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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
TORONTO, ON, M4V-2Y7
Telephone: (416) 325-9297
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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
May 31, Jun 1, 4, 5, 6, 2012	2012_078202_0015	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 - ETOBICOKE
70 HUMBERLINE DRIVE, ETOBICOKE, ON, M9W-7H3

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

VALERIE JOHNSTON (202)

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 Administrator, Director of Care, Registered Nurses, Registered Practical Nursing Student, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision or care to residents, reviewed clinical records, educational records, home policies related to Abuse and Neglect

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect
Specifically failed to comply with the following subsections:

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 :

The licensee failed to ensure that residents are protected from abuse by anyone. [s.19.(1)]

On May 29, 2012 the licensee reported to the Director that a Personal Support Worker (PSW) hit resident A with an open hand, grabbed resident A's hair with both hands and laughed at this resident while providing care on May 25, 2012 at 1900 hours. [s.19. (1)]

On May 25, 2012 at 1900 hours, resident A was sitting in a wheelchair by the nursing station appearing agitated. Registered Practical Nursing Student (RPNS) alerted (PSW) B that resident A required assistance. (PSW) B responded to resident A by offering personal care. Resident A refused to have care provided and became further agitated when asked by (PSW) B.(PSW) B requested assistance from Personal Support Worker (PSW) C, proceeded to push resident A's wheelchair into the nearest resident room and was witnessed to be kicking and screaming by the (RPNS).

The (RPNS) continued to hear resident A screaming from the room and entered. The (RPNS) witnessed resident A trying to hit (PSW) B while taking resident A's shirt off. (PSW) B then hit resident A on the right upper arm with an open hand and continued to pull the shirt off with such force that resident A's upper body was pulled straight forward in the wheelchair. (PSW) B began to laugh at resident A who appeared to become increasingly angry and agitated. (PSW) B then put resident A's gown on forcefully over resident A's head.

(PSW) B and (PSW) C continued to provide personal care to resident A.(PSW) C held the back of resident A's wheel chair because the resident was so angry the wheel chair was lifting upwards. (PSW) B directed (PSW) C to take the resident out of the washroom and into the bedroom. (PSW) B directed (PSW) C to take the front of the wheelchair while (PSW) B held the back of the wheelchair so that (PSW) C could try and pull the resident's pants off.(PSW) B then grabbed resident A's hair with both hands bending the resident's head backwards into the wheelchair while (PSW) C continued to pull the remainder of the pants off. Resident A slid to the floor from the wheelchair as the pants were forcefully removed by (PSW) C.

(PSW) B began to laugh at resident A while the resident was on the floor. (PSW) B then opened the bedroom door and called the charge nurse.
The charge nurse entered the room and found resident A sitting on the floor, appearing distressed and agitated.
The charge nurse offered resident A assistance back to the wheelchair but refused. The charge nurse directed staff to leave resident A on the floor until the resident calmed down. Resident A was assisted back to the wheelchair approximately 30-45 minutes after the incident.

The(RPNS)reported the incident immediately to the charge nurse. The charge nurse discussed the issue with (PSW) B and provided verbal discipline.

An interview with the charge nurse on May 31, 2012 confirmed that the witnessed abuse reported to by the (RPNS) on May 25, 2012 at 1930 hours was not reported to the Director.

On Monday May 28, 2012 the(RPNS)reported the incident to a Registered Practical Nurse(RPN)assigned to resident A's home area.

The (RPN) reported the incident to administration on May 29, 2012 and police were notified.
The (RPN) confirmed in an interview that the witnessed abuse reported to him by the (RPNS) on May 28, 2012 at 14:00 was not immediately reported to the Director.

On May 29, 2012, the home conducted an immediate investigation into the incident. Resident A was assessed for injury and was noted to have a green colored bruise on the back of right upper arm 6.0 cm x 3.0 cm.

On May 29, 2012 the police charged (PSW)B with assault and is to appear in court July 2012. The home has terminated (PSW)B and (PSW)C. The charge nurse has been disciplined.

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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
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 :

The licensee failed to ensure that an incident of staff to resident abuse was immediately reported to the Director. [s.24.(1)]

On May 25, 2012 at approximately 1900 hours, a Registered Practical Nursing Student witnessed a Personal Support Worker (PSW) hit resident A on the back of right upper arm and grabbed this resident's hair with both hands.

The (RPNS) reported the incident to the Registered Practical Nurse (RPN) in charge immediately.

An interview with the charge nurse (RPN) on May 31, 2012 confirmed that the witnessed abuse reported by the (RPNS) on May 25, 2012 at 1930 hours was not reported to the Director.

On Monday May 28, 2012 the (RPNS) reported the incident witnessed on May 25, 2012 at 1900 hours to another Registered Practical Nurse (RPN) assigned to resident A's home area.

The (RPN) confirmed in an interview that the witnessed abuse reported by the (RPNS) on May 28, 2012 at 14:00 was not immediately reported to the Director. [s.24.(1)]

On May 29, 2012 the (RPN) reported the incident to the Director of Care, who then reported the incident to the Director.

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6.(7)]

Resident A's care plan identifies this resident to be easily agitated and resistive to care. Resident A's written plan of care directs staff to re-approach resident A in 15 minutes if agitated or refuses care.

Staff interviews revealed that on May 25, 2012 at 1900 hours, resident A appeared to be agitated. The Registered Practical Nursing Student (RPNS) observed this resident to refuse personal care.
Personal Support Worker (PSW)B and Personal Support Worker (PSW)C proceeded to push resident A's wheelchair into the nearest resident room while resident A was kicking and screaming.

The(RPNS)revealed in an interview that resident A continually refused care on May 25, 2012, while staff were trying to provide care. Resident A became so agitated and angry that this resident fell onto the floor from the wheelchair during care.

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 subsections:

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 home's written policy Abuse and Neglect V3-010 February 2012 is complied with. [s.20.(1)].

The home's written policy Abuse and Neglect V3-010 February 2012 directs the charge nurse to immediately report an incident that constitutes resident abuse to the Director.

On May 25, 2012 a Registered Practical Nursing Student (RPNS) witnessed a Personal Support Worker (PSW) hit resident A with an open hand, grabbed her hair with both hands and laughed at resident A during care on May 25, 2012 at 1900 hours.

The(RPNS) reported the incident immediately to the Registered Practical Nurse in Charge.

An interview with (RPN) in charge on May 31, 2012 confirmed that the witnessed abuse reported to on May 25, 2012 at 1900 hours was not reported to the Director.[s.20.(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 the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 18th day of June, 2012

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

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

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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2012_078202_0015
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	May 31, Jun 1, 4, 5, 6, 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 - ETOBICOKE 70 HUMBERLINE DRIVE, ETOBICOKE, ON, M9W-7H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LORA PALMER

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

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 : 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 shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by anyone. Please submit plan to valerie.johnston@ontario.ca by June 22, 2012.

Grounds / Motifs :

1. The licensee failed to ensure that residents are protected from abuse by anyone. [s.19.(1)]

On May 29, 2012 the licensee reported to the Director that a Personal Support Worker (PSW) hit resident A with an open hand, grabbed resident A's hair with both hands and laughed at this resident while providing care on May 25, 2012 at 1900 hours. [s.19. (1)]

On May 25, 2012 at 1900 hours, resident A was sitting in a wheelchair by the nursing station appearing agitated. Registered Practical Nursing Student (RPNS) alerted (PSW) B that resident A required assistance. (PSW) B responded to resident A by offering personal care. Resident A refused to have care provided and became further agitated when asked by (PSW) B.
(PSW) B requested assistance from Personal Support Worker (PSW) C, proceeded to push resident A's wheelchair into the nearest resident room and was witnessed to be kicking and screaming by the (RPNS).

The (RPNS) continued to hear resident A screaming from the room and entered. The (RPNS) witnessed resident A trying to hit (PSW) B while taking resident A's shirt off. (PSW) B then hit resident A on the right upper arm with an open hand and continued to pull the shirt off with such force that resident A's upper body was pulled straight forward in the wheelchair. (PSW) B began to laugh at resident A who appeared to become increasingly angry and agitated. (PSW) B then put resident A's gown on forcefully over resident A's head.

(PSW) B and (PSW) C continued to provide personal care to resident A. (PSW) C held the back of resident A's wheel chair because the resident was so angry the wheel chair was lifting upwards. (PSW) B directed (PSW) C to take the resident out of the washroom and into the bedroom. (PSW) B directed (PSW) C to take the front of the wheelchair while (PSW) B held the back of the wheelchair so that (PSW) C could try and pull the resident's pants off. (PSW) B then grabbed resident A's hair with both hands bending the resident's head backwards into the wheelchair while (PSW) C continued to pull the remainder of the pants off. Resident A slid to the floor from the wheelchair as the pants were forcefully removed by (PSW) C.

(PSW) B began to laugh at resident A while the resident was on the floor. (PSW) B then opened the bedroom door and called the charge nurse.
The charge nurse entered the room and found resident A sitting on the floor, appearing distressed and agitated. The charge nurse offered resident A assistance back to the wheelchair but refused. The charge nurse directed staff to leave resident A on the floor until the resident calmed down. Resident A was assisted back to the wheelchair approximately 30-45 minutes after the incident.

The (RPNS) reported the incident immediately to the charge nurse. The charge nurse discussed the issue with

(PSW) B and provided verbal discipline.

An interview with the charge nurse on May 31, 2012 confirmed that the witnessed abuse reported to by the (RPNS) on May 25, 2012 at 1930 hours was not reported to the Director.

On Monday May 28, 2012 the (RPNS) reported the incident to a Registered Practical Nurse (RPN) assigned to resident A's home area.

The (RPN) reported the incident to administration on May 29, 2012 and police were notified.
The (RPN) confirmed in an interview that the witnessed abuse reported to him by the (RPNS) on May 28, 2012 at 14:00 was not immediately reported to the Director.

On May 29, 2012, the home conducted an immediate investigation into the incident. Resident A was assessed for injury and was noted to have a green colored bruise on the back of right upper arm 6.0 cm x 3.0 cm.

On May 29, 2012 the police charged (PSW) B with assault and is to appear in court July 2012. The home has terminated (PSW) B and (PSW) C. The charge nurse has been disciplined. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 2012

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone reports the suspicion and information upon which it is based immediately to the Director. Please submit plan to valerie.johnston@ontario.ca by June 22, 2012.

Grounds / Motifs :

1. The licensee failed to ensure that an incident of staff to resident abuse was immediately reported to the Director. [s.24.(1)]

On May 25, 2012 at approximately 1900 hours, a Registered Practical Nursing Student witnessed a Personal Support Worker (PSW) hit resident A on the back of right upper arm and grabbed this resident's hair with both hands.

The (RPNS) reported the incident to the Registered Practical Nurse (RPN) in charge immediately.

An interview with the charge nurse (RPN) on May 31, 2012 confirmed that the witnessed abuse reported by the (RPNS) on May 25, 2012 at 1930 hours was not reported to the Director.

On Monday May 28, 2012 the (RPNS) reported the incident witnessed on May 25, 2012 at 1900 hours to another Registered Practical Nurse (RPN) assigned to resident A's home area.

The (RPN) confirmed in an interview that the witnessed abuse reported by the (RPNS) on May 28, 2012 at 14:00 was not immediately reported to the Director. [s.24.(1)]

On May 29, 2012 the (RPN) reported the incident to the Director of Care, who then reported the incident to the Director. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 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 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
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 6th day of June, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

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