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

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, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Jun 26, 2014	2014_189120_0038	H-000126-14/H-000425-14	Complaint

Licensee/Titulaire de permis

HENLEY HOUSE LIMITED
200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9

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

THE HENLEY HOUSE
20 Ernest Street, St. Catharines, ON, L2N-7T2

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Environmental Services Supervisor and Registered staff

During the course of the inspection, the inspector(s) toured the building, tested bed side rails, measured illumination levels reviewed resident care records and environmental policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Infection Prevention and Control
Safe and Secure Home

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 residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails are used.

A registered staff member, Director of Care and Administrator confirmed that residents had not been assessed using any formal process with respect to bed rail use, other than what would be used to determine a resident's need for a personal assistance services device (PASD) for repositioning. Two identified resident plans were reviewed and the PASD assessments were not completed even though both of the residents were observed to be in bed with their rails elevated and in use. Resident #001 and resident #002 were both observed with 3/4 rails elevated on both sides of their beds. Neither of these residents had any information in their care plans for staff direction regarding the reason for applying the bed rails.

In reviewing the homes' assessments on resident bed safety, it was evident that the guidelines identified in the prevailing practices known as the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003" had not been incorporated. The guideline has been endorsed by Health Canada and is a companion guide to the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008".

The home's questionnaire around the use of bed rails was limited and failed to incorporate many of the questions identified in the guideline. Management staff did not ensure that a consistent approach was used by all registered staff during bed rail use assessments. The current assessment was not interdisciplinary and the assessment

did not include a risk-benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the preferred treatment of the residents. The plan of care did not present clear directions for further investigation of less restrictive care interventions. The documentation did not describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet the resident's assessed needs. [s. 15. (1) (a)]

2. The licensee did not take appropriate steps to prevent resident entrapment (taking into consideration all potential zones of entrapment) where bed rails were in use.

The licensee completed a bed safety audit in January 2014, where all potential zones of entrapment were measured. The results of the audit identified that over 70% of the beds failed one or more zones of entrapment. The licensee responded by ordering new mattresses on April 10, 2014 which had not been delivered or in use by the time the inspection was completed. The licensee failed to ensure that residents who were required to have a bed rail and who were identified sleeping in beds that failed one or more entrapment zones, were provided with interventions to minimize resident entrapment as soon as the risks were identified in January 2014. Other interventions could have been implemented until the mattresses were replaced and the beds re-tested.

During the inspection, many beds in each home area were observed to have at least one bed rail in the elevated position when residents were out of bed. The rail remained elevated when the resident returned to the bed either independently or assisted. Residents were observed lying in bed in 4 identified rooms which had one or more bed rails elevated. One of these residents was lying on a therapeutic mattress with bed rails elevated without any gap fillers or bolsters. The therapeutic mattress was easily compressed down in and around the rail and had large gaps under the bed rails, a common entrapment zone. A resident in another identified room whose bed failed zones 2 and 4 (gaps between mattress and rail) was observed lying in bed with their right assist rail in the elevated position. No interventions were observed to minimize the gaps in the identified zones.

Loose and unstable rotating assist bed rails were noted in rooms 1049, 1121, 1219, 1201, 2098, 2135, 2190 and 2198. The majority of these beds passed all entrapment zones when tested in January 2014, however over time, the rails became loose with use and had not been monitored. The bed rails, when tested during the inspection, were observed to extend out and away from the mattress, creating a large gap

between the rail and the mattress, an entrapment zone. The bed rails were identified to be elevated on at least one side of the bed, either in the transfer position or the guard position when observed. Residents trying to use these rails for stabilization when getting in and out of bed would have encountered a very unstable and loose rail.

[s. 15(1)(b)]

Additional Required Actions:

CO # - 001, 002 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

Using a hand held Sekonic Handi Lumi analog illumination meter, illumination levels were measured in various areas of the home. Non-compliance with levels were specifically identified in resident bedrooms and corridors of the home.

*All six home areas had corridors that were equipped with fluorescent tube lights, recessed and covered with light deflectors as opposed to the typical opaque plastic cover. Factors affecting illumination levels in the corridors depended on the colour of the carpets and walls, age of the tubes and distance between the light fixtures. The deflectors presented the largest factor affecting light levels.

* The Lakeside home area was painted blue and carpets were dark. An area outside of room 1223 was measured. There was 8 feet between fixtures, with a lux of 590 under one light fixture and 150 lux in the centre between two light fixtures. Pot lights were observed over the entrance to each room in the hall. As the meter was held 36 inches above and parallel to the floor and was taken down the hall cenrally, the lux levels fluctuated between 600 and 100 lux. A consistent and continuous reading of ~~215.28~~ lux was not achieved.
322.92 SJ

* The Lancaster Park home area corridor was 500 lux under one corridor light and the fixtures were spaced 10, 8 and 6 feet apart. The lux between fixtures that were 6 feet apart was 200 lux and 100 lux between fixtures spaced 8 feet apart.

* The Morningstar Mill home area was painted yellow with dark carpet. One corridor light fixture was 480 lux and another was 390 lux. The fixtures were spread 8 feet apart and the area between the fixtures was 200 lux.

*Resident rooms were not equipped with ceiling lights, but had 2 wall mounted light fixtures (high above the beds), with a valence on their underside, directing the light toward the ceiling. Ceiling height was higher than the standard 8 feet. A pot light was available in the entrance to the room which was 300 lux and 2 wall sconces. All light fixtures were already on in the room and the curtain shades were drawn to exclude daylight. The area above the center of both beds in the room was measured and was 120 lux. When standing centrally, between the two bed areas, the general room light was 190 lux. The minimum required level of ~~215.28~~ lux could not be achieved. [s. 18.]
322.92 SJ

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 lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to the outside of the home (other than doors leading to secure outside areas that preclude exit by a resident) were kept locked. During the tour of the home on June 11, 2014, the door located in the community kitchen and lounge area of the Lancaster Park home area was found unlocked. The door was equipped with a key lock which was locked by the registered nurse when it was brought to her attention. The area directly outside the door was a patio which was not enclosed to prevent exit by a resident, and instead led to a path on the property leading to a road. According to staff, a competent resident uses the exit on a regular basis. The staff confirmed that it was the expectation that the door be kept locked before and after the resident leaves. Consideration shall be made to either enclose the patio or provide a key pad on the door whereby the door locks automatically upon exit. [s. 9.(1)]

Issued on this 27th day of June, 2014

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

B. Sosnik

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0038
Log No. / Registre no:	H-000126-14/H-000425-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 26, 2014
Licensee / Titulaire de permis :	HENLEY HOUSE LIMITED 200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	THE HENLEY HOUSE 20 Ernest Street, St. Catharines, ON, L2N-7T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOHN BERGIN

To HENLEY HOUSE LIMITED, 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:

1. Develop a formal tool/form that incorporates the guidelines in the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003".
2. Assess all residents using the tool/form.
3. Update all resident care plans to include whether rails are used, how many, which side of the bed and the reason. Include the use of any interventions such as bed accessories if the bed has not passed all entrapment zones.
4. Educate all staff who care for residents on bed safety, bed rail use and entrapment zones.

Grounds / Motifs :

1. The licensee failed to ensure that residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails are used.

A registered staff member, Director of Care and Administrator confirmed that residents had not been assessed using any formal process with respect to bed rail use, other than what would be used to determine a resident's need for a personal assistance services device (PASD) for repositioning. Two identified resident plans were reviewed and the PASD assessments were not completed even though both of the residents were observed to be in bed with their rails elevated and in use. Resident #001 and resident #002 both had their 3/4 rails elevated on both sides of their beds. Neither of these residents had any information in their care plans for staff direction regarding the reason for applying the bed rails.

In reviewing the homes' assessments on resident bed safety, it was evident that the guidelines identified in the prevailing practices known as the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003" had not been incorporated. The guideline has been endorsed by Health Canada and is a companion guide to the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008".

The home's questionnaire around the use of bed rails was limited and failed to incorporate many of the questions identified in the guideline. Management staff did not ensure that a consistent approach was used by all registered staff during bed rail use assessments. The current assessment was not interdisciplinary and the assessment did not include a risk-benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the preferred treatment of the residents. The plan of care did not present clear directions for further investigation of less restrictive care interventions. The documentation did not describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet the resident's assessed needs. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

Order # / Ordre no : 002

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;

1. Mitigate any entrapment zone risks for residents who currently use a bed rail by using any of the available interventions identified in the prevailing practices called "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008"
2. Evaluate all bed rails to ensure they are tight-fitting and in good condition.
3. Establish a preventive maintenance program for all beds.
4. Educate all staff to monitor and report loose rails or bed components in poor condition.

Grounds / Motifs :

1. The licensee did not take appropriate steps to prevent resident entrapment (taking into consideration all potential zones of entrapment) where bed rails were in use.

The licensee completed a bed safety audit in January 2014, where all potential zones of entrapment were measured. The results of the audit identified that over 70% of the beds failed one or more zones of entrapment. The licensee responded by ordering new mattresses on April 10, 2014 which had not been delivered or in use by the time the inspection was completed. The licensee failed to ensure that residents who were required to have a bed rail and who were identified sleeping in beds that failed one or more entrapment zones, were provided with interventions to minimize resident entrapment as soon as the risks were identified in January 2014. Other interventions could have been implemented until the mattresses were replaced and the beds re-tested.

During the inspection, many beds in each home area were observed to have at least one bed rail in the elevated position when residents were out of bed. The rail remained elevated when the resident returned to the bed either independently or assisted. Residents were observed lying in bed in 4 identified rooms which had one or more bed rails elevated. One of these residents was lying on a therapeutic mattress with bed rails elevated without any gap fillers or bolsters. The therapeutic mattress was easily compressed down in and around the rail and had large gaps under the bed rails, a common entrapment zone. A resident in another identified room whose bed failed zones 2 and 4 (gaps between mattress and rail) was observed lying in bed with their right assist rail in the elevated position. No interventions were observed to minimize the gaps in the identified zones. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 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 26th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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