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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
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Bureau régional de services de Sudbury
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 24, 2013	2013_246196_0003	S-000092-13,S-000165-13	Complaint

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

LAUREN TENHUNEN (196)

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): September 23, 24, 25, 26, 2013

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care (MORC), Program Coordinators, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance and Housekeeping staff members, Physiotherapist (PT), Residents and Family Members

During the course of the inspection, the inspector(s) conducted a tour of home areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, reviewed various policies and procedures

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. Resident #006 was admitted to the home in May 2013 and sustained an injury from a fall, ten days later. The health care records were reviewed by the inspector and the initial physiotherapy (PT) assessment and note, identified the resident to be "at high risk for falls" and that the resident "requires one person minimal assistance for transfers and for ambulation for safety". The care plan that was in place at the time of the fall, included the focus of "risk for falls" but did not specify the resident as being a high risk for falls and also identified that they were "independent without the assistance of staff but with the use of walker". The plan of care was contradictory to the assessment completed by the PT, and therefore the assessment had not been integrated into the plan of care for resident #006.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

2. Resident #006 was admitted to the home in May 2013 and staff member #103 reported to the inspector that the resident was given a bed with full bilateral side rails. According to the substitute decision-maker (SDM), it was reported to staff at the time of admission, that their family member needed the same half rails as they had at the hospital in order to get up out of bed. A referral was sent two days after admission, via the computer, to the PT/OT department for the bed rails to be changed from full rails to half rails and noted "(resident #006) would benefit with bed with half rails. Rail at nite table side in horizontal position to assist with transfers". Ten days after admission, resident #006 sustained an injury from a fall after attempting to get out of bed. The railing which had been in use was a full rail and it had been lowered down. A progress note from June 2013 identified the receipt of a referral requesting partial bed rails but this was after the fall with injury and therefore had not been implemented.

The licensee failed to ensure that the resident's substitute decision-maker, was given an opportunity to participate fully in the development and specifically, the implementation of the resident's plan of care as it relates to bed rails. [s. 6. (5)]

3. In early May 2013, a Critical Incident report was submitted to the Director, outlining resident #004's fall with injury and subsequent transfer to hospital. According to the report, a staff member was assisting the resident to walk, had the transfer belt on the resident and the staff turned away and let go of the transfer belt for a short moment,

and the fall occurred. The health care records for resident #004 were reviewed. The fall risk assessment completed by nursing staff prior to this fall incident, noted the resident to be a moderate risk for falls. The care plan in place at the time of the fall was reviewed and included, under the focus of transferring, the goal of "(resident #004) will receive the necessary physical assistance provided by staff" along with the intervention of "One person assist from bed to/from w/c using walker with transfer belt....".

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. On September 25, 2013, the health care records for resident #006, specifically the kardex and the care plan, were reviewed for information. The kardex with a print date of Sept. 16, 2013 and the current care plan, identified the resident as being "bed ridden", and for transferring it identified the resident as "provide 2 person extensive assistance when transferring the resident from bed to w/c and w/c to bed with a transfer belt. Remove the left armrest. Use the walker and let (resident #006) walk for few steps to position (themself) on the w/c properly prior to sitting on it". An interview was conducted with staff member #104 and it was reported that this information is not accurate as it has not been updated to reflect the current needs of the resident, as the resident is no longer bed ridden and can't walk.

The licensee failed 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, the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002, 003 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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1. In early May 2013 a Critical Incident report was submitted to the Director, outlining resident #004's fall with injury and subsequent transfer to hospital. According to the report, a staff member was assisting the resident to walk, had the transfer belt on the resident and the staff turned away and let go of the transfer belt for a short moment and the fall occurred. The health care records for resident #004 were reviewed. The fall risk assessment completed by nursing staff prior to this fall incident, noted the resident to be a moderate risk for falls. The RAI/MDS assessment completed prior to the fall, identified the resident as having an unsteady gait and requiring extensive assistance of one person for transfers. The care plan in place at the time of the fall under the focus of "transferring from one position to another related to: unsteady gait, physical limitations" identified the goal of "(resident #004) will receive the necessary physical assistance provided by staff" and the intervention of "One person assist from bed to/from w/c using walker with transfer belt. Sit to Stand lift to be used when afternoon or when (the resident) is fatigued. (resident #004) is weak/tired which is observed mostly in the afternoon".
The health care records identified the resident's need for assistance of one staff with transfer belt and use of a walker due to risk for falls and unsteady gait. On a particular day in May 2013, staff did not use safe transferring techniques when assisting resident #004, in that staff failed to use a transfer belt and a walker throughout the entire transfer.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

Additional Required Actions:

CO # - 004 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. In June 2013, a Critical Incident report was submitted to the Director, outlining resident #006's fall with fracture and subsequent transfer to hospital. The health care records for resident #006 were reviewed and a post-fall assessment could not be found. An interview was conducted with management staff member #100 and it was reported as being done but it could not be located online by management staff.

The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. On Sept. 23, 2013 at 1500hrs, the hand rail between room K124 and the clean utility room on the Killarney unit was observed to be missing and there was an electrical tube taped to the wall and holes in the wall board where the railing had previously been affixed. An interview was conducted with management staff member #102 on Sept. 25, 2013 and it was reported that the hand rail was damaged the previous Friday Sept. 20, 2013. In addition, it was reported that the electrical wires had been made safe, wrapped in electrical tape and that staffing issues in the maintenance department have delayed the repair and it will be repaired tomorrow Sept. 26, 2013.

As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee failed to ensure that, (a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair. [s. 90. (1) (a)]

Issued on this 30th day of December, 2013

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

Lauren Lenhurst #196.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2013_246196_0003
Log No. / Registre no:	S-000092-13,S-000165-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 24, 2013
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY PARMAR

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

Order / Ordre :

The licensee shall ensure that the staff and others involved in the different aspects of care for resident #006, collaborate with each other, in the assessment of this resident so that their assessments are integrated and are consistent with and complement each other.

Grounds / Motifs :

1. Resident #006 was admitted to the home in May 2013 and sustained an injury from a fall ten days later. The health care records were reviewed by the inspector and the initial physiotherapy (PT) assessment and note, identified the resident to be "at high risk for falls" and that the resident "requires one person minimal assistance for transfers and for ambulation for safety". The care plan that was in place at the time of the fall, included the focus of "risk for falls" but did not specify the resident as being a high risk for falls and also identified that they were "independent without the assistance of staff but with the use of walker". The plan of care was contradictory to the assessment completed by the PT, and therefore the assessment had not been integrated into the plan of care for resident #006.

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

Previous non-compliance resulting in a WN pursuant to s. 6.(4)(a) was issued December 11, 2012, inspection report #2012_138151_0018. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

Order # / Ordre no : 002

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee shall ensure that resident #006's substitute decision-maker and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Grounds / Motifs :

1. Resident #006 was admitted to the home in May 2013 and staff member #103 reported to the inspector that the resident was given a bed with full bilateral side rails. According to the substitute decision-maker (SDM), it was reported to staff at the time of admission, that the resident needed the same half rails as they had at the hospital in order to get up out of bed. A referral was sent two days after admission, via the computer, to the PT/OT department for the bed rails to be changed from full rails to half rails and noted "(resident #006) would benefit with bed with half rails. Rail at nite table side in horizontal position to assist with transfers". Ten days after admission, in early June 2013, resident #006 sustained a fracture from a fall after attempting to get out of bed. The railing which had been in use was a full rail and it had been lowered down. A progress note dated the day after the fall, identified the receipt of referral requesting partial bed rails but this was after the fall with fracture and therefore had not been implemented.

The licensee failed to ensure that the resident's substitute decision-maker, was given an opportunity to participate fully in the development and specifically, in the implementation of the resident's plan of care, as it relates to bed rails.

Previous non-compliance resulting in a WN/VPC pursuant to s.6.(5) was issued December 11, 2012, inspection #2012_138151_0017. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

Order # / Ordre no : 003 **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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to resident #004 as specified in the plan.

Grounds / Motifs :

1. In May 2013, a Critical Incident report was submitted to the Director, outlining resident #004's fall with injury and subsequent transfer to hospital. According to the report, a staff member was assisting the resident to walk, had the transfer belt on the resident and the staff turned away and let go of the transfer belt for a short moment, and the fall occurred. The health care records for resident #004 were reviewed. The fall risk assessment completed prior to this fall incident, noted the resident to be a moderate risk for falls. The care plan in place at the time of the fall was reviewed and included, under the focus of transferring, the goal of "(resident #004) will receive the necessary physical assistance provided by staff" with the intervention of "One person assist from bed to/from w/c using walker with transfer belt....".

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Previous non-compliance resulting in a WN/VPC pursuant to s. 6.(7) was issued May 3, 2013, inspection #2013_138151_0016.
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting resident #004.

Grounds / Motifs :

1. In May 2013 a Critical Incident report was submitted to the Director, outlining resident #004's fall with injury and subsequent transfer to hospital. According to the report, a staff member was assisting the resident to walk, had the transfer belt on the resident and the staff turned away and let go of the transfer belt for a short moment and the fall occurred. The health care records for resident #004 were reviewed. The fall risk assessment completed prior to this fall incident, noted the resident to be a moderate risk for falls. The RAI/MDS assessment completed prior to the fall, identified the resident as having an unsteady gait and requiring extensive assistance of one person for transfers. The care plan in place at the time of the fall under the focus of "transferring from one position to another related to: unsteady gait, physical limitations" identified the goal of "(resident #004) will receive the necessary physical assistance provided by staff" and the intervention of "One person assist from bed to/from w/c using walker with transfer belt. Sit to Stand lift to be used when afternoon or when (the resident) is fatigued. (resident #004) is weak/tired which is observed mostly in the afternoon".
The health care records identified the resident's need for assistance of one staff with transfer belt and use of a walker due to risk for falls and unsteady gait. On a particular day in May 2013, staff did not use safe transferring techniques when assisting resident #004, in that staff failed to use a transfer belt and a walker throughout the entire transfer.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #196.

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

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