Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 29, Jul 3, 6, 9, 24, 26, 27, 31, Aug 2, 3, 7, 8, 2012	2012_147113_0028	Critical Incident

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

JANE CARRUTHERS (113), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, charge nurse (RNA) for Resident Home Area 4A, laundry worker, Personal Support Workers(PSW), Student PSWs, housekeeping staff, Environmental Service Manager and maintenance staff.

During the course of the inspection, the inspector(s) conducted a walk through Resident Home Area 4A, inspected the laundry/garbage chute room and door security, reviewed last fire inspection, a repair invoice for the laundry chute door, and plan of care and progress notes for Resident #1.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. An identified resident gained access to a secured area of the home and died subsequent to injuries sustained.
There was no self closing devise, as required, on the laundry chute door to ensure the door would close tightly and the latch would engage.
One staff member interviewed after the incident stated that the chute door was left wide open at the time she entered the room to throw her laundry down sometime between 13:00 and 13:20 hrs.

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. On July 6, 2012, at approximately 10:30hrs stairway #3 door in the secure unit was not secure. The door could be pushed open because the mag lock was not engaged. A maintenance person stated that this happens when air pressure prevents the doors from closing tightly.[sect 9(1)1i]
2. On July 6, 2012 when the stairway #3 door was not secured, there was no audible alarm to warn the staff. It was determined that the alarm in the enunciator panel had been turned down so low it was unable to alert staff that the door was not secured.
On July 24, 2012 the stairway #3 door was reinspected. At that time when the door was opened and the alarm sounded, a staff member canceled the alarm through a devise located in a nearby hallway. The enunciator panel still indicated the stairway door was open with the sound of the alarm but the call was canceled on a pager that was being tested. [sect 9 (1)iiiA]

Additional Required Actions:

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

WN #3: 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 subsections:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure the resident was reassessed related to mobility and responsive behaviors and the plan of care was reviewed and revised when the resident's care needs changed and when the care set out in the plan was not effective.

Review of clinical health record for resident #1 in the progress notes indicated:
On June 28/12 @ approximately 13:00 hrs the resident was noted to be missing by a PSW. The charge nurse (RPN) was notified and a code yellow was initiated. The charge nurse (RPN) indicated she received a call at approximately 13:30 hrs from the laundry department that the resident was found. Resident was transferred to hospital at approximately 13:45 hrs.
On June 30/12 a call was received from the coroner indicating the resident had died.

Review of the clinical health record for resident #1 in the written plan of care (July 4/12) indicated:
-locomotion in room/in corridor: requires no aids, full weight bearing with supervision, and no setup or physical help from staff.
-responsive behaviours: wandering (history of exit seeking while at home, behaviour not present but wandering potential).

Review of the clinical health record for resident #1 in the progress notes indicated:
-the resident was exit-seeking on the home area on Apr.13, May 14, June 18, 19, 24, 26, & 28, 2012.
-the resident had eloped outside of the home area to the elevator on June 18/12, June 19/12, June 26/12 and June 28/12 @ approx. 11:00 hrs.

Interview of PSW 's indicated resident #1 did not speak English, could walk short distances, sometimes walked behind a wheelchair while pushing it, occasionally would pack up belongings, exit seeks and has managed to exit out of the unit, can be very agitated and and verbally aggressive at times.

Interview of PSW's indicated on June 28/12 that resident #1 was very agitated all morning and was exit seeking. Resident had managed to exit the unit near the elevators at approx. 12:00 hrs when another staff was coming into the unit. The resident was very resistive and had even punched two staff in the stomach. The resident was returned to the unit but refused to go to the dining room for lunch and refused to go to room. PSW's indicated the RPN gave the resident a prn for agitation at lunch. The resident sat on the floor just outside the dining room and ate lunch on the floor. PSW's indicated all staff was in the dining room serving/assisting with lunch until approx. 12:45 hrs. and the resident was last seen between 12:45-13:00 hrs. [s.6(10)(b)(c)]
2. The licensee failed to ensure that the care set out in the plan of care was based on the assessment of the residents' needs and preferences related to the high risk responsive behaviours of exit seeing and elopement.

Review of the clinical health record for resident #1 in the plan of care (July 4/12) indicated:
Wandering-history of exit seeking while at home. Has been found and returned home by police. Behaviour not present but wandering potential.

Review of the clinical health record for resident #1 indicated:
- the resident was exit seeking on Apr.13, May 14, June 18, 19, 24, 26, & 28, 2012.
- the resident had eloped from the unit on June 18/12 , June 19/12 , June 26/12 and June 28/12 @ approx. 11:00 hrs.
-the resident had eloped from the unit on June 28/12 @ approx. 12:45-13:00 hrs. resulting in serious injury and death. [s.6(2)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 31st day of August, 2012

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANE CARRUTHERS (113), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2012_147113_0028
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 29, Jul 3, 6, 9, 24, 26, 27, 31, Aug 2, 3, 7, 8, 2012
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

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:

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall ensure that the home is a safe and secure environment for its residents.

Grounds / Motifs :

1. An identified resident gained access to a secured area of the home and died subsequent to injuries sustained. There was no self closing devise, as required, on the laundry chute door to ensure the door would close tightly and the latch would engage.
One staff member interviewed after the incident stated that the chute door was left wide open at the time she entered the room to throw her laundry down sometime between 13:00 and 13:20 hrs. (113)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 13, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee shall ensure that all doors leading to stairways that residents have access to are kept closed and locked, equipped with an audible door alarm and that calls can only be cancelled at the point of activation.

Grounds / Motifs :

1. On July 6, 2012, at approximately 10:30hrs stairway #3 door in the secure unit was not secure. The door could be pushed open because the mag lock was not engaged. A maintenance person stated that this happens when air pressure prevents the doors from closing tightly. [sect 9 (1)1i)] (113)
2. On July 6, 2012 when the stairway #3 door was not secured, there was no audible alarm to warn the staff. It was determined that the alarm in the enunciator panel had been turned down so low it was unable to alert staff that the door was not secured.
On July 24, 2012 the stairway #3 door was reinspected. At that time when the door was opened and the alarm sounded, a staff member canceled the sound of the alarm through a devise located in a nearby hallway. The enunciator panel still indicated the stairway door was open with the sound of the alarm but the call was canceled on a pager that was being tested. [sect 9(1)iiiA] (113)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 13, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that all current residents are reassessed and the plan of care is reviewed and revised related to responsive behaviours when the residents' care needs change or care set out in the plan is no longer necessary or when the care set out in the plan has not been effective. [s.6(10)(b)(c)]

The plan is to be submitted to Lynda Brown via email to: lynda.brown2@ontario.ca by August 20, 2012.

Grounds / Motifs :

1. Review of the clinical health record for resident #1 in the progress notes indicated:
-On June 28/12 @ approximately 13:00 hrs the resident was noted to be missing by a PSW. The charge nurse (RPN) was notified and a code yellow was initiated. The charge nurse (RPN) indicated she received a call at approximately 13:30 hrs from the laundry department that the resident was found. Resident was transferred to hospital at approx. 13:45 hrs.
-On June 30/12 a call was received from the coroner indicating the resident had died. (111)
2. Review of the clinical health record for resident #1 in the written plan of care (July 4/12) indicated:
-locomotion in room/in corridor: required no aids, full weight bearing with supervision, and no setup or physical help from staff.
-responsive behaviours: wandering (history of exit seeking while at home, behaviour not present but wandering potential).

Review of the clinical health record for resident #1 in the progress notes indicated:
- the resident was exit-seeking on the home area on Apr.13, May 14, June 18, 19, 24, 26, & 28, 2012.
- the resident had eloped outside of the home area to the elevator on June 18/12, June 19/12, June 26/12 and June 28/12 @ approx. 11:00 hrs.

Interview of PSW 's indicated resident #1 did not speak English, could walk short distances, sometimes walked behind a wheelchair while pushing it, occasionally would pack up belongings, exit seeks and has managed to exit out of the unit, can be very agitated and and verbally aggressive at times.

Interview of PSW's indicated on June 28/12 that resident #1 was very agitated all morning and was exit seeking. Resident had managed to exit the unit near the elevators at approx. 12:00 hrs when another staff was coming into the unit. The resident was very resistive and had even punched two staff in the stomach. The resident was returned to the unit but refused to go to the dining room for lunch and refused to go to room. PSW's indicated the RPN gave the resident a prn for agitation at lunch. The resident sat on the floor just outside the dining room and ate lunch on the floor. PSW's indicated all staff was in the dining room serving/assisting with lunch until approx. 12:45 hrs. and the resident was last seen between 12:45-13:00 hrs. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 20, 2012

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that the care set out in the plan of care for every current resident with responsive behaviours, is based on an assessment of the resident and the needs and preferences of that resident. [s.6(2)]

This plan is to be submitted to Lynda Brown via email: lynda.brown2@ontario.ca by August 20, 2012.

Grounds / Motifs :

1. Review of the clinical health record for resident #1 in the plan of care (July 4/12) indicated:
Wandering - history of exit seeking while at home. Has been found and returned home by police. Behaviour not present but wandering potential. (111)
2. Review of the clinical health record for resident #1 indicated:
- the resident was exit seeking on Apr.13, May 14, June 18, 19, 24, 26, & 28, 2012.
- the resident had eloped from the unit on June 18/12 , June 19/12 , June 26/12 and June 28/12 @ approx. 11:00 hrs.
-the resident had eloped from the unit on June 28/12 @ approx. 12:45-13:00 hrs. resulting in serious injury and death. (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 20, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 8th day of August, 2012

Signature of Inspector / Signature de l'inspecteur : Jane Carruthers

Name of Inspector / Nom de l'inspecteur : JANE CARRUTHERS

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