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 28, 2016	2016_265526_0012	019514-16	Complaint

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

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

THERESA MCMILLAN (526)

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): July 13, 14, and 15, 2016.

Critical Incident Inspection #020094-16 was conducted simultaneously in relation to the same complaint.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the complainant.

During the course of this inspection the inspector toured the home, observed care, and reviewed health records and investigative notes.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was protected from abuse by anyone and that the resident was not neglected by the licensee or staff.

According to health records, on a specified day in 2016, resident #001 complained to RN #102 that they had pain and numbness in an extremity. Interview with RN #102, and progress notes revealed that the RN observed an issue of concern involving the extremity and the presence of pain.

During the following three weeks, the concerning issue worsened. The resident complained of pain several times during this time with increased frequency and severity as the time period progressed; their request for pain medication also increased in number. At the end of this time period, they were admitted to hospital and required extensive treatment of the affected extremity.

According to health records, the home's investigative notes, interviews with staff RNs #101, #102, RPN's #103 and #104, and the home's DOC, staff neglected to do the following for resident #001 during this three week time period:
i) Pain assessments;
ii) Assessment of the affected extremity; and
iii) Request the MD/RN in extended class to assess the resident when their condition worsened between physician visits.

The home conducted an investigation of resident #001's care. The DOC confirmed that the pattern of staff inaction over a three week period in 2016, jeopardized the health, safety and well-being of resident #001 and constituted neglect as follows:
i) Neglecting to conduct pain assessments using an instrument designed for that purpose when initial interventions were not effective in managing pain;
ii) Neglecting to conduct skin and wound assessments when the condition of the extremity deteriorated;
iii) Neglecting to assess resident #001 when they complained of pain and numbness in their extremity when their care needs changed; and
iv) Neglecting to inform and/or request physician/RN in extended class to assess the resident when the resident's care needs changed. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

According to health records, on a specified day in 2016, resident #001 complained to RN #102 that they had pain and numbness in an extremity. Interview with RN #102, and progress notes revealed that the RN observed an issue of concern involving the extremity and the presence of pain.The RN completed a pain assessment using an instrument specifically designed for this purpose on that day, and an increase in medication was prescribed. During the following three weeks, the concerning issue worsened. The resident complained of pain several times during this time with increased frequency and severity as the time period progressed. Their pain medication was increased again and their request for medication also increased in number. According to health records, interviews with RNs #101 and #102, and the home's investigative notes, initial pain management interventions were not effective in relieving resident #001's pain during the three week time period. At the end of this time period, they were admitted to hospital and required extensive treatment of the affected extremity.

According to interview with the DOC, the home's "Pain and Symptom Management" policy number VII-G-30.10 last revised on January 2015, and investigative notes, staff were expected to conduct a pain assessment using the home's clinically relevant instrument designed for that purpose on residents who had new or worsening pain, or when the pain management plan of care was not effective in relieving their pain. In addition, resident #001's plan of care directed staff regarding monitoring and management of their pain characteristics, aggravating factors and relieving factors.

During interview, the DOC confirmed that resident #001 complained of progressively more pain including severe pain, had their pain medication increased, and requested more medication, all while the condition of their extremity worsened. The DOC confirmed that resident #001 had not been assessed when their pain was not relieved by initial interventions using a clinically appropriate assessment instrument specifically designed for pain assessment during a three week time period in 2016. [s. 52. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, and was reassessed by a member of registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) According to interviews with the DOC, RN's #101 and #102, progress notes, and review of the home's investigative notes, staff observed that resident #001 complained of pain in their extremity that progressively worsened over a three week time period in 2016. The resident was admitted to hospital requiring urgent treatment to the extremity.

During interview with the LTC inspector, the DOC stated that when staff noted resident #001's worsening extremity, they were expected to conduct a skin and wound assessment using an instrument specifically designed for that purpose. Review of health records indicated that staff had not conducted an initial skin assessment or weekly reassessments of the resident's altered skin integrity using an instrument specifically designed for that purpose. The DOC confirmed this.

B) According to health records, resident #004's most recent plan of care identified their increased risk for alterations in skin integrity. They developed three areas of altered skin integrity including an area on an extremity, where weekly skin and wound reassessments were not completed.

The area on the extremity was assessed by a physician and treatment prescribed that was not implemented until several days later. Review of health records revealed that weekly skin and wound assessment of the area was not completed, during which time the condition of the area worsened. The resident was sent to hospital for treatment of the progressively worsening area of altered skin integrity.

The DOC confirmed that the resident's skin integrity on their extremity worsened between the time it was initially observed and when they were hospitalized. The DOC also confirmed that according to health records, the resident had not received the skin and wound care to promote healing and prevent infection, as prescribed and that weekly skin assessments of the altered skin integrity on resident #004's extremity had not been conducted. [s. 50. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months or at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

According to health records, on a specified day in 2016, resident #001 complained to RN #102 that they had pain and numbness in an extremity. Interview with RN #102, and progress notes revealed that the RN observed an issue of concern involving the extremity and the presence of pain.

The resident had medical assessments on the following two days with accompanying diagnostic and treatment orders. According to progress notes over the next 6 days, the resident complained of pain several times. Staff failed to assess the resident's pain, or

the condition of the extremity that was the basis of the resident's complaints. Staff also failed to request an assessment of the resident by MD/RN in extended class when their pain intensified and care needs changed. A physician did not assess the resident until three days later.

After this medical assessment, the resident continued to complain of severe pain with increasingly more frequent requests for pain medication.They were told to wait for the physician to visit five days later; the physician was not contacted during the intervening time period while the resident's condition worsened. Five days later, the physician attended the resident and prescribed a treatment. Symptoms worsened, a different physician attended the resident two days later and recommended hospital admission for urgent treatment.

During interview, the DOC confirmed that:
i) staff had not assessed the resident when they complained of pain and numbness in their extremity;
ii) staff did not request that the resident be assessed by an MD/RN in extended class when they complained of “severe pain”;
iii) staff did not assess the resident or notify an MD/RN in extended class when the extremity and associated pain worsened, with subsequent increased use of pain medication, telling them to wait for five days;
iv) the resident's plan of care was not reviewed and revised when their pain increased, and the condition of their extremity deteriorated.

The DOC confirmed that staff failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when their care needs changed during a three week period in 2016. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 9th 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) :	THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2016_265526_0012
Log No. / Registre no:	019514-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 28, 2016
Licensee / Titulaire de permis :	2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Maple Grove Care Community 215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michele Mackenzie

To 2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents including resident #001 from abuse and neglect by doing the following:

1. Conduct pain assessments using an instrument designed for that purpose when initial interventions are not effective in managing pain;

2. Conduct skin and wound assessments and, at minimum, weekly reassessments according to the home's policy and legislative requirements;

3. Assess and reassess residents when their care needs change and update the plan of care accordingly; and

4. Inform and/or request a physician/RN in Extended Class to assess the resident when the resident's care needs change.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual Harm/risk
Scope: Isolated
Compliance history: Previous unrelated non compliance

2. The licensee failed to ensure that resident #001 was protected from abuse by anyone and that the resident was not neglected by the licensee or staff.

According to health records, on a specified day in 2016, resident #001 complained to RN #102 that they had pain and numbness in an extremity. Interview with RN #102, and progress notes revealed that the RN observed an

issue of concern involving the extremity and the presence of pain.

During the following three weeks, the concerning issue worsened. The resident complained of pain several times during this time with increased frequency and severity as the time period progressed; their request for pain medication also increased in number. At the end of this time period, they were admitted to hospital and required extensive treatment of the affected extremity.

According to health records, the home's investigative notes, interviews with staff RNs #101, #102, RPN's #103 and #104, and the home's DOC, staff neglected to do the following for resident #001 during this three week time period:
i) Pain assessments;
ii) Assessment of the affected extremity; and
iii) Request the MD/RN in extended class to assess the resident when their condition worsened between physician visits.

The home conducted an investigation of resident #001's care. The DOC confirmed that the pattern of staff inaction over a three week period in 2016, jeopardized the health, safety and well-being of resident #001 and constituted neglect as follows:
i) Neglecting to conduct pain assessments using an instrument designed for that purpose when initial interventions were not effective in managing pain;
ii) Neglecting to conduct skin and wound assessments when the condition of the extremity deteriorated;
iii) Neglecting to assess resident #001 when they complained of pain and numbness in their extremity when their care needs changed; and
iv) Neglecting to inform and/or request physician/RN in extended class to assess the resident when the resident's care needs changed. [s. 19. (1)]
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall do the following:

1. Assess a resident's pain using an instrument specifically designed for that purpose when they complain of pain according to the the home's policy;

2. Administer analgesia as prescribed, monitor the frequency of use, monitor the effectiveness of analgesia; and

3. Inform physician or RN in Extended Class if a resident's pain has increased as evidenced by increased use and decreased effectiveness of administered analgesia.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual Harm/risk
Scope: Isolated
Compliance history: This non compliance was previously issued as a VPC in January 2015.

2. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

According to health records, on a specified day in 2016, resident #001 complained to RN #102 that they had pain and numbness in an extremity. Interview with RN #102, and progress notes revealed that the RN observed an

issue of concern involving the extremity and the presence of pain.The RN completed a pain assessment using an instrument specifically designed for this purpose on that day, and an increase in medication was prescribed. During the following three weeks, the concerning issue worsened. The resident complained of pain several times during this time with increased frequency and severity as the time period progressed. Their pain medication was increased again and their request for medication also increased in number. According to health records, interviews with RNs #101 and #102, and the home's investigative notes, initial pain management interventions were not effective in relieving resident #001's pain during the three week time period. At the end of this time period, they were admitted to hospital and required extensive treatment of the affected extremity.

According to interview with the DOC, the home's "Pain and Symptom Management" policy number VII-G-30.10 last revised on January 2015, and investigative notes, staff were expected to conduct a pain assessment using the home's clinically relevant instrument designed for that purpose on residents who had new or worsening pain, or when the pain management plan of care was not effective in relieving their pain. In addition, resident #001's plan of care directed staff regarding monitoring and management of their pain characteristics, aggravating factors and relieving factors.

During interview, the DOC confirmed that resident #001 complained of progressively more pain including severe pain, had their pain medication increased, and requested more medication, all while the condition of their extremity worsened. The DOC confirmed that resident #001 had not been assessed when their pain was not relieved by initial interventions using a clinically appropriate assessment instrument specifically designed for pain assessment during a three week time period in 2016. [s. 52. (2)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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
TORONTO, 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
TORONTO, 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 28th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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