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

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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
Jun 12, 2014	2014_258519_0013	L-000617-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF WELLINGTON
74 WOOLWICH STREET, GUELPH, ON, N1H-3T9

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

WELLINGTON TERRACE LONG-TERM CARE HOME
474 Wellington Road 18, FERGUS, ON, N1M-0A1

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

SHERRI GROULX (519), DEBORA SAVILLE (192), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 3, 4, 5, 6, 9, 10, 2014

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, the Director of Care, the Environmental Services Manager, a Team Leader, a Nutritional Service Worker, Environmental Service Workers, Registered Practical Nurses, Registered Nurses, a Family Council member, Personal Support Workers, Family members and Residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage area and care provided to Residents, reviewed medication records and plans of care for specified Residents, reviewed policy and procedures, observed recreational programming, staff interaction with Residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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 O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and , if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Interview with the Director of Care (DOC) confirmed that where bed rails are used Residents of the home have not been assessed to minimize risk to the Resident and bed systems where bed rails are used have not been evaluated to identify potential zones of entrapment.

During observation in Stage 1 of this inspection, 27 of 40 residents were observed by the Inspectors to have one or more bed rails in the up position.

It was also observed that where the bed rails were in the up position, beds were observed to have keepers at the foot of the bed to secure the mattress but no keepers were in place at the head of the bed, allowing the mattress at the head of the bed to move out of place with minimal lateral pressure and creating a potential zone of entrapment. This was confirmed with the Director of Care. [s. 15. (1) (a)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
A review of a Resident's records revealed that the resident had altered skin integrity however, there were no weekly reassessments completed for the resident.

A Resident assessment indicated that the Resident had altered skin integrity however, there were no weekly reassessments completed. This was confirmed by the Director of Care. [s. 50. (2) (b) (iv)]

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 ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances are labeled properly and kept inaccessible to residents at all times.

During the inspection a housekeeping cart was observed in a corridor unattended and unlocked.

The cart contained chemicals that were accessible to Residents passing by, including window cleaner, toilet bowl cleaner and other substances. The cart was left unattended for a period greater than five minutes. The housekeeper was observed to have returned to the cart and was locking the storage compartment several minutes later.

Hazardous substances were left accessible to residents in the unlocked, unattended housekeeping cart. [s. 91.]

2. The licensee of the long term care home failed to ensure that all hazardous substances at the home were labeled properly and kept inaccessible to Residents at all times.

During the inspection the hair salon was left open and unattended. Barbicide and disinfectant chemicals were located in the unlocked cabinet and accessible to Residents. A Registered Practical Nurse and the Director of Care confirmed that the door was to be locked when left unattended. [s. 91.]

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 ensuring that all hazardous substances are labeled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there is a written plan of care for each resident that sets out, the planned care for the resident.

A Resident was observed to be laying in bed with two quarter rails in place at the head of the bed.

The plan of care was reviewed and did not include the use of bed rails.

Interview with Registered staff confirmed the use of bed rails for this Resident.

Interview with the Director of Care confirmed that any resident using a bed rail in any position should be included on the plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the resident was 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 changed.

A Resident's plan of care indicated that the Resident currently had altered skin integrity however, a Registered Practical Nurse stated the Resident currently did not.

The Director of Care verified using the health care record that the Resident currently had skin irritation however, did not have altered skin integrity at this time.

The Resident's plan of care was not revised when the Resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

3. The licensee failed to ensure that when the resident is reassessed that the the plan of care is 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.

A Resident had an exam where a request was made for a new personal aid. This Resident picked out this new personal aid. The personal aid was received from the Vendor. Upon review of the Resident's care plan it was noted that this updated assessment and the fact that this Resident had a new personal aid was not included in the plan of care. According to a Registered Practical Nurse (RPN) responsible for this Resident it was stated that the direct care staff access information regarding the Resident's personal aids at the bedside. This information is in a folder that contains the care plan, therefore this information was not accessible to them. This was confirmed by the RPN. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's Falls Prevention policy indicated that follow up documentation on the Resident's health care record was required for three consecutive shifts following a fall without injury and for six consecutive shifts following a fall with injury.

A review of a Resident's health care record revealed that the second shift of three consecutive shifts did not complete follow up documentation on the Resident's health care record after a fall. The third shift of three consecutive shifts did not complete follow up documentation on the Resident's health care record after a fall.

The Director of Care verified that the documentation was incomplete following both falls and that the home's falls policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's Falls Prevention policy indicated that a falls risk assessment would be completed on the day of admission, when there had been a change in the Resident's health status, when a fall Resident Assessment Protocol (RAP) was triggered by Resident Assessment Instrument (RAI) Minimum Data Set (MDS) and annually on all residents during the first quarter of a calendar year.

A review of a Resident's records revealed that there was no falls risk assessment completed when a fall RAP was triggered by RAI-MDS.

The Director of Care confirmed that the falls risk assessment was not completed as indicated in the home's policy.

The home's Falls Prevention policy indicated that follow up documentation on the Resident's health care record was required for three consecutive shifts following a fall without injury and for six consecutive shifts following a fall with injury.

A review of a Resident's health care record revealed that the sixth shift of six did not complete follow up documentation on the Resident's health care record when the Resident sustained a fall with injury.

The Director of Care verified that the home's fall policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with applicable requirements under the Act.

The home's Skin and Wound policy indicated that the Registered Dietitian and Physiotherapy would be notified of any new pressure ulcer of stage II or greater however, section 50(2)(b)(iii) of the Ontario Regulation 79/10 indicates that a Resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will be assessed by a Registered Dietitian who is a member of the staff of the home and and any changes made to the Resident's plan of care relating to nutrition and hydration are implemented.

The Director of Care confirmed that the home's practice did not include a referral to the Registered Dietitian for completion of assessments for Resident's exhibiting altered skin integrity including skin breakdown, skin tears and stage I ulcers. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a Resident received fingernail care, including cutting of fingernails.

During observation in the inspection a Resident was observed to have long finger nails. During interview the Resident stated they prefer their finger nails to be shorter. Record review and interview confirm that Resident's are to have their finger nails trimmed on their designated bath day.

Observation after the Resident's bath day identified the Resident to have long finger nails. There was no documentation of finger nail care having been provided.

Review of the plan of care indicated that the Resident's preference is to have their nails trimmed regularly. [s. 35. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and in the case of new items, of acquiring.

A Resident acquired a new personal aid. Upon interview with a Registered Practical Nurse (RPN) it was confirmed that this Resident's personal aid had not been labeled with their name more than 48 hours after acquiring them. Four days later it was confirmed with the same RPN that this Resident's personal aid had still not been labeled with their name. The personal aid was observed by the inspector to be in the Resident's bed side table in a case, and were not labeled with their name. [s. 37. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that any pet visiting as part of a pet visitation program had up to date immunizations.

The home had an agreement with St.John's Ambulance Therapy Dog program however, the Director of Care confirmed that they do not track immunization of the visiting dogs at the home. [s. 229. (12)]

Issued on this 12th day of June, 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) :	SHERRI GROULX (519), DEBORA SAVILLE (192), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_258519_0013
Log No. / Registre no:	L-000617-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 12, 2014
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF WELLINGTON 74 WOOLWICH STREET, GUELPH, ON, N1H-3T9
LTC Home / Foyer de SLD :	WELLINGTON TERRACE LONG-TERM CARE HOME 474 Wellington Road 18, FERGUS, ON, N1M-0A1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER BARNES

To CORPORATION OF THE COUNTY OF WELLINGTON, 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 :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that the residents are assessed and their bed system is evaluated in accordance with evidence-based practices, to minimize risk to the resident.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and , if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Interview with the Director of Care (DOC) confirmed that where bed rails are used residents of the home have not been assessed to minimize risk to the resident and bed systems where bed rails are used have not been evaluated to identify potential zones of entrapment.

During observation in Stage 1 of this inspection; 27 of 40 residents were observed by the Inspectors to have one or more bed rails in the up position.

It was also observed that where the bed rails were in the up position, beds were observed to have keepers at the foot of the bed to secure the mattress but no keepers were in place at the head of the bed, allowing the mattress at the head of the bed to move out of place with minimal lateral pressure and creating a potential zone of entrapment. This was confirmed with the Director of Care. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 29, 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 12th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Groulx

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