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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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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
Mar 8, 2017	2017_539120_0011	033990-16	Follow up

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

VALLEY PARK LODGE
6400 VALLEY WAY NIAGARA FALLS ON L2E 7E3

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 Follow up inspection.

This inspection was conducted on the following date(s): February 15 & 16, 2017

An inspection (2016-205129-0005) was previously conducted between March 29 and April 25, 2016 at which time non-compliance was identified related to bed system evaluations and resident clinical assessments related to the safety of bed rail use. An order was issued on July 22, 2016. For this follow-up inspection, the order was not fully complied with and remains outstanding. See below for further details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Practical Nurses, Registered Nurses and Personal Support Workers.

During the course of the inspection, the inspector toured the home and observed resident bed systems, reviewed bed evaluation results, bed safety policies and procedures and resident clinical assessment records.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 :

The licensee did not ensure that where bed rails were used, the residents were assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted March 29 to April 25, 2016, and non-compliance was identified with this section. An order was issued for the licensee to develop and implement an interdisciplinary training program for staff who participate in the assessment of the resident when bed rails are used. The training was to be based on directions contained in the guidance document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). The training was to include, at a minimum, factors to be considered when assessing residents, where and how staff document the rationale for the implementation of bed rails or the decision not to implement bed rails, as well as specific information to be documented when the residents' written plan of care is developed or revised related to the use of bed rails.

For this follow up inspection, three residents (#108, #109 and #113) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical guidance document and if risks were identified, evaluated and mitigated if necessary.

According to a personal support worker (PSW) and a registered staff member, all residents were re-assessed following the previous inspection by both registered staff and a PSW for three nights and one full day for sleeping patterns and bed rail use while in

bed. PSWs were required to document their observations on a form titled "Three Night/One Day Bed Mobility Observation for Resident" by identifying if the resident was asleep, awake, calm or restless, used their bed rail, fell from bed or attempted to get out of bed. Registered staff completed a different form titled "Safety Assessment – fall, restraint and bed rail" which identified many of the factors identified in the Clinical Guidance document. The information from both forms were collected by registered staff and transferred to the residents' written plan of care.

The "Safety Assessment – fall, restraint and bed rail" form included the resident's status (medication use, falls history, cognitive status), risk factors (perceptual deficits, mobility status, pain, continence, bed rail injuries, disturbed sleep cycle, co-ordination, safe use of mobility aid, hallucinations, and many others), alternatives in use (toileting routine, behavioural approaches, bed alarm, hourly checks, curved mattress, bolsters – for air mattress only) and a separate bed rail assessment section. Missing risk factors included involuntary movements and additional sleeping characteristics (or sleeping disorders) and behaviours. The alternatives listed were extensive and included many relevant interventions for alternatives to bed rails, however the form identified that bolsters or "soft rails" would be trialled only for air mattresses. The use of "perimeter reminders" or "border definers" such as body pillow, cushions, bolsters (soft rails) and hand grips are included as options in the Clinical Guidance document on all types of beds, not just on beds with therapeutic mattresses.

The following residents were reviewed and determined that the staff who participated in the assessments of the residents where bed rails were used were not fully aware of all of the directions contained in the guidance document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003".

Resident #108 was not observed in bed, however their bed system was observed with both 3/4 length bed rails elevated and both were padded. The resident was admitted December 2016, and, had a 3 night/1 day sleep observation completed over the following 3 nights. The resident was identified to have used a bed rail for turning. No side was identified and whether the resident used the bed rail independently or with staff assistance was not identified. The resident's written plan of care included that the resident and their SDM requested the use of both bed rails and that the resident did not use them for bed mobility. It further included that the resident had muscle weakness and poor trunk control the resident had a specific personal reason for preferring the bed rails. The plan did not include why the bed rails were padded. The resident's "Safety

Assessment" completed in December 2016, identified a recent change in status and/or safe mobility. The alternative that was selected included hourly safety checks. The assessment did not include what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with bed rails applied. The assessor concluded that the resident/SDM requested the use of the bed rail and that after being informed of the risks, they were given a document titled "Consent for Acceptance of Resident Risk" form to sign. The form included information that the options and alternate choices were discussed with the resident/SDM. The resident was not observed in bed without bed rails or with alternatives in place before deciding whether the hard bed rails were the safest alternative.

Resident #109 was observed in bed with their left 3/4 length bed rail elevated and it was padded. Their plan of care identified the same and the reasons for bed rail use included "for safety and to assist with bed mobility". The plan of care did not identify why the bed rail was to be padded and what the "safety" reasons were for the application of the bed rail. Their most recent 3 night/1 day bed mobility observation was completed in January 2016, where PSWs identified that the resident used the bed rails for turning and repositioning several times throughout two separate nights. It did not identify whether the resident used the bed rails independently or with staff assistance. When the resident was observed on other nights, the form used was different and did not include any information about bed rail use or attempts to get out of bed. According to the resident's other activities of daily living identified in their plan of care, the resident required one staff assistance with bed mobility for repositioning and that they used other support equipment with staff direction. The resident's "Safety Assessment" dated December 2016, included, information that the resident had cognitive impairment, difficulty following instructions, agitation, confusion, muscle weakness and that the resident was at risk of climbing over the bed rails. The assessment form included that if the resident was at risk of climbing over the bed rails, that the bed rails should not be used. The alternatives that were selected included hourly safety checks and a curved perimeter mattress with the use of a hard bed rail. The assessment did not include what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with bed rails applied. The assessor concluded that the resident/SDM requested the use of the bed rail and that after being informed of the risks, they were given a document titled "Consent for Acceptance of Resident Risk" form to sign. The form included information that the options and alternate choices were discussed with the resident/SDM. The resident was not observed in bed without bed rails or with alternatives in place before deciding whether the hard bed rails were the

safest alternative.

Resident #113 was not observed in bed, however, their bed system was observed with both 3/4 length bed rails elevated. The resident's written plan of care identified that both bed rails were to be "up at all times when in bed" as they made the resident feel safe and secure when in bed as they feared they would fall and for bed mobility. The plan also identified that the resident required staff to turn and reposition them while in bed. Their most recent 3 night/1 day bed mobility observation was completed in December 2015, which, identified that the resident used the bed rails for one night. The resident's PSW stated that the resident could not use the bed rails independently and needed assistance from staff. The resident's "Safety Assessment" forms dated March 2016, and December 2016, both identified that the resident was immobile, at risk of falling out of bed, had muscle weakness and was uncoordinated. Alternatives to the use of bed rails were not trialled and the outcomes documented. The form included that the family and resident requested the bed rail and as such, it was applied automatically. The assessor provided the resident/family a document titled "Consent for Acceptance of Resident Risk" form to sign. The form included information that the options and alternate choices were discussed with the resident/SDM. The resident was not observed in bed without bed rails or with alternatives in place before deciding whether the hard bed rails were the safest alternative.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. According to the licensee's policy CN-B-08-1 dated September 2014, titled "Bed Rails - Safe Use and Entrapment Risk Management", many of the guidelines identified in the Clinical Guidance document were not included. [s. 15. (1) (a)]

Additional Required Actions:

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

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 9th day of March, 2017

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0011
Log No. / Registre no:	033990-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 8, 2017
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	VALLEY PARK LODGE 6400 VALLEY WAY, NIAGARA FALLS, ON, L2E-7E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JENNIFER ANDERSON

To 955464 ONTARIO 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)

Linked to Existing Order / Lien vers ordre existant: 2016_205129_0005, CO #002;

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. Amend the home's existing forms related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time, to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time, to establish safety

risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form(s) and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form(s). Include in the written plan of care any necessary interventions that are required to mitigate any identified bed safety hazards.

5. Amend the existing policy "Bed Rails - Safe Use and Entrapment Risk Management" related to bed systems so that it will guide an assessor in completing resident clinical bed safety assessments in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" and implement the policy.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the residents were assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted March 29 to April 25, 2016, and non-compliance was identified with this section. An order was issued for the licensee to develop and implement an interdisciplinary training program for staff who participate in the assessment of the resident when bed rails are used. The training was to be based on directions contained in the guidance document "Clinical Guidance for the Assessment and Implementation of Bed Rails in

Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). The training was to include, at a minimum, factors to be considered when assessing residents, where and how staff document the rationale for the implementation of bed rails or the decision not to implement bed rails, as well as specific information to be documented when the residents' written plan of care is developed or revised related to the use of bed rails.

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mattresses.

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Resident #109 was observed in bed with their left 3/4 length bed rail elevated and it was padded. Their plan of care identified the same and the reasons for bed rail use included "for safety and to assist with bed mobility". The plan of care did not identify why the bed rail was to be padded and what the "safety" reasons were for the application of the bed rail. Their most recent 3 night/1 day bed mobility observation was completed in January 2016, where PSWs identified that the resident used the bed rails for turning and repositioning

several times throughout two separate nights. It did not identify whether the resident used the bed rails independently or with staff assistance. When the resident was observed on other nights, the form used was different and did not include any information about bed rail use or attempts to get out of bed. According to the resident's other activities of daily living identified in their plan of care, the resident required one staff assistance with bed mobility for repositioning and that they used other support equipment with staff direction. The resident's "Safety Assessment" dated December 2016, included, information that the resident had cognitive impairment, difficulty following instructions, agitation, confusion, muscle weakness and that the resident was at risk of climbing over the bed rails. The assessment form included that if the resident was at risk of climbing over the bed rails, that the bed rails should not be used. The alternatives that were selected included hourly safety checks and a curved perimeter mattress with the use of a hard bed rail. The assessment did not include what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with bed rails applied. The assessor concluded that the resident/SDM requested the use of the bed rail and that after being informed of the risks, they were given a document titled "Consent for Acceptance of Resident Risk" form to sign. The form included information that the options and alternate choices were discussed with the resident/SDM. The resident was not observed in bed without bed rails or with alternatives in place before deciding whether the hard bed rails were the safest alternative.

Resident #113 was not observed in bed, however, their bed system was observed with both 3/4 length bed rails elevated. The resident's written plan of care identified that both bed rails were to be "up at all times when in bed" as they made the resident feel safe and secure when in bed as they feared they would fall and for bed mobility. The plan also identified that the resident required staff to turn and reposition them while in bed. Their most recent 3 night/1 day bed mobility observation was completed in December 2015, which, identified that the resident used the bed rails for one night. The resident's PSW stated that the resident could not use the bed rails independently and needed assistance from staff. The resident's "Safety Assessment" forms dated March 2016, and December 2016, both identified that the resident was immobile, at risk of falling out of bed, had muscle weakness and was uncoordinated. Alternatives to the use of bed rails were not trialled and the outcomes documented. The form included that the family and resident requested the bed rail and as such, it was applied automatically. The assessor provided the resident/family a document

titled "Consent for Acceptance of Resident Risk" form to sign. The form included information that the options and alternate choices were discussed with the resident/SDM. The resident was not observed in bed without bed rails or with alternatives in place before deciding whether the hard bed rails were the safest alternative.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. According to the licensee's policy CN-B-08-1 dated September 2014, titled "Bed Rails - Safe Use and Entrapment Risk Management", many of the guidelines identified in the Clinical Guidance document were not included.

This Order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of O. Regulation 79/10, the scope of the non-compliance is widespread, as none of the residents who used one or more bed rails were assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and the history of non-compliance is on-going. An order was previously issued on July 22, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
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Inspection de soins de longue durée
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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 March, 2017

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