



**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**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**

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, 4ième étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

**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**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 18, 31, 2013	2013_031194_0001	001171- 12,001230- 12,000014- 13	Critical Incident System

**Licensee/Titulaire de permis**

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP  
302 Town Centre Blvd., Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - ELLESMERE  
1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2

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

CHANTAL LAFRENIERE (194)

**Inspection Summary/Résumé de l'inspection**



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 9, 10 & 11, 2013

During the course of this inspection, the inspector completed three Critical Incident Inspections; Log#001171-12, Log#001230-12 and Log#000014-13

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care(DOC), one Registered Nurse(RN), one Registered Practical Nurse(RPN), three Personal Support Worker(PSW), and residents.

During the course of the inspection, the inspector(s) reviewed five resident's clinical health records, the licensee's Abuse Policy, the licensee's abuse training education records, and a Critical Incident Report. Observed meal service and resident/staff interactions.

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

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



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des  
Soins de longue durée

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

Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée

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 :**



**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**

---

1. The licensee failed to comply with LTCHA, 2007 s.19(1) when residents #03 and #04 were not protected from neglect by a staff on an identified date.

Ontario Regulation 79/10, made under the Long Term Care Homes Act 2007, defines "neglect" as the failure to provide a resident with the treatment, care, service or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee's internal investigation confirms that on an identified date, a PSW staff witnessed resident #05 being inappropriate with two other residents and did not act to ensure the well being of the residents

It was confirmed by Nurse Manager that both resident identified were cognitively impaired and not able to defend themselves against the behaviour exhibited by resident #05.

Review of resident #05 clinical documentation confirms the resident has previous history of this behaviour.

The licensee was not able to provide records of abuse training for the identified staff members. The inspector was given verbal confirmation by the DOC that the identified staff members had been provided with abuse training at the home.

The Licensee's policy "Abuse and Neglect Resident" V3-010 dated February 2012 directs staff to:

- a) Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident
- b) Remove the resident from the abuser, or if that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident
- c) Immediately inform the Director of Administration and/or Charge Nurse in the home.

The licensee's internal investigation confirms that the PSW who witnessed the incidents, did not provide the care and assistance required for the safety or well-being of resident #03 and #04 and did not immediately report the incidents. [s. 19. (1)]



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

---

***Additional Required Actions:***

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

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**  
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**  
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**  
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

---

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 s.6.1(c) when resident's #05 plan of care did not provide clear direction to staff related to responsive behaviour

On an identified date, a PSW staff witnessed resident #05 being inappropriate with two other residents on three separate occasions.

It was confirmed by Nurse Manager that both resident #03 and #04 are cognitively impaired and not able to defend themselves against the behaviour exhibited by resident #05.

Resident #05 was discharged for further assessment.

Review of resident #05 clinical documentation confirms that the resident has previous history of the behaviour, but the plan of care does not provide clear directions for interventions related to this behaviour. [s. 6. (1) (c)]



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des  
Soins de longue durée

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

Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée

---

**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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the residents with abusive behaviours, to be implemented voluntarily.***

---

**WN #3: 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).**

---

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 s. 23 when resident #02 reported an allegation of abuse to the charge nurse and it was not immediately investigated.

Critical Inspection report and clinical health records reviewed by the inspector confirm that resident #02 reported an allegation of abuse to the charge nurse and it was not immediately investigated by the licensee[s. 23. (1) (a)]

---

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

---

**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, ss. 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, ss. 24 (1), 195 (2).**

**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).**

**4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).**

---

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 s. 24(1) when resident #02 reported an allegation of abuse to the charge nurse and it was not immediately reported to the Director.

The licensee's internal investigation confirms that resident #02 reported an incident of abuse to the charge nurse on an identified date and it was not immediately reported to the Director [s. 24. (1)]

---



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

---

**Issued on this 31st day of January, 2013**

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

*Chantal Japeneere (194)*





**Ministry of Health and  
Long-Term Care**

**Ministère 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) :** CHANTAL LAFRENIERE (194)

**Inspection No. /**

**No de l'inspection :** 2013\_031194\_0001

**Log No. /**

**Registre no:** 001171-12,001230-12,000014-13

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Jan 18, 31, 2013

**Licensee /**

**Titulaire de permis :** 2063414 ONTARIO LIMITED AS GENERAL PARTNER  
OF 2063414 INVESTMENT LP  
302 Town Centre Blvd., Suite #200, TORONTO, ON,  
L3R-0E8

**LTC Home /**

**Foyer de SLD :** LEISUREWORLD CAREGIVING CENTRE -  
ELLESMERE  
1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2

**Name of Administrator /**

**Nom de l'administratrice  
ou de l'administrateur :** DENISE BROWN

---



**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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414  
INVESTMENT LP, you are hereby required to comply with the following order(s) by  
the date(s) set out below:



**Ministry of Health and  
Long-Term Care**

**Ministère 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

---

**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. 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 :**

The licensee will prepare, submit and implement a plan to ensure that action is taken to protect residents from neglect by the staff as well as a plan including staff training to ensure the licensee's policy and procedures on "Abuse and Neglect Resident" V3-010 are followed

This plan must be submitted in writing to inspector :Chantal Lafreniere at 347 Preston Street, 4th Floor, Ottawa, ON. K1S 3J4 or by fax at 613-569-9670 on or before January 25, 2013

**Grounds / Motifs :**

1. The licensee failed to comply with LTCHA, 2007 s.19(1) when residents #03 and #04 were not protected from neglect by a staff on an identified date.

Ontario Regulation 79/10, made under the Long Term Care Homes Act 2007, defines "neglect" as the failure to provide a resident with the treatment, care, service or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee's internal investigation confirms that on an identified date, a PSW staff witnessed resident #05 being inappropriate with two other residents and did not act to ensure the well being of the residents

It was confirmed by Nurse Manager that both resident identified were cognitively impaired and not able to defend themselves against the behaviour exhibited by resident #05.



**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

Review of resident #05 clinical documentation confirms the resident has previous history of this behaviour.

The licensee was not able to provide records of abuse training for the identified staff members. The inspector was given verbal confirmation by the DOC that the identified staff members had been provided with abuse training at the home.

The Licensee's policy "Abuse and Neglect Resident" V3-010 dated February 2012 directs staff to:

- a) Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident
- b) Remove the resident from the abuser, or if that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident
- c) Immediately inform the Director of Administration and/or Charge Nurse in the home.

The licensee's internal investigation confirms that the PSW who witnessed the incidents, did not provide the care and assistance required for the safety or well-being of resident #03 and #04 and did not immediately report the incidents. [s. 19. (1)] (194)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :** Feb 22, 2013



**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

## **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



**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

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](http://www.hsarb.on.ca).



**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*

## **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.



**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](http://www.hsarb.on.ca).

**Issued on this 18th day of January, 2013**

**Signature of Inspector /**

**Signature de l'inspecteur :** *Chantal Lafreniere (194)*

**Name of Inspector /**

**Nom de l'inspecteur :** Chantal Lafreniere

**Service Area Office /**

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