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 sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d’Ottawa
347 rue Preston bureau 420
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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 23, 2016	2016_360111_0004	005660-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571), SARAH GILLIS (623)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): February 29, March 1-3 , & 8, 2016

The following inspections were completed concurrently during this inspection :anonymous complaint (log # 005660-16) related to medications, pain management and responsive behaviours; complaint and critical incident (log # 006079-16) related to allegations of staff to resident abuse and/or neglect; and a critical incident (log #011572-15) related to allegation of staff to resident abuse (completed by Inspector Patti Mata #571).

During the course of the inspection, the inspector(s) spoke with Residents, Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), RAI -Coordinator, Registered Nurses (RN), Registered Practical Nurses(RPN), and Personal Support Workers(PSW).

During the course of the inspection, the inspector(s) also observed residents, reviewed health records, reviewed the home's investigations, and reviewed the following policies:prevention of abuse, pain management, and responsive behaviours.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of

abuse and neglect of residents was complied with.

Related to log # 006079-16:

Under O.Reg.79/10, s.2(1) For the purpose of the definition of abuse in subsection 2(1) of the Act, emotional abuse means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

This definition is included in the home's policy.

Review of the home's policy "Resident Non-Abuse-Ontario" (LP-C-20-ON) revised March 2013 indicated:
-on page 4 of 14, any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) or if unavailable, to the most senior supervisor on shift at that time.
-On page 5 of 14, the first priority is to ensure the safety and comfort of the abuse victim (s), then a completion of full assessments.
-On page 6 of 14, accurate detailed description of injuries/condition is documented in the resident chart; the resident substitute decision maker (SDM) (if any) and/or any other person specified by the Resident, will be notified immediately upon the home becoming aware of any alleged, suspected or witnessed incident of abuse or neglect that causes distress to the resident that could potentially be detrimental to the residents health or well-being; an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the home ED or designate.
-On page 7 of 14, if a staff member is alleged, suspected or witnessed to have abused and/or neglected a resident , that staff member will be immediately suspended from their duties with pay and required to leave the premises pending the investigation.

Review of the home's investigation, interview of staff, observation of residents, and review of the residents health records indicated on a specified date and time, a staff member witnessed two incidents of staff to resident emotional abuse towards two different residents (#001 & #002)by the same staff member. Both incidents were not documented indicating assessment of the residents as per the home's policy. The SDM's were also not immediately notified as per the home's policy. The investigation was not commenced immediately and thoroughly by the ED as per the home's policy and the staff

member involved in the alleged abuse was not suspended pending the investigation as per the home's policy.

A compliance order was issued as the scope demonstrated that more than one allegation of staff to resident abuse occurred in this incident and many staff did not follow the home's prevention of the abuse policy. The severity was demonstrated as the home had previous non-compliance under LTCHA, 2007, s.20(1) April 7, 2015 during the RQI inspection #2015_195166_007 as a VPC and again on September 21, 2015 during inspection #2015_328571_0009. [s. 20. (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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated: (i) Abuse of a resident by anyone.

Related to log #006079-16 for resident #001 & #002:

Review of the home's investigation, interview of staff, observation of residents, and review of the residents health records indicated on a specified date and time, a staff member witnessed two incidents of staff to resident emotional abuse towards two different residents (#001 & #002)by the same staff member.

Review of the home's investigation, interview of staff, observation of residents, and review of the residents health records indicated the investigation was not completed until two days after the first incident occurred, and one day after the second incident occurred. Furthermore, the Critical Incident Report completed by the ED indicated on a specified date, that the investigation was completed and determined the allegations were unfounded despite four staff that were either being present, or having knowledge of the incidents were never interviewed regarding the allegations. Two staff of the staff that were interviewed regarding the allegations were not interviewed until 4-5 days after the ED indicated the investigation was completed and abuse was "not substantiated".[s. 23. (1) (a)]

2. The licensee has failed to ensure that the results of an investigation for alleged neglect of resident #030 was reported to the Director.

Regarding Log # 011572-15 for resident #030:

A Critical Incident was reported to the Director for an allegation of neglect towards resident #030 that occurred on a specified date.

The outcome of the investigation was not reported to the Director until approximately nine months later, after the inspector interviewed the Director of Care.(571) [s.23(2)]

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 all allegations, suspicions or witnessed incidents of abuse towards residents are immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log #006079-16 for resident #001 & #002:

A critical incident report was received on a specified date for an allegation of staff to resident emotional abuse towards resident #001 was reported to an RN supervisor. The ED and DOC confirmed the Director was notified when the critical incident was submitted (two days later).

A second allegation was reported ED and DOC on a specified date of staff to resident abuse. Interview of the ED regarding the second allegation of staff to resident abuse towards resident #002 stated “I didn’t look at the situation as an allegation of abuse". Therefore, the allegation of staff to resident abuse was not reported to the Director until 15 days after the allegation was reported, when it was reported to the inspector.[s. 24. (1)]

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 any alleged, suspected or witnessed incidents of staff to resident abuse are immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to log # 006079-16 for resident #001 & #002:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident emotional abuse towards resident #001. The CIR indicated the Substitute Decision Maker was notified but no name was provided.

Review of the health care record of resident #001 had no documented evidence of the incident or whether the SDM was ever notified of the allegation.

Interview of the ED indicated no awareness of the SDM of resident #001 was notified of the allegation of staff to resident emotional abuse.

A second allegation of staff to resident abuse towards resident #002 was reported to the ADOC and ED on a specified date. Interview of the charge nurse who witnessed the

incident indicated the SDM was not contacted regarding incident.

Review of the health care record for resident #002 had no documented evidence of the incident or to indicate the SDM was notified.

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Interview of the ED confirmed the SDM of resident #001 was not notified of the outcome of the home's investigation.[s.97(2)]. [s. 97. (1) (b)]

2. Related to log #011572-15 for resident #30:

A Critical Incident was reported to the Director for an alleged neglect of care that was reported to the DOC. The CIR indicated the incident occurred on a specified date. The outcome of the home's investigation was not reported to the Director on the CIR.

The outcome of the investigation was still not reported to the Director at the time of the RQI inspection (571). [s.97(2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of any staff members who were present at the incident.

Related to log #005660-16 for resident #007:

A critical incident report was submitted to the Director on a specified date for an allegation of staff to resident sexual abuse. The CIR indicated the home received the allegation from the police the same day the allegation was reported to the Director. The CIR did not indicate which staff member was involved in the allegation.

Interview of the ED identified who the staff member involved in the allegation was and confirmed the staff member was not identified on the CIR. [s. 104(1) 2.]

2. Related to log #006079-16 for resident #001:

A critical incident report was received on a specified date regarding an alleged staff to resident emotional abuse towards resident #001. The CIR identified four staff that were present and/or discovered the incident. The CIR was completed by the Executive Director (ED).

Review of the home's investigation and interview of staff indicated four additional staff were also either present during the incident and/or discovered the incident and they were not identified in the CIR. [s.104(1) 2.]

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2016_360111_0004
Log No. / Registre no:	005660-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 23, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAY RIDGES 900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea DeLuca

To REVERA LONG TERM CARE 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall develop, implement and submit a corrective action plan to ensure the following is completed:
-review the home's policy with all nursing staff and management to ensure awareness of roles and responsibilities related to responses to alleged, suspected or witnessed incidents of abuse and/or neglect of residents by staff, documentation of incidents, and reporting requirements of same.
-develop a monitoring process to ensure staff compliance with same, and measures to be taken when non-compliance occurs.

This plan is to be completed and submitted to Lynda Brown, Long Term Care Inspector (Nursing) via email to OttawaSAO.MOH@ontario.ca by April 4, 2016.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to log # 006079-16:

Under O.Reg.79/10, s.2(1) For the purpose of the definition of abuse in subsection 2(1) of the Act, emotional abuse means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

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-On page 6 of 14, accurate detailed description of injuries/condition is documented in the resident chart; the resident substitute decision maker (SDM) (if any) and/or any other person specified by the Resident, will be notified immediately upon the home becoming aware of any alleged, suspected or witnessed incident of abuse or neglect that causes distress to the resident that could potentially be detrimental to the residents health or well-being; an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the home ED or designate.
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A compliance order was issued as the scope demonstrated that more than one allegation of staff to resident abuse occurred in this incident and many staff did not follow the home's prevention of the abuse policy. The severity was demonstrated as the home had previous non-compliance under LTCHA, 2007, s.20(1) April 7, 2015 during the RQI inspection #2015_195166_007 as a VPC and again on September 21, 2015 during inspection #2015_328571_0009. [s.

20. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2016

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 sions 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
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions 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

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 March, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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