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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
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Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
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Télécopieur: (416) 327-4486

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
Apr 11, 2014	2014_163109_0010	T-195-14	Complaint

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

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

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

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

This inspection was conducted on the following date(s): March 14, 17, 19, 20, 2014.

Areas of noncompliance related to Resident Rights from inspection #2014_163109_0005 which corresponds with Log # T-430-13 and inspection # 2014_163109_0009 and corresponds with Log # T-659-13 and T-156-14 are included in this inspection report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Dietitian (RD), Personal Support Workers (PSW), Substitute Decision Maker (SDM), registered staff.

During the course of the inspection, the inspector(s) conducted a walk through of care units, observed staff interactions, observed lunch meal, review of health record for identified resident, review of policies related to nutritional care and zero tolerance of abuse and neglect, reviewed the home's complaints for identified resident.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to promote resident #10's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date resident #10's evening care (from 3-11pm) was provided by an identified PSW. When resident #10 called for assistance with specified care, the staff member asked the resident why he/she was ringing the call bell again. The staff member then told the resident about his/her own health conditions, the need to take a break to eat and that the resident would have to wait for care. Resident #10 responded by offering some of her/his own food.

An interview conducted with the identified staff member confirmed that the statements were made to resident #10. Furthermore, the staff member stated that she/he only told the resident because she/he felt that resident #10 would call again.

The resident indicated that he/she felt angry and frustrated that he/she has to wait for care to be provided. A progress note on a specified date states that resident #10 was tired of having to fight to keep clean, and experiencing a guilt trip from unprofessional staff when he/she uses the call bell and asks for assistance with care.

Resident #10 told the inspectors that he/she has experienced numerous instances of

staff treating him/her disrespectful and has complained numerous times to the home's management. Resident #10 told inspectors that the staff member from a specified date also told her that he/she was very busy, and that resident #10 is not the only person living here, and that the staff member was going to leave and the resident would just have to wait. The accused staff member denied saying this to the resident.

Resident #10 further alleged that another PSW left him/her lying on the bed exposed when the staff became frustrated with the resident during continence care and walked out of the room. [s. 3. (1) 1.]

2. The licensee failed to ensure that resident #10's right to be protected from abuse was fully respected and promoted.

Section 3(1)2 was previously issued for resident #10 in inspection #2012_162109_0003 with a compliance order served on November 27, 2012.

Resident #10 was subject to verbal abuse which included communication that diminished the resident's sense of well-being, dignity and self-worth from the staff. In addition, the resident was subject to emotional abuse including shunning, ignoring and lack of acknowledgement from the staff.

On an identified date, the resident was engaged in a verbal altercation with an identified staff member, during which the staff member told the resident that she/he was wicked and evil, and not Christian.

A record review of the home's incident investigation and interview of staff and resident revealed that both the resident and the staff confirmed that this verbal altercation had occurred. The staff member was disciplined. Resident #10 stated that she/he is tired of being humiliated and not getting help from some staff when requested. [s. 3. (1) 2.]

3. The licensee failed to ensure that resident #5's right to be protected from abuse was fully respected and promoted.
Record review and staff interviews confirmed that resident #5 was abused by co-resident #4. Both residents are cognitively impaired.

4. The licensee failed to ensure that the resident's right not to be neglected by the licensee or staff was respected and promoted.

On an identified date resident #11 was neglected when the staff refused to provide care and the resident was left sitting in soiled incontinence brief.

At an identified time the call bell was activated from the resident #11's bedroom. The call bell was activated 9 more times by the POA during a 2 hour time frame from 7:20 pm to 9:17 pm requesting care to be provided to the resident. Staff members attempted to shut the call bell off and the family member refused to let them shut the bell off until care was provided to the resident. The call bell was noted on the call bell detail report to have rang for 30 min or longer on more than one occasions over the 2 hour period of time. The assigned staff member refused to allow the POA to assist with care, and refused to leave the bathroom door open during care at the POA's request. Staff interview revealed that the assigned PSW refused to provide care to the resident while the resident's POA was in attendance even when other staff offered to assist. The charge nurse then summoned another staff member to provide care to the resident which was over 2 hours past the initial care request. When the care was finally rendered, the resident was found to be incontinent of bowel and bladder functions.

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident was immediately reported to the Director.
On an identified date, resident #11 sustained a bruise to the right eye. The physician assessed the resident for injury and was unable to determine how the bruise was sustained. The SDM for the resident suspected that the resident had been abused by the staff and called the police to report an abuse. The police investigated the suspicion of abuse and determined that there was no evidence of assault.
The licensee did not report the suspicion of abuse to the Director. [s. 24. (1)]

Ontario

Ministry of Health and Long-Term Care

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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

Issued on this 30th day of April, 2014

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

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

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) :	SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2014_163109_0010
Log No. / Registre no:	T-195-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 11, 2014
Licensee / Titulaire de permis :	WEST PARK HEALTHCARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	WEST PARK LONG TERM CARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TRISH TALABIS

To WEST PARK HEALTHCARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

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

i. the Residents' Council,

ii. the Family Council,

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

iv. staff members,

v. government officials,

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that the following resident rights are fully respected and promoted.

Resident #10's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Resident #5 and #10's right to be protected from abuse.

Resident #11's right not to be neglected by the licensee or staff.

Please submit compliance plan to susan.squires@ontario.ca on or before April 18, 2014

Grounds / Motifs :

1. The licensee failed to promote resident #10's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date resident #10's evening care (from 3-11pm) was provided by an identified PSW. When resident #10 called for assistance with specified care, the staff member asked the resident why he/she was ringing the call bell again. The staff member then told the resident about her own health conditions, the need to take a break to eat and that the resident would have to wait for care. Resident #10 responded by offering some of her/his own food.

An interview conducted with the identified staff member confirmed that the statements were made to resident #10. Furthermore, the staff member stated that she/he only told the resident because she/he felt that resident #10 would call again.

The resident indicated that he/she felt angry and frustrated that he/she has to wait for care to be provided. A progress note on a specified date states that resident #10 was tired of having to fight to keep clean, and experiencing a guilt trip from unprofessional staff when he/she uses the call bell and asks for assistance with care.

Resident #10 told the inspectors that he/she has experienced numerous instances of staff treating him/her disrespectful and has complained numerous times to the home's management. Resident #10 told inspectors that the staff member from a specified date also told her that he/she was very busy, and that resident #10 is not the only person living here, and that the staff member was going to leave and the resident would just have to wait. The accused staff member denied saying this to the resident.

Resident #10 further alleged that another PSW left him/her lying on the bed exposed when the staff became frustrated with the resident during continence care and walked out of the room

(109)

2. The licensee failed to ensure that resident #5's right to be protected from abuse was fully respected and promoted.

Record review and staff interviews confirmed that resident #5 was abused by co-resident #4. Both residents are cognitively impaired.

(109)

3. The licensee failed to ensure that resident #10's right to be protected from abuse was fully respected and promoted.

Section 3(1)2 was previously issued for resident #10 in inspection #2012_162109_0003 with a compliance order served on November 27, 2012.

Resident #10 was subject to verbal abuse which included communication that diminished the resident's sense of well-being, dignity and self-worth from the staff. In addition, the resident was subject to emotional abuse including shunning, ignoring and lack of acknowledgement from the staff.

On an identified date, the resident was engaged in a verbal altercation with an identified staff member, during which the staff member told the resident that she/he was wicked and evil, and not Christian.

A record review of the home's incident investigation and interview of staff and resident revealed that both the resident and the staff confirmed that this verbal altercation had occurred. The staff member was disciplined. Resident #10 stated that she/he is tired of being humiliated and not getting help from some staff when requested.

(109)

4. The licensee failed to ensure that the resident's right not to be neglected by the licensee or staff was respected and promoted.

On an identified date resident #11 was neglected when the staff refused to provide care and the resident was left sitting in soiled incontinence brief.

At an identified time the call bell was activated from the resident #11's bedroom. The call bell was activated 9 more times by the POA during a 2 hour time frame from 7:20 pm to 9:17 pm requesting care to be provided to the resident. Staff members attempted to shut the call bell off and the family member refused to let them shut the bell off until care was provided to the resident. The call bell was noted on the call bell detail report to have rang for 30 min or longer on more than one occasions over the 2 hour period of time. The assigned staff member refused to allow the POA to assist with care, and refused to leave the bathroom door open during care at the POA's request. Staff interview revealed that the assigned PSW refused to provide care to the resident while the resident's POA was in attendance even when other staff offered to assist. The charge nurse then summoned another staff member to provide care to the resident which was over 2 hours past the initial care request. When the care was finally rendered, the resident was found to be incontinent of bowel and bladder functions.
(109)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 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 Licensée 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.

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

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 11th day of April, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SUSAN SQUIRES

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