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
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
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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 |
|---|---|---|---|
| Feb 6, 2014 | 2014_241502_0001 | T-697-13 | Follow up |

**Licensee/Titulaire de permis**

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

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

JULIENNE NGONLOGA (502)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): January 14, 15, 2014.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON), Nurse Managers (NM), Dietitian, Nutritional Managers, Registered staff, Personal Care Aides (PCA).**

**During the course of the inspection, the inspector(s) observed dining services, provision of resident care, staff/resident interactions, review health records, staff training records.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

A review of the home's education package, "safe positioning and assisting the residents at mealtime and snacks", used during a mandatory staff in-service July and August 2013, outlined the home's expectation on the correct position of residents and staff during meals. The information included the following: the resident must be in the correct position, feet on the ground, seating up straight/upright, chin at 90 degrees angle and seated at an appropriate height. The staff must be in the correct position to help a resident to eat, seated and face to face; same height as resident; and they must adjust their seat so they are at the resident's eye level.
On an identified date, during the afternoon snack service, Resident #5 was observed to be in an unsafe feeding position while being assisted with eating by personal care aide #1 (PCA). Resident #5 was observed in a reclined position in his/her chair while PCA #1 spoon fed him/her snack. The staff member was standing over the reclined resident to assist with feeding. The resident was lying back in a reclined, resting position, his/her head was facing towards the ceiling, resident's eyes were alert and resident was taking spoonful of snack.

An interview with PCA #1 revealed that he/she acknowledged that Resident #5 was not being assisted in the proper feeding position and that the resident does not hold his/her head upright. The PCA then proceeded to elevate the resident's head with a folded cloth, which slightly elevated the resident head until he/she finished feeding.

Registered nurse was notified by the inspector to assess Resident #5 position for feeding. The registered staff stated that the position was not safe for feeding, that it was a "resting position", and confirmed that all staff should put residents upright as close to a 90 degree angle as possible prior to assisting with feeding. To demonstrate the proper feeding position, the registered staff moved Resident #5 upright into the expected feeding position by adjusting the resident's chair.

An interview with the registered dietitian revealed that Resident #5 is at risk of aspiration with his/her diet modified. The RD stated a reclined position is not safe to feed anyone and the resident should be seated upright, close to a 90 degree angle and feet flat on the floor. The RD stated that the described feeding position of Resident #5 was not safe, and "I would not let anyone put something in my mouth at that angle".

Record review of Resident #5's current care plan revealed directions to staff to ensure resident is upright at 90 degree angle during meals.

On an identified date, the inspector observed Resident #6, being fed breakfast in bed by a PCA. The resident was observed having been fed with signs of cereal on his/her mouth when inspectors entered resident's room. The resident was reclined, not upright or close to a 90 degree angle and the resident was heard coughing.

After the inspector entered the room, PCA #2 instantly raised the head of the resident's bed. After raising the head of Resident #6's bed, his/her head was leaning back and his/her eyes were in line with the top of the resident's privacy curtain; not positioned at staff's eye level. The position caused resident's chin to be raised, not at a 90 degree angle, while being fed. The resident was heard with a wet cough. Staff member continued to feed.

A RN was approached by inspector and entered Resident #6's room while resident was being fed. The RN stated that the resident should be fed in an upright position at eye level to the staff assisting and that Resident #6's feeding position was not correct. The RN insisted that little could be done because the bed's head was elevated to its maximum. Despite the RN acknowledging that the resident feeding position was not upright and not safe, the PCA continued to feed the resident.

After the inspector questioned the feeding position of Resident #6 the RN and PCA repositioned the resident to an upright position whereby residents chin was down, eyes and face in line with staff at eye level. Both staff stated that the resident's position was better for feeding and close at 90 degree angle. After the resident was in an upright position, the inspector did not hear any further coughing from the resident.

Record review of Resident #6's current care plan revealed directions to staff to ensure resident is upright at 90 degree angle during meals.

On an identified date, PCA #3 was observed assisting resident #3 to eat breakfast in the unit dining room. The PCA was seated approximately a head above the resident's eye level.

The inspector approached PCA #3 and asked what would be an appropriate safe position for a resident who requires assistance with feeding. The PCA stated that the resident should be at eye level, and stated that he/she was at eye level with Resident

#3. The inspector asked the nurse manager if the staff was sitting appropriately while feeding, and if the staff was seated at eye level. The nurse manager replied no, and stated that the PCA should be at a lower level. The PCA replied that the chair was in the lowest position, and then he/she attempt to prove that the feeding chair would not go any lower by adjusting it, however the chair fell lower. The nurse manager stated the feeding chair was still not low enough, and replaced the feeding chair with a dining room chair which allowed the PCA to be at eye level with resident. Personal care aide was not clear on the meaning of sitting at eye level with the resident. [s. 73. (1) 10.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**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).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care for Resident #5 and Resident #6 is provided to the residents as specified in the plan.

Record review of Resident #5's current care plan, requires staff to ensure that resident is upright at 90 degrees angle during meals and for 30 minutes post meals. Interview with the Registered Dietitian confirmed that Resident #5 is at risk of aspiration.

On an identified date, the inspector observed Resident #5 being assisted in a reclined position during afternoon snack, and left in the same position after snack.
Staff interview confirmed that the resident was not at the required position for feeding. [s. 6. (7)]

2. Record review of Resident #6's current care plan requires staff to ensure that resident's head is positioned for safe swallowing; also to ensure that Resident #6 is seated upright at 90 degrees angle during meals and for 30 minutes post swallowing.

On January 14, 2014, the inspector observed and staff interview confirmed that Resident #6 was not sitting upright, while being fed breakfast in bed. The resident was positioned lower than the staff who was feeding him/her. The resident was observed with his/her head leaning back and his/her eyes were in line with the top of the resident's privacy curtain, not at eye level with the staff. Resident #6 was not seated upright at a 90 degree angle at the breakfast meal as specified in his/her care plan.

Staff interview confirmed that the resident should be seated as close to a 90 degree angle as possible. They stated that "there are set expectations when assisting a resident and staff are expected to be seated in the feeding chairs which would put them at eye level", noting that the chairs are adjustable. [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 that the care set out in the plan of care for Resident #5 and Resident #6 is provided to residents as specified in their plans, to be implemented voluntarily.***

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

**Issued on this 27th day of February, 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) :** | JULIENNE NGONLOGA (502) |
| **Inspection No. / No de l'inspection :** | 2014_241502_0001 |
| **Log No. / Registre no:** | T-697-13 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Feb 6, 2014 |
| **Licensee / Titulaire de permis :** | TORONTO LONG-TERM CARE HOMES AND SERVICES<br>55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6 |
| **LTC Home / Foyer de SLD :** | CASTLEVIEW WYCHWOOD TOWERS<br>351 CHRISTIE STREET, TORONTO, ON, M6G-3C3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Nancy Lew |

To TORONTO LONG-TERM CARE HOMES AND SERVICES, 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**

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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

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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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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2013_103193_0008, CO #008;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

**Order / Ordre :**

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg 79/10, s. 73. (1) to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The plan must include a sustainable system for ongoing monitoring for meal and snack services to safeguard residents are assisted / fed safely at all times, including safe positioning. The plan must also identify who will be responsible to monitor meal and snack service to safeguard that residents are assisted/fed safely at all times, including safe positioning.

The plan must be submitted to juliene.ngonloga@ontario.ca by February 28, 2014.

**Grounds / Motifs :**

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

Section 73(1) of the O. Reg 79/10 was previously issued on July 5, 2013, as a Compliance Order for inspection #2013_103193_0008.

A review of the home's education package, "safe positioning and assisting the residents at mealtime and snacks", used during a mandatory staff in-service July and August 2013, outlined the home's expectation on the correct position of residents and staff during meals. The information included the following: the resident must be in the correct position, feet on the ground, seating up straight/upright, chin at 90 degrees angle and seated at an appropriate height. The staff must be in the correct position to help a resident to eat, seated and face to face; same height as resident; and they must adjust their seat so they are at the resident's eye level.

On an identified date, during the afternoon snack service, Resident #5 was observed to be in an unsafe feeding position while being assisted with eating by personal care aide #1 (PCA). Resident #5 was observed in a reclined position in his/her chair while PCA #1 spoon fed him/her snack. The staff member was standing over the reclined resident to assist with feeding. The resident was lying back in a reclined, resting position, his/her head was facing towards the ceiling, resident's eyes were alert and resident was taking spoonful of snack.

An interview with PCA #1 revealed that he/she acknowledged that Resident #5 was not being assisted in the proper feeding position and that the resident does not hold his/her head upright. The PCA then proceeded to elevate the resident's head with a folded cloth, which slightly elevated the resident head until he/she finished feeding.

Registered nurse was notified by the inspector to assess Resident #5 position for feeding. The registered staff stated that the position was not safe for feeding, that it was a "resting position", and confirmed that all staff should put residents upright as close to a 90 degree angle as possible prior to assisting with feeding. To demonstrate the proper feeding position, the registered staff moved Resident #5 upright into the expected feeding position by adjusting the resident's chair.

An interview with the registered dietitian revealed that Resident #5 is at risk of aspiration with his/her diet modified. The RD stated a reclined position is not safe to feed anyone and the resident should be seated upright, close to a 90 degree angle and feet flat on the floor. The RD stated that the described feeding position of Resident #5 was not safe, and "I would not let anyone put something in my mouth at that angle".

Record review of Resident #5's current care plan revealed directions to staff to ensure resident is upright at 90 degree angle during meals.

On an identified date, the inspector observed Resident #6, being fed breakfast in bed by a PCA. The resident was observed having been fed with signs of cereal on his/her mouth when inspectors entered resident's room. The resident was reclined, not upright or close to a 90 degree angle and the resident was heard coughing.

After the inspector entered the room, PCA #2 instantly raised the head of the resident's bed. After raising the head of Resident #6's bed, his/her head was leaning back and his/her eyes were in line with the top of the resident's privacy curtain; not positioned at staff's eye level. The position caused resident's chin to be raised, not at a 90 degree angle, while being fed. The resident was heard with a wet cough. Staff member continued to feed.

A RN was approached by inspector and entered Resident #6's room while resident was being fed. The RN stated that the resident should be fed in an

upright position at eye level to the staff assisting and that Resident #6's feeding position was not correct. The RN insisted that little could be done because the bed's head was elevated to its maximum. Despite the RN acknowledging that the resident feeding position was not upright and not safe, the PCA continued to feed the resident.
After the inspector questioned the feeding position of Resident #6 the RN and PCA repositioned the resident to an upright position whereby residents chin was down, eyes and face in line with staff at eye level. Both staff stated that the resident's position was better for feeding and close at 90 degree angle. After the resident was in an upright position, the inspector did not hear any further coughing from the resident.

Record review of Resident #6's current care plan revealed directions to staff to ensure resident is upright at 90 degree angle during meals.

On an identified date, PCA #3 was observed assisting resident #3 to eat breakfast in the unit dining room. The PCA was seated approximately a head above the resident's eye level.

The inspector approached PCA #3 and asked what would be an appropriate safe position for a resident who requires assistance with feeding. The PCA stated that the resident should be at eye level, and stated that he/she was at eye level with Resident #3. The inspector asked the nurse manager if the staff was sitting appropriately while feeding, and if the staff was seated at eye level. The nurse manager replied no, and stated that the PCA should be at a lower level. The PCA replied that the chair was in the lowest position, and then he/she attempt to prove that the feeding chair would not go any lower by adjusting it, however the chair fell lower. The nurse manager stated the feeding chair was still not low enough, and replaced the feeding chair with a dining room chair which allowed the PCA to be at eye level with resident. Personal care aide was not clear on the meaning of sitting at eye level with the resident. (502)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 28, 2014

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

## 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.

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

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

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

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 6th day of February, 2014**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Julienne NgoNloga

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