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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Apr 2, 2013	2013_204133_0007	O-002357-12	Follow up

Licensee/Titulaire de permis

The Royale Development LP
302 Town Centre Blvd, Suite 200, MARKHAM, ON, L3R-0E8

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

Leisureworld Caregiving Centre - Madonna
1541 St Joseph Blvd, Orleans, ON, K1C-7L3

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

---

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 18th and 19th 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nursing Rehabilitation Coordinator, registered and non registered nursing staff and laundry staff.

During the course of the inspection, the inspector(s) followed up on compliance order #002, issued to the home on November 14th 2012 for inspection #2012_204133_0004, related to the availability of 6 loop transfer slings following a lift accident in September 2012. The inspector observed some of the home's residents identified to require a 6 loop transfer sling (vs 4 loop transfer sling) and reviewed these resident's plan of care. The inspector verified the availability of 6 loop transfer slings on four of the home's care units.

Ad-hoc notes were used during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, c.8, s.6(7) in that the care set out in the plan of care of three identified residents was not provided to the residents as specified in the plan. Specifically, on March 18th 2013, resident #001, #002 and #005, who are supposed to be transferred with a mechanical lift and a 6 loop transfer sling, were transferred with a mechanical lift and a 4 loop transfer sling.

The inspector arrived on to one of the home's care units at approximately 10:30am on March 18th 2013 to begin follow up to compliance order #002, issued to the home on November 14th 2012, for inspection #2012_204133_0004, related to the availability of 6 loop transfer slings following a mechanical lift accident, in September 2012. Resident #001, at the time of the inspection, resides on the care unit. As per resident #001's plan of care, resident #001 is to be transferred with a mechanical lift and a medium 6 loop transfer sling. During the inspection, on March 18th 2013, at approximately 11am, the inspector observed that resident #001 was in their bedroom, sitting in their wheelchair with a transfer sling underneath them. With the assistance of staff member #S100, the inspector determined that it was a large 4 loop transfer sling underneath resident #001, which is both the wrong size and wrong style of transfer sling. Staff member #100 confirmed this was the sling used to transfer resident #001, with a mechanical lift, from their bed to their wheelchair earlier that morning. Following that, the inspector observed that resident #002 was in the dining room, sitting in their wheelchair with a transfer sling underneath them. As per resident #002's plan of care, resident #002 is to be transferred using a large 6 loop transfer sling. With the assistance of staff member #S101, the inspector determined that it was a large 4 loop transfer sling underneath the resident, which is the wrong style of transfer sling. Staff member #S101 informed the inspector that they had assisted staff member #100 transfer resident #002 that morning using a mechanical lift and the sling that the resident was sitting on in their wheelchair.

In addition to resident #001 and #002 noted above, there are two other residents (#003, #004) who require the use of a 6 loop transfer sling with a mechanical lift for their transfers on the care unit. As noted above, resident #001 requires a medium 6 loop transfer sling. Residents #002-#004 require a large 6 loop transfer sling. The home's nursing rehabilitation coordinator told the inspector that on the care unit, there should be three 6 loop transfer slings, one medium and two large, that are to be shared amongst the residents who require them. Only one large 6 loop transfer sling could be found while the inspector was on the care unit in the morning of March 18th 2013. It was found underneath resident #003, who was sitting in their wheelchair, in

their bedroom. Staff member #S100 informed the inspector that when the large 6 loop transfer sling is not underneath resident #003, this transfer sling typically stays in resident #003's bedroom as it is required multiple times throughout the day. With regards to resident #004, the inspector was told, by staff member #S103, that they had used a 6 loop transfer sling with a mechanical lift to transfer resident #004 earlier that day. Staff member #S100, who helped staff member #S103 transfer resident #004 earlier that day, told the inspector that they did not know what kind of transfer sling that they and staff member #S103 had used to transfer resident #004. Apart from the one large 6 loop transfer sling underneath resident #003, no other 6 loop transfer sling could be located at the time. Later in the day, at 3:25pm on March 18th 2013, the inspector was made aware that at the end of the day shift, care unit nursing staff had located two medium 6 loop transfer slings within the care unit. One large 6 loop transfer sling remained unaccounted for.

On another care unit, at approximately 1:30pm on March 18th 2013, the inspector went into resident #005's bedroom and found a large 4 loop transfer sling on their comfortable easy chair. It is noted that resident #005 was previously involved in a lift accident at the home, in May 2012. As per resident #005's plan of care, staff are to use a large 6 loop transfer sling with a mechanical lift for all transfers of resident #005. The inspector spoke with staff member #S105 who confirmed that they had transferred resident #005 earlier that day, from bed to wheelchair, with the assistance of staff member #S106, using a mechanical lift and the 4 loop transfer sling that the inspector had observed on the resident's comfortable easy chair. This is the wrong style of transfer sling. Following discussion with the inspector about the transfer sling, staff member #S105 explained that they thought the 4 loop sling was a 6 loop sling, due to the 2 leg straps at the base of the sling in addition to the 4 side loops, and that this had been discussed with their superior, staff member #S107. Another staff member, #S108, found a large 6 loop transfer sling in the linen storage room several minutes later, across the hall from resident #005's bedroom. Staff member #S108 explained to the inspector that this indicated that the large 6 loop transfer sling had recently been returned to the care unit from the laundry. The home's nursing rehab coordinator told the inspector that one medium 6 loop transfer sling and one large 6 loop transfer sling have been provided to this care unit for use with the two residents who require them. The medium 6 loop transfer sling was located within a resident's bedroom.

The plan of care for resident #001, #002 and #005 indicates they are to be transferred

with a mechanical lift and a 6 loop transfer sling. On March 18th 2013, the inspector found that staff had used a 4 loop transfer sling to transfer these residents with a mechanical lift, which is the wrong style of transfer sling. As well, resident #001 was transferred with the wrong size of transfer sling. This presents a potential risk to the safety and well-being of these three residents. The licensee has failed to comply with LTCHA, 2007, c.8, s.6(7). [s. 6. (7)]

Additional Required Actions:

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

Issued on this 2nd day of April, 2013

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

Jessica Lapensée

Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
1-877-779-5559
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
1-877-779-5559
Télécopieur: 613-569-9670

Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
March 18, 19 - 2013	2013_204133_0007	Follow Up

Licensee/Titulaire de permis

The Royale Development LP
302 Town Centre Blvd, Suite 200, MARKHAM, ON, L3R-0E8

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

Leisureworld Caregiving Centre - Madonna

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

Jessica Lapensée, #133

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O. Reg. 79/10, s.44	CO #002	2012_204133_0004 (conducted November 2,5,6 – 2012)	#133

Issued on this 2nd day of April , 2013

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

Jessica Lapensée

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_204133_0007
Log No. / Registre no:	O-002357-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 2, 2013
Licensee / Titulaire de permis :	The Royale Development LP 302 Town Centre Blvd, Suite 200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Leisureworld Caregiving Centre - Madonna 1541 St Joseph Blvd, Orleans, ON, K1C-7L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Wendt

To The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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).

Order / Ordre :

The licensee will prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, c.8, s.6(7). Specifically, the plan will outline how the licensee will ensure that when it is identified in a resident's plan of care that the resident requires a 6 loop transfer sling be used with a mechanical lift for their transfers, nursing staff use a 6 loop transfer sling of the correct size (as per the plan of care) to transfer the resident at all times. The plan must address the temporary lack of availability of 6 loop transfer sling(s) on the care units that may be created when they are sent to the laundry. This portion of the plan must outline how all nursing staff, including part time and casual staff, have been informed of this process and how supervisory staff and or management staff will ensure that the process is effective and does not cause delays in transferring residents who require it. Overall, the plan must include measures that will be taken by supervisory staff and/or management staff to ensure immediate and sustained compliance with the requirement that residents identified as requiring it are transferred with a 6 loop transfer sling of the correct size, as indicated within their plan of care.

The plan is to be submitted in writing to Long Term Care Home inspector Jessica Lapensee at 347 Preston Street, 4th floor, Ottawa, Ontario, K1S 3J4. Alternately, the plan may be faxed to the inspector's attention at (613) 569-9670. The plan must be submitted by Wednesday April 9th 2013. The plan must be fully implemented by Wednesday, April 12th 2013. When submitting the plan, please ensure that it is identified that the plan is associated with inspection number 2013_204133_0007.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, c.8, s.6(7) in that the care set out in the plan of care of three identified residents was not provided to the residents as specified in the plan. Specifically, on March 18th 2013, resident #001, #002 and #005, who are supposed to be transferred with a mechanical lift and a 6 loop transfer sling, were transferred with a mechanical lift and a 4 loop transfer sling.

The inspector arrived on to one of the home's care units at approximately 10:30am on March 18th 2013 to begin follow up to compliance order #002, issued to the home on November 14th 2012, for inspection #2012_204133_0004, related to the availability of 6 loop transfer slings following a mechanical lift accident, in September 2012. Resident #001, at the time of the inspection, resides on the care unit. As per resident #001's plan of care, resident #001 is to be transferred with a mechanical lift and a medium 6 loop transfer sling. During the inspection, on March 18th 2013, at approximately 11am, the inspector observed that resident #001 was in their bedroom, sitting in their wheelchair with a transfer sling underneath them. With the assistance of staff member #S100, the inspector determined that it was a large 4 loop transfer sling underneath resident #001, which is both the wrong size and wrong style of transfer sling. Staff member #100 confirmed this was the sling used to transfer resident #001, with a mechanical lift, from their bed to their wheelchair earlier that morning. Following that, the inspector observed that resident #002 was in the dining room, sitting in their wheelchair with a transfer sling underneath them. As per resident #002's plan of care, resident #002 is to be transferred using a large 6 loop transfer sling. With the assistance of staff member #S101, the inspector determined that it was a large 4 loop transfer sling underneath the resident, which is the wrong style of transfer sling. Staff member #S101 informed the inspector that they had assisted staff member #100 transfer resident #002 that morning using a mechanical lift and the sling that the resident was sitting on in their wheelchair.

In addition to resident #001 and #002 noted above, there are two other residents (#003, #004) who require the use of a 6 loop transfer sling with a mechanical lift for their transfers on the care unit. As noted above, resident #001 requires a medium 6 loop transfer sling. Residents #002-#004 require a large 6 loop transfer sling. The home's nursing rehabilitation coordinator told the inspector that on the care unit, there should be three 6 loop transfer slings, one medium and two large, that are to be shared amongst the residents who require them.

Only one large 6 loop transfer sling could be found while the inspector was on the care unit in the morning of March 18th 2013. It was found underneath resident #003, who was sitting in their wheelchair, in their bedroom. Staff member #S100 informed the inspector that when the large 6 loop transfer sling is not underneath resident #003, this transfer sling typically stays in resident #003's bedroom as it is required multiple times throughout the day. With regards to resident #004, the inspector was told, by staff member #S103, that they had used a 6 loop transfer sling with a mechanical lift to transfer resident #004 earlier that day. Staff member #S100, who helped staff member #S103 transfer resident #004 earlier that day, told the inspector that they did not know what kind of transfer sling that they and staff member #S103 had used to transfer resident #004. Apart from the one large 6 loop transfer sling underneath resident #003, no other 6 loop transfer sling could be located at the time. Later in the day, at 3:25pm on March 18th 2013, the inspector was made aware that at the end of the day shift, the care unit nursing staff had located two medium 6 loop transfer slings within the care unit. One large 6 loop transfer sling remained unaccounted for.

On another care unit, at approximately 1:30pm on March 18th 2013, the inspector went into resident #005's bedroom and found a large 4 loop transfer sling on their comfortable easy chair. It is noted that resident #005 was previously involved in a lift accident at the home, in May 2012. As per resident #005's plan of care, staff are to use a large 6 loop transfer sling with a mechanical lift for all transfers of resident #005. The inspector spoke with staff member #S105 who confirmed that they had transferred resident #005 earlier that day, from bed to wheelchair, with the assistance of staff member #S106, using a mechanical lift and the 4 loop transfer sling that the inspector had observed on the resident's comfortable easy chair. This is the wrong style of transfer sling. Following discussion with the inspector about the transfer sling, staff member #S105 explained that they thought the 4 loop sling was a 6 loop sling, due to the 2 leg straps at the base of the sling in addition to the 4 side loops, and that this had been discussed with their superior, staff member #S107. Another staff member, #S108, found a large 6 loop transfer sling in the linen storage room several minutes later, across the hall from resident #005's bedroom. Staff member #S108 explained to the inspector that this indicated that the large 6 loop transfer sling had recently been returned to the care unit from the laundry. The home's nursing rehab coordinator told the inspector that one medium 6 loop transfer sling and one large 6 loop transfer sling have been

provided to this care unit for use with the two residents who require them. The medium 6 loop transfer sling was located within a resident's bedroom.

The plan of care for resident #001, #002 and #005 indicates they are to be transferred with a mechanical lift and a 6 loop transfer sling. On March 18th 2013, the inspector found that staff had used a 4 loop transfer sling to transfer these residents with a mechanical lift, which is the wrong style of transfer sling. As well, resident #001 was transferred with the wrong size of transfer sling. This presents a potential risk to the safety and well-being of these three residents. The licensee has failed to comply with LTCHA, 2007, c.8, s.6(7).
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 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.

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of April, 2013

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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