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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 13, Sep 4, 2013	2013_170203_0018	L-000217-13	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street, MARKDALE, ON, N0C-1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH, MARKDALE, ON, N0C-1H0

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

CARMEN PRIESTER (203), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

Ontario

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

This inspection was conducted on the following date(s): April 24, 25, May 3, June 6, 11, 13, 18, 19, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Office Manager, 9 Residents, 2 Family members, 16 Personal Support Workers, 1 Registered Nurse, 3 Registered Practical Nurses, Chair of Family Council, President of Resident's Council and 1 Volunteer.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed minutes of meetings, documentation related to staff education, home's investigation records, staff employment records, documentation regarding concerns and complaints, minutes of Resident and Family Council meetings, reviewed staff schedules and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

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. A critical incident was submitted to the Ministry of Health and Long Term Care, with accompanying videotape, of staff to resident verbal and physical abuse. The exact date of the abuse is unknown, but is captured on videotape between the dates of February 12 and February 22, 2013. The videotape was brought forward to the management of the home by the resident's daughter.

i) The licensee did not ensure that a specified resident was protected from abuse as evidenced by:
- Three Personal Support Workers (PSW's) who witnessed physical and verbal abuse, failed to report the incident of abuse to their supervisors, management or the Director under the Long Term Care Homes Act.
- In interviews conducted during the inspection, 35% of PSW's stated that they had witnessed abuse, but did not report the abuse to anyone.
- The videotape was viewed by the inspectors and confirms physical and verbal abuse.

ii) The licensee failed to provide a culture in the home that encourages and supports staff to report and provide information to discourage abuse and neglect. Of the total number of staff interviewed:
- 20% of staff stated that they were afraid or intimidated by the abuser, one of their co-workers.
- 60% of staff stated that they were aware that the abuser was having "difficulty coping" over the last six to eighteen months
- 50% of staff stated that they thought the abuser was "burned out and needed time off".
- Incidents of bullying and intimidation by the abuser were reported by 30% of PSW's interviewed by the inspectors and further confirmed by Registered Staff. Registered staff stated that the abuser could be sarcastic, insubordinate, abrupt and disagreeable.

iii) The licensee failed to provide retraining of the PSW's that witnessed these incidents of abuse, prior to their return to work.
- Upon completion of the home's investigation the PSW's that witnessed the abuse, were returned to work but were not required to participate in retraining or further education.
- The Administrator confirmed that the staff were not retrained as they had just

completed the required training on Prevention of Abuse. These PSW's witnessed abuse while completing their education and failed to report the abuse.
- At the time of the interview with the inspectors, one of the PSW's could not recall the training on abuse prevention and had difficulty describing verbal and physical abuse.

iv) The licensee failed to report to the Director under the Long Term Care Homes Act, abuse to another resident, that was revealed to the management of the home, in the course of the home's investigation into these incidents of abuse. This is evidenced by:
- The home's investigation notes revealed during an interview it was alleged that the abuser had abused another identified resident.
There is no evidence to support that this information was further investigated or reported to the Director. [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. 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 staff interviewed indicated that the culture in the home was not conducive to the reporting of abuse and neglect. Registered staff members and 40% of the Personal Support Workers interviewed, reported that the abuser, bullied her co-workers and they feared repercussions from her. 20% of the Personal Support workers interviewed stated, "they were not sure anything would have been done had the incidents not been recorded on video." [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 see Order #1, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the policy of the home to promote zero tolerance of abuse and neglect of residents, identifies measures and strategies to prevent abuse.
This was confirmed by the Director of Care. [s. 96. (c)]

2. The Licensee has failed to ensure that the policy of the home to promote zero tolerance of abuse and neglect of residents, identifies the training and retraining requirements for all staff including situations that may lead to abuse and neglect and how to avoid such situations.
Personal Support Workers who failed to report witnessed abuse were returned to work with no retraining on prevention of abuse or mandatory reporting.
The administrator confirmed that these staff were not retrained as they had just completed this years training on prevention of abuse. These PSW's witnessed abuse while completing their education and failed to report the abuse. [s. 96. (e)]

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 see Order #2, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The Licensee has not ensured that at least once every calendar year, an evaluation is made to determine the effectiveness of their policy to promote zero tolerance of abuse and neglect of residents.
The home was unable to provide documentation to support that an annual evaluation of the Prevention of Abuse Program had occurred.
This was confirmed by the Administrator. [s. 99. (b)]

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 the Prevention of abuse and Neglect program is evaluated once every calendar year to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

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1. The Licensee did not ensure that every written or verbal complaint made to the Licensee or staff member concerning the care of a resident was investigated, as evidenced by:
- A Registered staff documented in the progress note for a specific resident, that the resident complained about 2 staff members.
- Interview with the Administrator confirmed that she was not aware of this complaint nor had it been investigated.
- A specified resident sustained a skin injury, this incident was not reported to the management, nor was the cause investigated. This was confirmed by the Administrator. [s. 101. (1) 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 every written or verbal complaint made to the licensee or staff member concerning the care of a resident is investigated, to be implemented voluntarily.

WN #6: 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 their policy to promote zero tolerance of abuse and neglect of residents, contains an explanation of the duty under section 24 to make mandatory reports as evidenced by:

- A review of documentation indicates that 100% of the homes' staff completed the current year's mandatory education regarding Prevention of Abuse and Neglect. Despite having just completed the education, interviews conducted by the inspectors revealed that:
- 35% witnessed abuse but did not report the abuse to anyone
- 10% could not recall the abuse prevention education that they had recently completed and;
- 15% of the staff could not define physical and verbal abuse

The Licensee failed to ensure that the Prevention of Abuse policy, identified measures and strategies to prevent abuse and neglect and provided training regarding recognizing and managing situations that may lead to abuse and neglect.
During interviews, 20% of the staff stated that they were afraid or intimidated by the abuser and 50% stated that they were aware of changes in the abuser's behaviour and that she was not "coping well". Despite being able to identify these changes, the staff were unable to identify that these changes might contribute to an increased potential for abuse to occur.

The Licensee failed to ensure that the staff understood the duty to report abuse to the Director is the responsibility of any person who had reason to suspect that abuse or neglect has occurred.
A review of the Long Term Care Home's policy and procedure does not identify the responsibility for staff to report to the Director. The staff did not understand that they had a duty to report.

- Personal Support Workers who witnessed physical and verbal abuse of residents, did not report the abuse to their supervisors, management or the Director.
- During interviews conducted by the inspectors, 7 staff members were able to identify acts of abuse that they had witnessed, however, when questioned by the inspectors about the action they would take in the future, only 4/7 stated they would report the abuse.
- a Registered staff member was made aware of and documented in the clinical record, a resident's complaint about care provided by staff members. The Registered

staff member failed to investigate the resident's complaint, nor was the concern/complaint reported to the management of the home.
- The management of the home did not report to the Director, under the Long Term Care Homes Act, nor did they further investigate, a past incident of abuse of a resident, that was reported to them. [s. 20. (2)]

CO #-002 will be served on the licensee. Refer to the "Order(s) of the Inspector.

Issued on this 17th day of September, 2013

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

CARMEN PRIESTER

Ontario

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

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Carmen Priester	**Inspector ID #**	203
Log #:	L-000217-13		
Inspection Report #:	2013-170203-0018		
Type of Inspection:	Critical Incident		
Date of Inspection:	April 24, 25, May 3, June 6, 11, 13, 18, 19, 2013		
Licensee:	Corporation of the County of Grey 206 Toronto, Street, Markdale, Ontario N0C 1H0		
LTC Home:	Grey Gables Home for the Aged 206 Toronto Street South, Markdale, Ontario N0H 1H0		
Name of Administrator:	Jennifer Cornell		

To Corporation of the County of Grey], you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
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.

Order:
The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone. The plan shall include the following:
a) How the Licensee will ensure staff who have reasonable grounds to suspect abuse or neglect of a resident by anyone shall immediately report the suspicion and the information on which it is based to the Director under the Long Term Care Homes Act (LTCHA) and:

b) How the licensee will establish a culture that promotes this reporting and that the information provided to staff on the obligation to report is provided in a manner that would not have the effect of discouraging such reporting.
This plan is to be submitted to Carmen.Priester@ontario.ca by August 30, 2013.

Grounds:

1. i) During this inspection it was confirmed that a specific resident suffered abuse.The licensee did not ensure that this resident was protected from abuse as evidenced by:
- Personal Support Workers (PSW's) who witnessed physical and verbal abuse, failed to report the incident of abuse to their supervisors, management or the Director under the Long Term Care Homes Act (LTCHA).
- In interviews conducted by the inspectors during this inspection, 35% of PSW's stated that they had witnessed abuse, but did not report the abuse to anyone.
- The videotape was viewed by the inspectors and confirm that physical and verbal abuse had occurred.

ii) The licensee failed to provide a culture in the home that encourages and supports staff to report and provide information to discourage abuse and neglect. Of the total number of staff interviewed by the inspectors:
- 20% of staff stated that they were afraid or intimidated by the abuser, one of their co-workers.
- 60% of staff stated that they were aware that the abuser was having "difficulty coping" over the last six to eighteen months
- 50% of staff stated that they thought the abuser was "burned out and needed time off".
- Incidents of bullying and intimidation by the abuser were reported by 30% of PSW's interviewed by the inspectors and further confirmed by Registered Staff. Registered staff stated that the abuser could be sarcastic, insubordinate, abrupt and disagreeable.

iii) The licensee failed to provide retraining of the PSW's that witnessed the abuse, prior to their return to work. This was evidenced by:
- Upon completion of the home's investigation the PSW's that witnessed the abuse, were returned to work , but were not required to participate in retraining or further education.
- The Administrator confirmed that the staff were not retrained as they had just completed the required training on Prevention of Abuse. These PSW's witnessed abuse while completing their education and failed to report the abuse

to anyone.
-At the time of the interview with the inspectors, one of the PSW's could not recall the training on abuse prevention and had difficulty describing verbal and physical abuse.
iv) The licensee failed to report to the Director under the Long Term Care Homes Act (LTCHA), abuse to another resident, that was revealed to the management of the home in the course of the home's investigation into these incidents of abuse. This is evidenced by:
a) The home's investigation notes revealed that during an interview it was alleged that the abuser had abused another identified resident.
There is no evidence to support that this information was further investigated or reported to the Director under the long Term Care Homes Act.

This order must be complied with by:	September 30, 2013

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
LTCHA, 2007 S.O.2007,c.8,s.20(2) At a minimum, the policy tp promote zero tolerance of abuse and neglect of residents,

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

Order:
The licensee shall update the policy for Prevention of abuse to contain:

1) **An explanation of the duty under section 24 of the Act that anyone suspecting or witnessing abuse has the responsibility to report**

immediately to the Director under the Long Term Care Homes Act,

2) Any additional matters as may be required in the regulations including identifying measures and strategies to prevent abuse and neglect, and identifies the training and retraining requirements for all staff, including situations that may lead to abuse and how to avoid such situations.

Grounds:

During this inspection it was confirmed that an identified resident suffered abuse. The Licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents, contains an explanation of the duty under section 24 to make mandatory reports as evidenced by:

- A review of documentation indicates that 100% of the homes' staff completed the current year's mandatory education regarding Prevention of Abuse and Neglect. Despite having just completed the education, interviews conducted during the investigation revealed that:
- 35% witnessed abuse but did not report the abuse to anyone
- 10% could not recall the abuse prevention education that they had recently completed and;
- 15% of the staff could not define physical and verbal abuse

The Licensee failed to ensure that the Prevention of Abuse policy, identified measures and strategies to prevent abuse and neglect and provided training regarding recognizing and managing situations that may lead to abuse and neglect. During interviews, 20% of the staff stated that they were afraid or intimidated by the abuser and 50% stated that they were aware of changes in the abuser's behaviour and that she was not "coping well". Despite being able to identify these changes, the staff were unable to identify that these changes might contribute to an increased potential for abuse to occur.

The Licensee failed to ensure that the staff understood the duty to report abuse to the Director under the Long Term Care Homes Act, is the responsibility of any person who had reason to suspect that abuse or neglect has occurred.
A review of the Long Term Care Home's policy and procedure does not identify the responsibility for staff to report to the Director. The staff interviewed by the inspector did not understand that they had a duty to report.

- Personal Support Workers who witnessed physical and verbal abuse of residents, did not report the abuse to their supervisors, management or the Director.
- During interviews conducted by the inspector, 7 of the staff were able to identify

acts of abuse that they had witnessed, however when questioned about the action they would take in the future, only 4/7 stated they would report the abuse. - A Registered staff member was made aware of and documented in the clinical record, a resident's complaint about care provided by staff members. The Registered staff member failed to investigate the resident's complaint, nor was the concern/complaint reported to the management of the home. - The management of the home did not report to the Director under the Long Term Care Homes Act, nor did they further investigate, a past incident of abuse of a resident, that was reported to them.

This order must be complied with by:	October 30, 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 service 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, Ontario
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver 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, Ontario
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, Ontario
M5S 2B1

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.

Issued on this 5th day of September, 2013.	
Signature of Inspector:	
Name of Inspector:	Carmen Priester #203
Service Area Office:	London service area Office