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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2014	2014_300560_0010	H-000518-14/H-000631-14	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

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

SUSAN PORTEOUS (560), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 4, 5 and 6, 2014.

This inspection included an inspection of log number H-000482-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), registered staff, resident assessment indicator coordinator(RAIC), personal support workers (PSW's), occupational therapist (OT) and residents.

During the course of the inspection, the inspector(s) reviewed clinical records, the home's relevant policies and procedures, internal investigative notes and mechanical lift manufacturers manual.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #001 was cared for in a manner consistent with their needs.

In April 2014 a resident was being aggressive, striking out, kicking and attempting to

bite a PSW who was providing care alone to the resident. The PSW held onto the resident's hands at their wrists in an attempt to prevent from being struck. The resident's arms were raised by the PSW towards the resident's face. The PSW's finger nails made contact with the left side of the resident's face resulting in two skin tears and bruising to the left side of the resident's chin and left lower arm. The resident's plan of care indicates that the resident will have two staff members present for all hygiene care and if the resident displays responsive behaviour the staff will leave the resident alone and reapproach at a later time. The DOC confirmed that the resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

2. The licensee did not ensure that resident #003 was properly cared for in a manner consistent with their needs.

The clinical record of resident #003 was reviewed. The resident's care needs necessitated a two person full lift transfer.

In early January 2014, the OT completed a seating assessment of the resident in their own upright wheelchair. Staff had reported the resident sometimes leaned forward and to either side while in their wheelchair. The OT recommended a tilt wheelchair. The power of attorney (POA) refused to purchase a new wheelchair but consented to trial the home's tilt wheelchair which was offered.

In the middle of January 2014 the resident's POA was notified that the resident had returned to using their own wheelchair at the resident's request and staff were utilizing pillows to position them comfortably.

In April 2014 two PSW's attempted a routine transfer of the resident from their wheelchair to bed using the mechanical ceiling lift. After raising the resident several inches above the wheelchair with the lift, they lowered the resident back into the wheelchair to readjust the sling which was sliding up the resident's back. The resident slid out of the wheelchair and sustained an injury and they were transferred immediately to the hospital. The resident died from complications related to the fall.

In June 2014 during an interview registered staff (who responded to the incident) reported that because the resident's own wheelchair was small it was difficult to reposition the resident in their wheelchair.

In June 2014 a PSW reported during an interview that sling placement was difficult

when the resident was in their own wheelchair but they did not report this to management before the incident occurred. This information was confirmed by the Administrator during an interview in June 2014.

In June 2014 a PSW (who had attempted to transfer the resident when the incident occurred) stated during an interview that the resident was not sitting all the way back in their wheelchair when the sling straps were disconnected.

The manual for the mechanical lift used during the incident instructs that an individual must be securely and safely supported in the final desired position before removing the sling straps. The Administrator confirmed during an interview that staff are expected to follow the manual's procedures.

During an interview in June 2014 the OT confirmed that a seating assessment of the resident was not completed after the resident had returned to using their own wheelchair.

The licensee did not ensure that resident #003 was properly cared for in a manner consistent with their needs. [s. 3. (1) 4.]

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.

A review of the resident #001's plan of care indicated that the resident was to have two PSW's present for all care due to responsive behaviours. In April 2014 only one staff member completed care for the resident and as a result the resident became resistive to care and sustained an injury. The DOC confirmed that the PSW did not follow the resident's plan of care which contributed to the resident's injury. [s. 6. (7)]

2. The licensee did not ensure that resident #003 was reassessed and the plan of care reviewed and revised when the plan of care related to the resident's use of a tilt wheelchair was not effective.

The resident's clinical record was reviewed and the following information was identified:

In early January 2014 the OT completed a seating assessment of the resident. The OT recommended a tilt wheelchair. The POA refused to purchase a new wheelchair but consented to trial the home's tilt wheelchair which was offered to the resident. The OT assistant assessed the resident in the home's tilt wheelchair. During this assessment the resident stated they wanted to use their own wheelchair.

After the resident had used the tilt wheelchair for a week the POA was notified that the resident had returned to using their old wheelchair at the resident's request and staff were utilizing pillows to position the resident comfortably.

The OT confirmed in June 2014 during an interview that a seating assessment of the resident in their own wheelchair was not completed after the resident had returned to using their own wheelchair.

The plan of care for the resident indicated use of the tilt wheelchair until April 2014. In June 2014 the DOC confirmed during an interview that the resident's plan of care was not revised to remove the tilt wheelchair intervention although the resident had not used it since January 2014. [s. 6. (10)]

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 the care set out in the plan of care for residents is provided as specified in their plan and that residents are reassessed and their plan of care reviewed and revised at any time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that staff used safe transferring and positioning techniques when transferring resident #003.

A review of the resident's clinical record identified that in April 2014 two PSW's attempted a routine transfer of the resident from wheelchair to bed using the mechanical ceiling lift. After raising the resident several inches above the wheelchair with the lift, they lowered the resident back into the wheelchair to readjust the sling which was sliding up the resident's back. The resident slid out of the wheelchair and sustained an injury and was transferred immediately to the hospital. The resident died from complications related to the fall.

A critical incident was reported to the Ministry of Health and Long Term Care regarding this matter. The report described the resident as being "towards the edge of the wheelchair" when the resident was lowered back to the wheelchair to readjust the sling.

In April 2014 a PSW's written statement (provided during the home's internal investigation) identified that when the resident was lowered to the wheelchair the resident was positioned sitting more to the front of the chair and there was a gap between the back of the chair and the resident when the resident began to slide forward.

In June 2014 a PSW identified during an interview with the compliance inspector that the resident was lowered into their wheelchair to readjust the sling and was positioned so that they were approximately 10 centimeters from the back of the chair at the time the sling straps were disconnected.

A review of the written statement made during the home's internal investigation by a PSW involved in the incident, identified that they disconnected the sling straps when the resident was not sitting at the back of the wheelchair.

The manual on the mechanical lift used during the incident instructs that when transferring an individual, the individual must be securely and safely supported in the final desired position before removing the sling straps.

The Administrator confirmed during an interview that the manual procedure for transferring individuals is expected to be followed by staff. [s. 36.]

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 staff use safe transferring and positioning techniques when transferring residents using a mechanical lift and sling, to be implemented voluntarily.

Issued on this 24th day of July, 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) :	SUSAN PORTEOUS (560), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2014_300560_0010
Log No. / Registre no:	H-000518-14/H-000631-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 26, 2014
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF HALTON 1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	CREEK WAY VILLAGE 5200 Corporate Drive, BURLINGTON, ON, L7L-7G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patti Coates

To THE REGIONAL MUNICIPALITY OF HALTON, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the right of every resident to be properly cared for in a manner consistent with their needs, including responsive behaviour and/or positioning/transferring needs, are fully respected and promoted. The plan must be submitted electronically on or before August 4, 2014 to Susan Porteous at susan.porteous@ontario.ca at the Ministry of Health and Long Term Care, Hamilton, ON.

Grounds / Motifs :

1. 1. The licensee did not ensure that resident #001 was cared for in a manner consistent with their needs.

In April 2014 a resident was being aggressive, striking out, kicking and attempting to bite a PSW who was providing care alone to the resident. The PSW held onto the resident's hands at their wrists in an attempt to prevent from being struck. The resident's arms were raised by the PSW towards the resident's face. The PSW's finger nails made contact with the left side of the resident's face resulting in two skin tears and bruising to the left side of the resident's chin and left lower arm. The resident's plan of care indicates that the resident will have two staff members present for all hygiene care and if the resident displays responsive behaviour the staff will leave the resident alone and reapproach at a later time. The DOC confirmed that the resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

2. The licensee did not ensure that resident #003 was properly cared for in a

manner consistent with their needs.

The clinical record of resident #003 was reviewed. The resident's care needs necessitated a two person full lift transfer.

In early January 2014, the OT completed a seating assessment of the resident in their own upright wheelchair. Staff had reported the resident sometimes leaned forward and to either side while in their wheelchair. The OT recommended a tilt wheelchair. The power of attorney (POA) refused to purchase a new wheelchair but consented to trial the home's tilt wheelchair which was offered.

In the middle of January 2014 the resident's POA was notified that the resident had returned to using their own wheelchair at the resident's request and staff were utilizing pillows to position them comfortably.

In April 2014 two PSW's attempted a routine transfer of the resident from their wheelchair to bed using the mechanical ceiling lift. After raising the resident several inches above the wheelchair with the lift, they lowered the resident back into the wheelchair to readjust the sling which was sliding up the resident's back. The resident slid out of the wheelchair and sustained an injury and they were transferred immediately to the hospital. The resident died from complications related to the fall.

In June 2014 during an interview registered staff (who responded to the incident) reported that because the resident's own wheelchair was small it was difficult to reposition the resident in their wheelchair.

In June 2014 a PSW reported during an interview that sling placement was difficult when the resident was in their own wheelchair but they did not report this to management before the incident occurred. This information was confirmed by the Administrator during an interview in June 2014.

In June 2014 a PSW (who had attempted to transfer the resident when the incident occurred) stated during an interview that the resident was not sitting all the way back in their wheelchair when the sling straps were disconnected.

The manual for the mechanical lift used during the incident instructs that an individual must be securely and safely supported in the final desired position

before removing the sling straps. The Administrator confirmed during an interview that staff are expected to follow the manual's procedures.

During an interview in June 2014 the OT confirmed that a seating assessment of the resident was not completed after the resident had returned to using their own wheelchair.

The licensee did not ensure that resident #003 was properly cared for in a manner consistent with their needs.

(560)

2.
(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 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 : Susan Porteous

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