



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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**

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, 4^{ième} étage
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**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 17, 25, 2014	2014_396103_0008	O-000872- 14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street, KINGSTON, ON, K7L-2Z3

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

RIDEAUCREST HOME
175 RIDEAU STREET, KINGSTON, ON, K7K-3H6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 12-14, 17-19, 2014

The following logs were included in this inspection: O-000872-14, O-000898-14 and O-001101-14.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Dietitian, the Assistant Director of Care (ADOC), Maintenance Supervisor, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) observed resident care and reviewed resident health care records.

**The following Inspection Protocols were used during this inspection:
Contenance Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :



1. The licensee has failed to ensure that a door leading to a non-residential area was locked when not being supervised by staff.

On November 17, 2014 on or about 1415 hours, this inspector found the door which leads into the service area elevator and the third floor servery propped open with a large yellow pylon and a note stating, "Do not remove, no code works".

This inspector was able to access the servery and had access to the hot water spigot utilized for hot drinks as well as the steam table, fridges etc.

There were six residents seated in the circle area that is adjacent to this door, one resident walking in the vicinity and there were no staff visible.

S#108 was interviewed and confirmed the keypad to the door had been problematic for one week and needed to be replaced. S#108 stated the door was observed propped open earlier in the day but the barrier was removed at that time. S#108 indicated service was requested one week ago, a part was required to be ordered and confirmed the service would be completed today. S#108 indicated dietary staff have access to the servery through the main dining room doors that are locked outside of regular dining service. S#108 indicated the staff should have been entering the servery through these locked doors until such time the keypad could be repaired.

In a discussion with the Administrator, she stated the door would not be left unsupervised until such time the keypad could be replaced and the door could be locked. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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).

Findings/Faits saillants :



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

On an identified date, Resident #3 was reported missing on or about 1515 hour. Staff conducted a search of the home unit and discovered the resident seated on the toilet in the tubroom. The incident was immediately reported to the ADOC. Upon investigation, the home found the resident had been toileted by a staff member from the day shift on or about 1415hr. The staff member left the resident unattended on the toilet and then went off duty, failing to report the resident's status to the oncoming shift.

Resident #3's care plan related to toileting, in effect at the time of this incident, stated:

- 1 person extensive assistance
- do not leave resident unattended on toilet, due to recent falls
- resident is known to attempt to transfer on own
- too high a risk to leave alone.

During the investigation into this incident, the ADOC interviewed S#113 who stated they were unaware the resident could not be left unattended and that they had previously left the resident alone during toileting. During the investigation it was determined the information related to this resident's toileting needs were outlined in the binder that is accessible to the PSW staff. [s. 6. (7)]

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 the care set out in Resident #3's care plan is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints



Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure written complaints received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

On an identified date, a written complaint was sent by a family member to the Director of Care and the Administrator alleging resident neglect. This written complaint was not forwarded to the Director until two days later.

On the same identified date, a second written complaint was sent by a family member to the Commissioner at the City of Kingston alleging that basic needs are not being met due to staffing shortages. The DOC was made aware of this letter the following day. To date of this inspection, this written complaint has not been forwarded to the Director. [s. 22. (1)]

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 all written complaints concerning the care of a resident or the operation of the long term care home are immediately forwarded to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that the results of every investigation into allegations of resident abuse are reported to the Director.

On an identified date, an allegation of staff to resident abuse was reported to the home regarding Resident #4 by a family member. The home conducted an investigation into the allegations but failed to inform the Director (MOHLTC) of the outcome of the investigation.

Note that a Compliance Order #001 for LTCHA 2007, S.O. 2007, c.8, s.19, was issued during Inspection # 2014_179103_0015. Full compliance for this Compliance Order was due on September 15, 2014. Therefore, the above evidence is additional information for Compliance Order #001. [s. 19. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that the home's zero tolerance of abuse policy was complied with.

On an identified date, the home investigated an allegation of staff to resident neglect. An investigation into the allegation was completed by the home, but the home failed to notify the family of the outcome of the investigation.

The home's abuse policy, OPER-02-02-04 states under "Upon Notification", promptly notify the resident and their substitute decision maker/power of attorney, if any, of the investigation results.

Note that a Compliance Order #002 for LTCHA 2007, S.O. 2007, c.8, s.20, was issued during Inspection # 2014_179103_0015. Full compliance for this Compliance Order was due on September 15, 2014. Therefore, the above evidence is additional information for Compliance Order #002. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,

(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).

(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).

(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documented record of verbal and written complaints is reviewed and analyzed for trends at least quarterly and a written record is kept of each review and of the improvements made in response.

S#106 was asked to provide this inspector with the written record of the home's review and analysis of the verbal and written complaints received. S#106 stated from January 6, 2014 to the date of this inspection, there are no written records available. [s. 101. (3)]



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**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE
BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES
SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

**COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:**

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #901	2014_396103_0008	103

Issued on this 25th day of November, 2014

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



**Ministry of Health and
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**Ministère 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) : DARLENE MURPHY (103)

Inspection No. /

No de l'inspection : 2014_396103_0008

Log No. /

Registre no: O-000872-14

Type of Inspection /

Genre

d'inspection:

Critical Incident System

Report Date(s) /

Date(s) du Rapport : Nov 17, 25, 2014

Licensee /

Titulaire de permis : THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street, KINGSTON, ON, K7L-2Z3

LTC Home /

Foyer de SLD : RIDEAUCREST HOME
175 RIDEAU STREET, KINGSTON, ON, K7K-3H6

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Debra A Green

To THE CORPORATION OF THE CITY OF KINGSTON, you are hereby required to
comply with the following order(s) by the date(s) set out below:

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*

Order # /

Ordre no : 901

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

- i. kept closed and locked,
- ii. equipped with a door access control system that is kept on at all times, and
- iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee is hereby ordered to ensure all doors leading to non-residential areas are closed and locked when they are not being supervised by staff.

Grounds / Motifs :



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*

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This inspector was able to access the servery and had access to the hot water spigot utilized for hot drinks as well as the steam table, fridges etc.

There were six residents seated in the circle area that is adjacent to this door, one resident walking in the vicinity and there were no staff visible.

S#108 was interviewed and confirmed the keypad to the door had been problematic for one week and needed to be replaced. S#108 stated the door was observed propped open earlier in the day but the barrier was removed at that time. S#108 indicated service was requested one week ago, a part was required to be ordered and confirmed the service would be completed today. S#108 indicated dietary staff have access to the servery through the main dining room doors that are locked outside of regular dining service. S#108 indicated the staff should have been entering the servery through these locked doors until such time the keypad could be repaired.

In a discussion with the Administrator, she stated the door would not be left unsupervised until such time the keypad could be replaced and the door could be locked.

(103)



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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 : Nov 18, 2014



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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



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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.



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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, 11^e 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.



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de l'article 154 de la *Loi de 2007 sur les foyers
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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 17th day of November, 2014

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : DARLENE MURPHY

Service Area Office /

Bureau régional de services : Ottawa Service Area Office