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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Jul 15, 2016	2016_188168_0010	009128-16	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street Box 400 Cayuga ON N0A 1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST DUNNVILLE ON N1A 1V9

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

LISA VINK (168), GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 6, 20, 21, and 28, 2016.

This inspection was also conducted by Inspectors Kerry Abbott and Barbara Naykalyk- Hunt.

Please note: The inspection was a result of a Notice of Trespass being served on a visitor of a resident at Grandview Lodge on April 1, 2016. This Notice of Trespass banned the visitor from visiting the resident on the grounds of the home entirely.

There had previously been a visitation restriction in place for the complainant to follow when visiting the resident due to incidents that were deemed to be in violation of the home's Respect in the Workplace, POLICY No. 2001-1. The visitation restriction was previously inspected by the Ministry of Health and Long-Term Care in December 2014, January, April and September 2015, and determined to be respectful of the Resident's Right to receive visitors.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Senior Services, Director of Care (DOC), registered nursing staff, personal support workers (PSW), housekeeping staff, residents and families.

During the course of the inspection, the inspector(s): toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: health care records, policies and procedures, tracking logs and other correspondence.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residents' right to have his or her personal health information within the meaning of the Personal Health Information (PHI) Protection Act, 2004, was kept confidential in accordance with that Act.

During the 2014, Resident Quality Inspection (RQI), the Program Manager confirmed that boxes which contained paper for shredding was located in a common accessible area, as part of an activity program for at least one identified resident. It was also confirmed that the paper/records contained PHI of residents and was readily accessible to the public. Non compliance was identified during the 2014 RQI as a result of the identified information.

On April 6 and 28, 2016, it was observed that there were three full boxes in a common area of paper for shredding. The boxes were searched and it was discovered that they contained financial records belonging to residents, as well as "24 Shift Reports" which contained resident names and PHI.

This information was brought to the attention of the Administrator on the identified dates, who confirmed that the papers/documents contained PHI that should not be accessible to the residents and other members of the public. [s. 3. (1) 11. iv.]

2. The licensee failed to ensure that every residents' right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, was respected and promoted.

Resident #001, resided on an identified unit and was dependent on staff to meet their Activities of Daily Living (ADL).
The resident had multiple family members and appointed family member #002 as their Substitute Decision Maker (SDM).
Family member #003 had a history of visiting the resident in the home regularly.
The resident was able to verbalize their wishes and identified that they wanted to visit with family member #003 and preferred to visit with them in the home, outside of the unit.

The Administrator confirmed that in 2014, the home imposed visitation restrictions on family member #003 due to their conduct while in the home, which impacted resident #001 visits with family member #003. This restriction prohibited family member #003 from entering resident #001's unit to visit them and restricted contact to only registered nursing staff. Resident #001 was only able to visit family member #003 when the family member entered the home and followed a process to summon the registered staff on duty. Staff would bring the resident to the reception area, at which time the resident and family member #003, were permitted to visit in any of the common areas located outside of the unit, as well as the guest suite, when available.

In 2016, visitation restrictions were temporarily removed due to the resident's health status, which permitted family member #003 to enter the unit and visit resident #001 in their bedroom.
On a specified date in 2016, staff #006 accused family member #003 of an inappropriate action, when the staff attempted to provide care to resident #001. Staff #006 reported the action to the Administrator and the DOC, who then attempted to discuss the incident with

family member #003. This attempted discussion led to a verbal altercation which ultimately resulted in the police being called and family member #003 being asked to leave the premises.

The following month, family member #003 refused to comply with the home's process in place to summon the registered staff. The family member approached the resident's unit and attempted to alert staff verbally at the entrance to the unit that resident #001 required care. The Administrator observed family member #003 standing at the entrance, requesting care for resident #001 and proceeded to approach the family member and directed them to follow the process in place to alert staff. Family member #003 responded to this dismissal by refusing verbally, to comply with the Administrator's direction and repeatedly requested the assistance of staff to meet the care needs of the resident. According to family member #003 the Administrator ignored the requests of the family member and left the unit without seeking assistance of staff to care for resident #001. The Administrator returned a short while later with a Notice of Trespass for family member #003. When interviewed the Administrator stated that they felt threatened by the verbal altercation between herself and family member #003, although, was not able to provide specific statements or comments regarding the incident, confirmed that there were no verbal or physical threats made by the family member. As a result of the incident family member #003 was given a Notice of Trespass, which prohibited them from attending the land and buildings known as Grandview Lodge; consequently preventing them from visiting resident #001.
Resident #001 was interviewed during the inspection and stated they were not informed of the Notice of Trespass given to family member #003. The resident stated this made them feel "bad" and that they desired to visit with this family member. The Administrator confirmed that neither the resident nor family member #002, the resident's SDM, was informed of the Notice of Trespass given to family member #003. Resident #001 had no visitation with family member #003, as of the time of the inspection, despite their expressed desire to visit them.

The resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference was not fully promoted or respected. [s. 3. (1) 14.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every residents' right to have his or her personal health information within the meaning of the Personal Health Information (PHI) Protection Act, 2004, is kept confidential in accordance with that Act and to ensure that every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day, to be implemented voluntarily.

Issued on this 10th day of August, 2016

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) :	LISA VINK (168), GILLIAN TRACEY (130)
Inspection No. / No de l'inspection :	2016_188168_0010
Log No. / Registre no:	009128-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 15, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF HALDIMAND COUNTY 45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0
LTC Home / Foyer de SLD :	GRANDVIEW LODGE / DUNNVILLE 657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joanne McGuire

To THE CORPORATION OF HALDIMAND COUNTY, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The home shall prepare, submit and implement a plan that ensures that resident #001's right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference, is fully respected and promoted.

The licensee shall not ban family member #003 from the land and buildings known as Grandview Lodge.

This plan shall include but not be limited to securing an independent professional, with qualifications in alternate dispute resolution (ADR) / mediation, to work with the licensee and family member #003, to develop solutions that will allow resident #001 to visit with family member #003 at times, frequencies and locations, in the home, as preferred by the resident.

The date of the first ADR / mediation session shall be included in the plan.

The ADR / mediation sessions shall focus on developing and implementing a plan which details how the licensee shall:
a. respect resident #001's wishes and preferences related to visits with family member #003
b. ensure privacy and minimize interruption during visits with family member #003
c. provide details on how the visitation needs of resident #001 will be met if the resident is unable to leave their room
d. provide details on how the licensee will meet the resident's right to have family members present, including family member #003, 24 hours per day if they are dying.
e. provide and review with family member #003 a copy of the home's "Respect in the Workplace, POLICY No. 2001-18" and discuss descriptions of behaviours which would violate this policy.

The home shall provide a detailed report, at the completion of the ADR / mediation sessions, which outlines the decisions and agreements made between family member #003 and the licensee regarding visitation of resident #001 with family member #003.

The plan shall be submitted to inspector Gillian.Tracey@ontario.ca no later than August 22, 2016.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (3), in keeping with s. 3 of the Act, in respect to the potential for harm to the resident, the scope being isolated, and the licensee's history of non-compliance in a similar area. Section 3 was issued as a WN in previous inspections in 2013, 2014 and issued as a CO in 2013.

The licensee failed to ensure that every residents' right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, was respected and promoted.

Resident #001, resided on an identified unit and was dependent on staff to meet their Activities of Daily Living (ADL).
The resident had multiple family members and appointed family member #002 as their Substitute Decision Maker (SDM).
Family member #003 had a history of visiting the resident in the home regularly.
The resident was able to verbalize their wishes and identified that they wanted to visit with family member #003 and preferred to visit with them in the home, outside of the unit.

The Administrator confirmed that in 2014, the home imposed visitation restrictions on family member #003 due to their conduct while in the home, which impacted resident #001 visits with family member #003. This restriction prohibited family member #003 from entering resident #001's unit to visit them and restricted contact to only registered nursing staff. Resident #001 was only able to visit family member #003 when the family member entered the home and followed a process to summon the registered staff on duty. Staff would bring the resident to the reception area, at which time the resident and family member #003, were permitted to visit in any of the common areas located outside of the unit, as well as the guest suite, when available.

In 2016, visitation restrictions were temporarily removed due to the resident's health status, which permitted family member #003 to enter the unit and visit resident #001 in their bedroom.
On a specified date in 2016, staff #006 accused family member #003 of an inappropriate action, when the staff attempted to provide care to resident #001. Staff #006 reported the action to the Administrator and the DOC, who then attempted to discuss the incident with family member #003. This attempted

discussion led to a verbal altercation which ultimately resulted in the police being called and family member #003 being asked to leave the premises.

The following month, family member #003 refused to comply with the home's process in place to summon the registered staff. The family member approached the resident's unit and attempted to alert staff verbally at the entrance to the unit that resident #001 required care. The Administrator observed family member #003 standing at the entrance, requesting care for resident #001 and proceeded to approach the family member and directed them to follow the process in place to alert staff. Family member #003 responded to this dismissal by refusing verbally, to comply with the Administrator's direction and repeatedly requested the assistance of staff to meet the care needs of the resident. According to family member #003 the Administrator ignored the requests of the family member and left the unit without seeking assistance of staff to care for resident #001. The Administrator returned a short while later with a Notice of Trespass for family member #003. When interviewed the Administrator stated that they felt threatened by the verbal altercation between herself and family member #003, although, was not able to provide specific statements or comments regarding the incident, confirmed that there were no verbal or physical threats made by the family member. As a result of the incident family member #003 was given a Notice of Trespass, which prohibited them from attending the land and buildings known as Grandview Lodge; consequently preventing them from visiting resident #001.
Resident #001 was interviewed during the inspection and stated they were not informed of the Notice of Trespass given to family member #003. The resident stated this made them feel "bad" and that they desired to visit with this family member. The Administrator confirmed that neither the resident nor family member #002, the resident's SDM, was informed of the Notice of Trespass given to family member #003. Resident #001 had no visitation with family member #003, as of the time of the inspection, despite their expressed desire to visit them.

The resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference was not fully promoted or respected. (130)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 15th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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