



**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**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11ième étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 8, 2015	2015_240506_0012	H-002603-15	Critical Incident System

Licensee/Titulaire de permis

UNGER NURSING HOMES LIMITED
312 Queenston Street St. Catharines ON L2P 2X4

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

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST BURLINGTON ON L7T 1E8

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

LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection



**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**

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

This inspection was conducted on the following date(s): May 26, June 3, 5,11, 19 and 22, 2015.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), Quality Improvement (QI) Lead, Social Service Worker, Coroner, Registered Nursing staff, Personal Support Workers (PSW), Physiotherapist Assistant, Halton Police and residents.

During the inspection the inspector: toured the home, observed provision of care, reviewed clinical health records and policies and procedures.

**The following Inspection Protocols were used during this inspection:
Critical Incident Response
Minimizing of Restraining**

During the course of this inspection, Non-Compliances were issued.

5 WN(s)

3 VPC(s)

2 CO(s)

0 DR(s)

0 WAO(s)



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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 has failed to ensure that where bed rails were used, the resident was assessed and their bed system evaluated in accordance with evidence based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The management of the home had their bed systems evaluated for entrapment zones on an identified date in May, 2015, by an outside service, at which time 70 out of 100 beds were tested and failed entrapment zone 2. The DOC confirmed that the home had just received the results on an identified date in May, 2015, of the bed system audit and had not implemented any solutions from the audit to resolve the failed entrapment zones.

A review of resident #001's written plan of care indicated that they required the use of two quarter bed rails in the raised position when in bed, as per the family's request. A review of the resident's clinical health record did not include an assessment of the bed rails being used. The DOC confirmed that bed rail use assessment forms or tools had not yet been implemented to ensure that each resident was assessed consistently by an interdisciplinary team for their specific bed rail needs and bed rail hazards according to evidence-based practices. [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 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 resident #001 was protected and was not neglected by the licensee or staff.

Resident #001 was immobile and required the assistance of two staff members for all aspects of the resident's care. On an identified date in May, 2015, resident #001 was turned and repositioned on their side and the resident was safe and secure in their bed; this was confirmed through staff interviews and documentation review. The resident's plan of care directed staff to check the resident every one hour for safety and the home's policy "Resident Care Manual, bed time care" (policy number RC-04-02-19, last revised November 2014) indicated that staff are to complete hourly rounds and check the resident. The PSW confirmed the resident was not checked again until about two hours later when the resident was found on the floor and their feet remaining on the bed, both side rails were raised. The resident was assessed by the RN and vital signs were absent. The resident's physician came to the home and concluded the Coroner needed to be called. The Coroner contacted the Police to investigate, as they could not determine how the resident ended up on the floor. The DOC confirmed that the resident was not checked every one hour as the resident's plan of care indicated and the staff did not follow the home's policy that all residents will be checked every one hour. [s. 19.(1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**WN #3: 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 the care set out in the plan of care was provided to resident #001 as specified in their plan.

Resident #001's plan of care directed staff to check the resident every one hour to ensure safety as resident was immobile and needed staff assistance for all care. On an identified date in May, 2015, resident #001 was turned and repositioned and the resident was safe and secure as confirmed through documentation review and interviews. At approximately two hours later the resident was found by the PSW lying on the floor and both side rails were raised. The resident was assessed by the RN. The resident did not receive hourly checks as per the resident's plan of care to ensure resident's safety. The DOC confirmed that the staff did not follow the resident's plan of care. [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 is provided to residents as specified in their plans of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services



Specifically failed to comply with the following:

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
 - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
 - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that home's equipment is maintained in a safe condition and in a good state of repair.

During the inspection on an identified date in May, 2015, it was observed that various beds had loose side rails in place, specifically in residents' rooms #106 bed #1 and #2, room #107 bed #1 and #2, room #200 bed #1 and room #201 bed #1 and #2. Residents were not in these beds at the time of observation; however, staff confirmed that the residents used these rails for positioning and transferring and this was documented in the residents' plans of care. The staff also confirmed that the rails were unstable and very loose. The inspector was able to fit an arm through these rails. In room #200 bed #2, the rails were both loose and unstable, and the resident used both side rails as a restraint which may also contribute to entrapment zone risk. The side rails were not maintained in a safe condition or in a good state of repair. [s. 15. (2) (c)]

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 home's equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices



Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device was ordered or approved by a physician or registered nurse in the extended class.

A review of resident #001's health record revealed that the resident used two side rails while in bed for safety. There was no order by a physician or a registered nurse in the extended class for the use of the restraint. The QI lead confirmed that the side rails were considered a restraint as the resident could not release themselves. [s. 31. (2) 4.]

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 restraining of a resident by a physical device was ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

Issued on this 9th day of July, 2015

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

Original report signed by the inspector.



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

**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) : LESLEY EDWARDS (506)

Inspection No. /

No de l'inspection : 2015_240506_0012

Log No. /

Registre no: H-002603-15

Type of Inspection /

Genre

Critical Incident System

d'inspection:

Report Date(s) /

Date(s) du Rapport : Jul 8, 2015

Licensee /

Titulaire de permis :

UNGER NURSING HOMES LIMITED
312 Queenston Street, St. Catharines, ON, L2P-2X4

LTC Home /

Foyer de SLD :

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST, BURLINGTON, ON, L7T-1E8

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Donna Spasic

To UNGER NURSING HOMES LIMITED, 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 : 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 complete the following:

1. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
2. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
3. Educate all health care staff who care for residents with respect to entrapment zones, bed safety and rail use hazards using the following document as a guide "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards".

Grounds / Motifs :



**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*

1. r. 15. (1)(a) previously issued as a VPC on August 18, 2014 and r. 15. (1)(b) was issued as an immediate order on March 3, 2013.

The licensee has failed to ensure that where bed rails were used, the resident was assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The management of the home had their bed systems evaluated for entrapment zones in May 2015, by an outside service, at which time 70 out of 100 beds were tested and failed entrapment zone 2. The DOC confirmed that the home had just received the results on an identified date in May, 2015, of the bed system audit and had not implemented any solutions from the audit to resolve the failed entrapment zones.

A review of resident #001's written plan of care indicated that they required the use of two quarter bed rails in the raised position when in bed as per the family's request. A review of the resident's clinical health record did not include an assessment of the bed rails being used. The DOC confirmed that bed rail use assessment forms or tools had not yet been implemented to ensure that each resident was assessed consistently by an interdisciplinary team for their specific bed rail needs and bed rail hazards according to evidence-based practices.

(506)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015



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

**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*

Order # /

Ordre no : 002

Order Type /

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee shall ensure that residents are protected and not neglected by the licensee or staff.

1. The home will educate staff on the policy bed time care and ensure that all staff are complying and conducting the hourly safety checks on the residents.

Grounds / Motifs :



**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*

1. The licensee has failed to ensure that resident #001 was protected and was not neglected by the licensee or staff.

Resident #001 was immobile and required the assistance of two staff members for all aspects of the resident's care. On an identified date in May, 2015, resident #001 was turned and repositioned on their side and the resident was safe and secure in their bed; this was confirmed through staff interviews and documentation review. The resident's plan of care directed staff to check the resident every one hour for safety and the home's policy "Resident Care Manual, bed time care" (policy number RC-04-02-19, last revised November 2014) indicated that staff are to complete hourly rounds and check the resident. The PSW confirmed the resident was not checked again until about two hours later when the resident was found on the floor and their feet remaining on the bed, both side rails were raised. The resident was assessed by the RN and vital signs were absent. The resident's physician came to the home and concluded the Coroner needed to be called. The Coroner contacted the Police to investigate, as they could not determine how the resident ended up on the floor. The DOC confirmed that the resident was not checked every one hour as the resident's plan of care indicated and the staff did not follow the home's policy that all residents will be checked every one hour. (506)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015



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

**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

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



**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*

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.



**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*

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.



**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 8th day of July, 2015

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

**Name of Inspector /
Nom de l'inspecteur :** Lesley Edwards

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