a plan that included the following:
1. A process to ensure that all physician's orders are followed and when there is a change in a resident's wounds that the Physician (Medical Director) is notified.
2. A process to ensure that staff and others involved in the different aspects of care of residents #005, #010 and #014 and all other residents, collaborate with other members of the care team, including the Medical Director and Physician Assistant to maintain effective communication regarding the status of resident's

wounds, so that their assessments are integrated and are consistent with and complement each other.
3. A process to ensure that the home maintains effective communication between the Wound Care Specialist, Physician, Medical Director, Physician Assistant, Nurse Practitioner or any other resources who are part of the interdisciplinary team for each resident.

The licensee had developed and submitted a plan to achieve compliance with this legislation. While the home completed #1 and #3, Inspector #196 determined that #2 had not been fully implemented, so that staff and others maintained effective communication regarding the status of a resident's altered skin integrity, and that their assessments were integrated and were consistent and complemented each other.

During the inspection, Inspector #196 reviewed the health care records of resident #010 for information regarding altered skin integrity.

The assessment document from a particular date in 2017, completed by RPN #116, identified a specific treatment to resident #010's area of altered skin integrity. The progress notes on this same date, completed by RPN #116, identified that treatment was provided to resident #010's altered skin integrity and that an assessment was completed and that the protocol was added to the Treatment Administration Record (TAR).

The licensee policy titled "Skin and Wound Care - #NP-010", dated February 2017, indicated the treatment for a specific type of altered skin integrity.

The current TAR was reviewed and identified that treatment for the altered skin integrity was as per the Medical Directive for a specific type of altered skin integrity.

The Inspector conducted an interview with PA #101, regarding the altered skin integrity needs of resident #010. They reported that they had given a verbal order for treatment of the resident's altered skin integrity on a date in 2017, during their rounds, and made a written order on the following date, which provided the details of the treatment was to be the same as had been order by Physician #114 for another area of the resident's body.

Inspector #196 reviewed Physician #114's orders, dated the fall of 2016, which

identified the treatment for the other area of the body to be a specific treatment for altered skin integrity.

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Previous non-compliance related to this legislation, LTCHA 2007, S.O.2007, c.8, s.6.(4) was issued in the following inspection report:
February 21, 2017 - Compliance Order from Inspection #2016_395613_0019.

The decision to re-issue this Compliance Order was based on the severity which indicates a potential risk of actual harm and although the scope was isolated, there is a compliance history which includes one compliance order previously issued in this area of the legislation. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Inspection de soins de longue durée
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 23rd day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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