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

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5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 23, 2013	2013_168202_0026	T-1797-12	Follow up

Licensee/Titulaire de permis

HUNTSVILLE DISTRICT NURSING HOME INC
14 MILL STREET, HUNTSVILLE, ON, P1H-2A4

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

FAIRVERN NURSING HOME
14 MILL STREET, HUNTSVILLE, ON, P1H-2A4

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

VALERIE JOHNSTON (202)

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): May 14, 15, 16, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing and Personal Care, Program Manager, Director of Support Services, Registered Nursing Staff, Personal Support Workers, Environmental Aide, Dietary Aide, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed the home's Abuse/Harassment policy, reviewed resident council and family council meeting minutes

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 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 failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. [s.19. (1)]

An identified staff member revealed in an interview that he/she witnessed Personal Support Worker A (PSWA) state, "stop eating like an animal and eat like a human" to an identified resident during a dinner meal service. The identified staff member indicated that he/she reported the incident of verbal abuse to the Director of Care the same evening of the occurrence. An interview with the Director of Care (DOC) confirmed receipt of the allegation of verbal abuse however indicated that the allegation of verbal abuse was reported the day after the incident occurred. The (DOC) indicated that this particular staff member is known to 'report' many concerns about the home and did not perceive this concern as serious, however confirmed a follow up to the allegation of verbal abuse with the staff in question was conducted. The (DOC) concluded that inappropriate statements were made by (PSWA) during an evening meal service at an unspecified date in 2013, however these statements should have been perceived as a 'joking gesture' and to have been taken 'lightly' as intended by (PSWA). The (DOC) revealed that it is normal for staff to joke in this manner amongst themselves when feeding residents especially among tables where residents require full staff assistance. The (DOC) revealed that the staff member knows that what was said to be inappropriate and has since apologized to the identified resident, however indicated that this resident may not have understood. Staff interviews revealed that the majority of staff are reluctant to report any issue or concern to management of the home, including concerns of abuse because managers do not respect confidentiality and would not take their concerns seriously.
During the course of this inspection on May 14, 15, 2013, residents were interviewed throughout the home which revealed:
Resident #002 stated that staff can be 'snappy' and will speak 'rough' at times. He/she indicated that you must be on the 'ball' when staff are providing care to you because if you do not follow what staff are doing, they will get really 'snappy'. Resident #006 indicated that staff will speak 'rough' or 'inappropriately' most of the time. Resident #006 revealed that staff will come into the room and speak to resident #003 in a derogatory manner for using the call bell and attempting to self-ambulate from his/her bed. Resident #006 has spoken up to the staff and indicated that he/she will tell them that they are wrong in how they treat resident #006 and will continue to speak up for him/her because he/she cannot speak for him/herself. Resident #006 indicated that other residents in the home are concerned by the way staff speak rude to them and indicated that the issue has been raised at previous Resident's Council meetings

including the one on May 14, 2013. A review of the Resident Council meeting minutes for December 2012-May 2013, revealed one documented concern on May 14, 2013, that staff can at time appear rude when providing care.
Staff interviews revealed no knowledge of the area of mandatory reporting under section 24 of the Act or whistle-blowing under section 26. Staff indicated that they have not been provided training in the area of mandatory reporting under section 24 of the Act or whistle-blowing under section 26. A review of the home's Abuse/Harassment policy dated October 2012 fails to include an explanation of mandatory reporting under section 24 of the Act. An interview with the Administrator confirmed that staff have not received training in the area of mandatory reporting under section 24 of the Act or whistle-blowing under section 26, however training is scheduled for the Fall of 2013. The Administrator confirmed that the home's Abuse/Harassment policy requires further updates and that the staff in the home have not been trained in the duty to report under section 24 of the Act and in the area of whistle-blowing protections afforded under section 26.
A compliance order related to this section was issued on September 12, 2012. [s. 19. (1)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall include an explanation of the duty under section 24 of the Act to make mandatory reports. [s.20. (2) (d)].

A review of the home's Abuse/Harassment policy dated October 2012 does not include an explanation of the duty under section 24 of the Act to make mandatory reports. The Abuse/Harassment policy directs staff to report abuse to the immediate supervisor at the earliest opportunity and the Director of Nursing and Personal Care shall be responsible for reporting, in consultation with the Medical Advisor, to the Ministry of Health by telephone immediately, and in writing within 10 working days or sooner if requested, via the Ministry of Health CIS report. [s. 20. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act prior to performing their responsibilities. [s.76. (2) 4].

Staff interviews revealed that staff had no knowledge of mandatory reporting under section 24 of the Act and have not been provided training prior to performing their responsibilities or during the course of employment. A review of the home's Abuse/Harassment policy dated October 2012 does not include reference to mandatory reporting under section 24 of the Act. An interview with the home's Administrator confirmed that mandatory reporting under section 24 of the Act was not included in the home's Abuse/Harassment policy and staff have not been trained under section 24 of the Act. [s. 76. (2) 4.]

2. The licensee failed to ensure that staff receive training in the area of whistle-blowing protection afforded under section 26, prior to performing their responsibilities. [s.76.(2) 5]

Staff interviews revealed no knowledge of the term whistle-blowing and indicated that they had not received any training in the area of whistle-blowing protection afforded under section 26 of the Act. An interview with the Administrator revealed that whistle-blowing protection training is not included in the orientation package provided to new employees and the home has not provided training in the area of whistle-blowing to any staff member currently working in the home. [s. 76. (2) 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. [s.96. (e) i].

A review of the home's Abuse/Harassment policy dated October 2012 does not include the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. [s. 96. (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

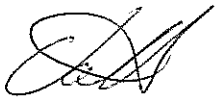
Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital. [s.107. (3) 4].

Clinical record review revealed that an identified resident had a fall on an identified date and was sent to hospital for assessment. The identified resident returned from hospital with no findings of injury, however continued to complain of pain and was sent back to hospital for further assessment. The identified resident return to the home and was diagnosed with injury as a result of the fall. An interview with the Administrator confirmed that the Director was not informed of the identified resident's injury in respect of which he/she was taken to hospital. [s. 107. (3)]

Issued on this 24th day of May, 2013

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



Ontario

Ministry of Health and Long-Term Care

Ministére 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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2013_168202_0026
Log No. / Registre no:	T-1797-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 23, 2013
Licensee / Titulaire de permis :	HUNTSVILLE DISTRICT NURSING HOME INC 14 MILL STREET, HUNTSVILLE, ON, P1H-2A4
LTC Home / Foyer de SLD :	FAIRVERN NURSING HOME 14 MILL STREET, HUNTSVILLE, ON, P1H-2A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TRACY BADGER

To HUNTSVILLE DISTRICT NURSING HOME INC, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_078202_0026, CO #001;

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 :

a) Amend the licensee's policy to promote zero tolerance of abuse and neglect of residents to ensure it provides all of the requirements in s.20 (2) of the LTCHA, including 20 (2)(d) in that it shall contain an explanation of the duty under section 24 to make mandatory reports;
b)Provide a plan to the Inspector, identifying when all staff and volunteers within the home will receive training on any changes to the licensee's policy to promote zero tolerance of abuse and neglect of residents, including the duty to report under section 24 to make mandatory reports and in the area of whistle-blowing protections afforded under section 26.
c) Provide a plan to the Inspector with time lines to provide training to staff responsible for investigating incidents of alleged abuse or neglect so that the staff responsible are able to establish an atmosphere that encourages and supports staff in providing information in a manner that would not have the effect of potentially discouraging that reporting.
Please submit plan to valerie.johnston@ontario.ca by June 14, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. [s.19. (1)]

An identified staff member revealed in an interview that he/she witnessed Personal Support Worker A (PSWA) state, "stop eating like an animal and eat like a human" to an identified resident during a dinner meal service. The identified staff member indicated that he/she reported the incident of verbal

abuse to the Director of Care the same evening of the occurrence. An interview with the Director of Care (DOC) confirmed receipt of the allegation of verbal abuse however indicated that the allegation of verbal abuse was reported the day after the incident occurred. The (DOC) indicated that this particular staff member is known to 'report' many concerns about the home and did not perceive this concern as serious, however confirmed a follow up to the allegation of verbal abuse with the staff in question was conducted. The (DOC) concluded that inappropriate statements were made by (PSWA) during an evening meal service at an unspecified date in 2013, however these statements should have been perceived as a 'joking gesture' and to have been taken 'lightly' as intended by (PSWA). The (DOC) revealed that it is normal for staff to joke in this manner amongst themselves when feeding residents especially among tables where residents require full staff assistance. The (DOC) revealed that the staff member knows that what was said to be inappropriate and has since apologized to the identified resident, however indicated that this resident may not have understood. Staff interviews revealed that the majority of staff are reluctant to report any issue or concern to management of the home, including concerns of abuse because managers do not respect confidentiality and would not take their concerns seriously.

During the course of this inspection on May 14, 15, 2013, residents were interviewed throughout the home which revealed:

Resident #002 stated that staff can be 'snappy' and will speak 'rough' at times. He/she indicated that you must be on the 'ball' when staff are providing care to you because if you do not follow what staff are doing, they will get really 'snappy'. Resident #006 indicated that staff will speak 'rough' or 'inappropriately' most of the time. Resident #006 revealed that staff will come into the room and speak to resident #003 in a derogatory manner for using the call bell and attempting to self-ambulate from his/her bed. Resident #006 has spoken up to the staff and indicated that he/she will tell them that they are wrong in how they treat resident #006 and will continue to speak up for him/her because he/she cannot speak for him/herself. Resident #006 indicated that other residents in the home are concerned by the way staff speak rude to them and indicated that the issue has been raised at previous Resident's Council meetings including the one on May 14, 2013. A review of the Resident Council meeting minutes for December 2012-May 2013, revealed one documented concern on May 14, 2013, that staff can at time appear rude when providing care.

Staff interviews revealed no knowledge of the area of mandatory reporting under section 24 of the Act or whistle-blowing under section 26. Staff indicated that

they have not been provided training in the area of mandatory reporting under section 24 of the Act or whistle-blowing under section 26. A review of the home's Abuse/Harassment policy dated October 2012 fails to include an explanation of mandatory reporting under section 24 of the Act. An interview with the Administrator confirmed that staff have not received training in the area of mandatory reporting under section 24 of the Act or whistle-blowing under section 26, however training is scheduled for the Fall of 2013. The Administrator confirmed that the home's Abuse/Harassment policy requires further updates and that the staff in the home have not been trained in the duty to report under section 24 of the Act and in the area of whistle-blowing protections afforded under section 26.

A compliance order related to this section was issued on September 12, 2012.

[s. 19. (1)]

(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 26, 2013

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 23rd day of May, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

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