Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Apr 8, 2015	2015_198117_0007	O-001456-14 & O-001538-15	Complaint

Licensee/Titulaire de permis

CVH (No. 4) GP Inc. as general partner of CVH (No. 4) LP, c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, Cambridge, ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

LYNE DUCHESNE (117)

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): February 25 and 26, 2015

It is noted that two (2) complaint inspections were conducted during inspection: Log # O-001456-14 and #O-001538-15

It is noted that inspection # 2015-346133-0005 Log #O-001534-14 was conducted by Inspector #133 concurrently with this inspection. Some of the findings noted within that report are related to Log # O-001456-14.

During the course of the inspection, the inspector(s) spoke with the home's Director of Care (DOC), RAI Coordinator, several Registered Nurses(RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Office Manager, Program Manager Rehabilitation Services, laundry aides, as well as to an identified resident. The inspector also reviewed two identified residents' health care records; reviewed several of the home's policies including: lost clothing and belongings, care of residents with cast; examined resident mobility equipment and availability of continence products.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Hospitalization and Change in Condition
Minimizing of Restraining
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 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. 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 the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change. [Log #O-001538-15]

Resident #2 has advanced dementia, osteoporosis and is wheelchair bound. On a specific day in November 2014, Resident #2 complained of pain to his/her right leg. Narcotic medication prn was given with effect for pain management. The next day, Resident #2 complained of pain to his/her right leg. A bruise was noted on the right ankle. Narcotic medication was given for pain management with effect. The next day, the resident's bruise was noted to be larger; the right foot was also noted to be swollen and painful to touch. The resident was transferred to hospital for further assessment. Resident #2 was diagnosed with a fracture.

On a specific day in November 2014, Resident #2 returned to the long-term care home with the following order: "right identified fracture – air cast – seen by ortho – not surgical – identified pain medication order – Follow up with FMD (family physician) in 1 week."

Nursing staff reviewed the medical orders and contacted the attending physician. The Tylenol 975 mg po TID for pain management was implemented. No directives were noted to have been given in regards to the care of the air cast.

On a specific day in January 2015, 47 days after the return from hospital, the night staff reported that there was an odour coming from Resident #2's left foot. The night RPN went and assessed the resident's foot. As per progress notes, dead skin was noted on the resident's left heel. The presence of a bad odour was noted; a black point, with no open area, on the resident's left heel was observed. The area was cleansed and a request was made to have day shift nursing staff further assess the resident's foot.

Later in the morning, Resident #2's left foot was evaluated by day shift RPN S#101, with the assistance of a PSW. No odour was noted from the left foot. The black spot was noted to be clean and dry. The RPN then examined the resident's right leg air cast. She noted that the lower section of the air cast appeared to be darkened and that the odour was coming from the cast. The RPN opened the air cast. She noted that the resident had a sock on under the air cast. There was a large darkened moist spot at the level of the right foot metatarsals. The air cast and the sock were removed. An infected, malodorous open wound was noted on the top of Resident #2's right foot. The unit RN and then the attending physician were notified of the open wound. Resident #2 was transferred to

hospital for further assessment. The resident was subsequently admitted to hospital with an infected wound and a specified diagnosis.

On February 26 2015, Inspector #117 conducted a review of Resident #2's health care record. As per the chart documentation, on the specified day in November 2014 that the resident returned from hospital, the clinical care nurse did contact the attending physician regarding the resident's diagnosis and treatment directives. There was information related to pain management but no information noted to be given related to the care of the air cast. Resident #2's plan of care was updated by the clinical care nurse. It indicated that nursing staff were to "monitor the resident for signs and symptoms of acute pain" and to "utilize the pain flow record to evaluate the pain and report ineffectiveness immediately to the physician. Apply bootie (air cast) as indicated". However no directives related to the care and monitoring of the air cast were found in the resident's chart or in the plan of care.

Documentation indicates that from the day of the resident's return to the home in November 2014 and the next 7 days, registered nursing staff did monitor the cast, ensuring that it was in place, that resident's pedal pulse was palpable and that narcotic pain medication was given when pain was identified. No other information related to the status and care of the air cast was identified in the resident's chart.

The resident's chart also documents that the attending physician did see the resident ten (10) days after Resident #2's return from hospital in November, and then on two identified days in December 2014. Physician notes indicate that the resident is stable, that prn narcotic medication is being given for pain management and that there is no change in medication. No information or directives were noted to be present related the status and care needs of the air cast.

On February 26, 2015 unit RPN S#101 and RAI Coordinator stated that when Resident #2 returned from the hospital, the clinical care nurse did try, with no success, to contact the hospital to get directives regarding the care of the air cast. Both stated that this is the first time that the home had received a resident with an air cast. Unit RNs S#102 and S#103 as well as RPN S#101 stated that no directives or care guidelines were ever received related to the care of the air cast from either the hospital, the attending physician or from any other source. The RPN S#101 indicated that to her knowledge the nursing staff did not consult with the home's rehabilitation services or the Extendicare Nursing Consultant to get any other information related to the care of an air cast.

On February 26, 2015, Inspector #117 spoke with the home's Program Manager in charge of rehabilitation services. The Program Manager confirmed that no nursing staff member had approached Rehabilitation Services to get any information related to air casts. Interviewed PSW S#106, who provided regular care to the resident, stated to Inspector #117 that staff did have clear directions related to Resident #2's provision of daily personal care and positioning however there were no directives as it relates to the care of the air cast. The RPN S#101, RAI Coordinator and RNs S#102 and S#103 confirmed that to their knowledge no staff member had ever opened the air cast since its application in hospital on the specified day in November 2014 until 47 days late on the specified day in January 2015, when a foul odour was noted to come from the air cast.

On February 26 2015, the Director of Care (DOC) stated to Inspector #117 that the home does have policies on the provision of care to regular casts but not air casts. The DOC stated that the home has never had to provide care to a resident with an air cast. The DOC stated that she is not aware if the Extendicare Nursing Consultant was asked about any procedures, directives or care guidelines related to Resident #2's air cast, even though the Extendicare Nursing Consultant is in the home on a weekly basis. The DOC confirmed to the Inspector that although Resident #2's plan of care was revised after his/her return from hospital, there was no specific care directives identified in the plan of care related to the care of Resident #2's air cast. [s. 6. (10) (b)]

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to a resident in accordance with the directions specified by the prescriber. [Log #O-001456-14]

Resident #1 is diabetic, is prone to having skin rashes to his/her lower legs and has very fragile skin at risk of skin breakdown. Resident #1's current plan of care noted that staff are to moisturize resident's skin every shift with lotion and to pay special attention to the shin areas. The resident also has two prescribed medicated cream, that are to be applied twice a day to the resident's skin.

A review of the resident's health care record was conducted by Inspector #117 on February 26, 2015. December 2014 chart documentation indicates that the resident was observed to be frequently scratching his/her lower legs. Documentation notes that on a specific day in December 2014 there was an open area to a heel and 6 days later there were open areas to the resident's heel and on his/her shin. The Medication Administration Records (MAR) for December 2014 were reviewed.

It is noted that one prescribed medicated cream was noted to be applied in the mornings of four (4)specified days in December 2014, and in on every evening in December 2014. No other information was found related to the prescribed medicated cream being applied any other mornings in December.

It is noted that the second prescribed medicated cream was applied in the evenings of December 2014 but no information was found related to it's application in the mornings of December 2014.

Interviewed staff member RPN S#101 stated that when medicated creams are applied, nursing staff are to document their administration in the MAR. S#101 did not have an explanation as why the administration of the medicated creams were not documented. She was also unable to give information as to whether the two medicated creams were administered in accordance with the medical order or if they were not administered. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to a resident in accordance with the directions specified by the prescriber, to be implemented voluntarily.

Issued on this 8th day of April, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2015_198117_0007
Log No. / Registre no:	O-001456-14 & O-001538-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 8, 2015
Licensee / Titulaire de permis :	CVH (No. 4) GP Inc. as general partner of CVH (No. 4) LP, c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, Cambridge, ON N3H 5L8
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bipin Raut

To 1663432 ONTARIO LTD., 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.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

In order to achieve compliance with LTCHA s.6 (10) (b), the licensee shall ensure the following occurs when a resident returns from hospital, with a change of condition requiring a new treatment plan:
• The new treatment plan and the resident plan of care are to be reviewed and revised by the registered nursing care team members.
• Other care team members, including external resources, are to be consulted and included in the assessment and development of the care directives when required by the new treatment plan, especially if this new intervention is not known to the home.
• When the resident returns from hospital with a new treatment plan, not known to the home, all staff members who provide care to the resident are to receive education on the new treatment plan.
• The new treatment plan and care directives are to be clearly identified in the resident's plan of care. These are to be implemented as per the treatment plan.
• The treatment plan is to be reviewed, revised and evaluated on a weekly basis or more often as needed.

Grounds / Motifs :

1. Resident #2 has advanced dementia, osteoporosis and is wheelchair bound. On a specific day in November 2014, Resident #2 complained of pain to his/her right leg. Narcotic medication prn was given with effect for pain management. The next day, Resident #2 complained of pain to his/her right leg. A bruise was

noted on the right ankle. Narcotic medication was given for pain management with effect. The next day, the resident's bruise was noted to be larger; the right foot was also noted to be swollen and painful to touch. The resident was transferred to hospital for further assessment. Resident #2 was diagnosed with a fracture.

On a specific day in November 2014, Resident #2 returned to the long-term care home with the following order: "right identified fracture – air cast – seen by ortho – not surgical – identified pain medication order – Follow up with FMD (family physician) in 1 week."

Nursing staff reviewed the medical orders and contacted the attending physician. The Tylenol 975 mg po TID for pain management was implemented. No directives were noted to have been given in regards to the care of the air cast.

On a specific day in January 2015, 47 days after the return from hospital, the night staff reported that there was an odour coming from Resident #2's left foot. The night RPN went and assessed the resident's foot. As per progress notes, dead skin was noted on the resident's left heel. The presence of a bad odour was noted; a black point, with no open area, on the resident's left heel was observed. The area was cleansed and a request was made to have day shift nursing staff further assess the resident's foot.

Later in the morning, Resident #2's left foot was evaluated by day shift RPN S#101, with the assistance of a PSW. No odour was noted from the left foot. The black spot was noted to be clean and dry. The RPN then examined the resident's right leg air cast. She noted that the lower section of the air cast appeared to be darkened and that the odour was coming from the cast. The RPN opened the air cast. She noted that the resident had a sock on under the air cast. There was a large darkened moist spot at the level of the right foot metatarsals. The air cast and the sock were removed. An infected, malodorous open wound was noted on the top of Resident #2's right foot. The unit RN and then the attending physician were notified of the open wound. Resident #2 was transferred to hospital for further assessment. The resident was subsequently admitted to hospital with an infected wound and a specified diagnosis.

On February 26 2015, Inspector #117 conducted a review of Resident #2's health care record. As per the chart documentation, on the specified day in

November 2014 that the resident returned from hospital, the clinical care nurse did contact the attending physician regarding the resident's diagnosis and treatment directives. There was information related to pain management but no information noted to be given related to the care of the air cast. Resident #2's plan of care was updated by the clinical care nurse. It indicated that nursing staff were to "monitor the resident for signs and symptoms of acute pain" and to "utilize the pain flow record to evaluate the pain and report ineffectiveness immediately to the physician. Apply bootie (air cast) as indicated". However no directives related to the care and monitoring of the air cast were found in the resident's chart or in the plan of care.

Documentation indicates that from the day of the resident's return to the home in November 2014 and the next 7 days, registered nursing staff did monitor the cast, ensuring that it was in place, that resident's pedal pulse was palpable and that narcotic pain medication was given when pain was identified. No other information related to the status and care of the air cast was identified in the resident's chart.

The resident's chart also documents that the attending physician did see the resident ten (10) days after Resident #2's return from hospital in November, and then on two identified days in December 2014. Physician notes indicate that the resident is stable, that prn narcotic medication is being given for pain management and that there is no change in medication. No information or directives were noted to be present related the status and care needs of the air cast.

On February 26, 2015 unit RPN S#101 and RAI Coordinator stated that when Resident #2 returned from the hospital, the clinical care nurse did try, with no success, to contact the hospital to get directives regarding the care of the air cast. Both stated that this is the first time that the home had received a resident with an air cast. Unit RNs S#102 and S#103 as well as RPN S#101 stated that no directives or care guidelines were ever received related to the care of the air cast from either the hospital, the attending physician or from any other source. The RPN S#101 indicated that to her knowledge the nursing staff did not consult with the home's rehabilitation services or the Extendicare Nursing Consultant to get any other information related to the care of an air cast.

On February 26, 2015, Inspector #117 spoke with the home's Program Manager in charge of rehabilitation services. The Program Manager confirmed that no

nursing staff member had approached Rehabilitation Services to get any information related to air casts. Interviewed PSW S#106, who provided regular care to the resident, stated to Inspector #117 that staff did have clear directions related to Resident #2's provision of daily personal care and positioning however there were no directives as it relates to the care of the air cast. The RPN S#101, RAI Coordinator and RNs S#102 and S#103 confirmed that to their knowledge no staff member had ever opened the air cast since its application in hospital on the specified day in November 2014 until 47 days late on the specified day in January 2015, when a foul odour was noted to come from the air cast.

On February 26 2015, the Director of Care (DOC) stated to Inspector #117 that the home does have policies on the provision of care to regular casts but not air casts. The DOC stated that the home has never had to provide care to a resident with an air cast. The DOC stated that she is not aware if the Extendicare Nursing Consultant was asked about any procedures, directives or care guidelines related to Resident #2's air cast, even though the Extendicare Nursing Consultant is in the home on a weekly basis. The DOC confirmed to the Inspector that although Resident #2's plan of care was revised after his/her return from hospital, there was no specific care directives identified in the plan of care related to the care of Resident #2's air cast.

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 08, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of April, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

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