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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2015	2015_365194_0011	O-001234-14, 001235-14, 001893-15, 001421-14	Follow up

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East Bowmanville ON L1C 1P9

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 23, 24,27,28,29,30 May 04,05 and 06, 2015

Six concurrent Logs were inspected during this inspection; Log #O-001234-14,#O-001235-14,#O-001893-15,#O-001077-14,#O-002049-15, #O-001421-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC),Residents, Registered Nurse (RN), Registered Practical Nurse (RPN), RAI Coordinator, Nurse Educator, Personal Support Worker (PSW)

Also reviewed the licensee's compliance plan, staff educational records, internal abuse investigations, identified Resident's clinical health record, Abuse policy. Observed staff/resident provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_293554_0028	194

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:

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. The licensee has failed to ensure that Residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Definitions:
2(1)For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means,
the use of physical force by anyone other than a resident that causes physical injury of pain

5. "Neglect" means the failure to provide a resident with the treatment, care, services 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 Resident Abuse Policy # V-B-30.00 dated October 2014 directs:

-"In ALL cases of alleged/witnessed abuse all persons in the home are obligated and required to immediately report their observations/suspicion to the Director of Care or other Registered Staff on duty. All cases of alleged/witnessed abuse will be immediately reported to the Ministry of Health and Long Term Care."
-The DOC immediately requests and/or obtains written signed and dated (including time) statements from staff member reporting incident, the resident, the alleged abuser.
-If the alleged abuser is a staff member, the person will be sent home immediately pending investigation

Log #O-001893-15

On an identified date, Resident #19 informed RN #114 that PSW #112 had been physically abusive during care. RN #114 did not immediately notify the Director of the allegations of physical abuse by staff. RN#114 left a message for the DOC of the incident

as reported by the resident. The DOC completed the Critical Incident Report and submitted the report the following afternoon.

The licensee failed to comply with:
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any
of the following has occurred shall immediately report the suspicion and the information upon which
it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee
or staff that resulted in harm or risk of harm. (WN#4)

Log#O-001893-15

On an identified date, Resident #20 reported to PSW's #115 and #116 that PSW #113 had been asked to provide continence care. Resident #20 reports that PSW #113 promised to return but never did.

Four days later, Resident #21 reported to PSW's #115 and #116 of being incontinent and rang the call bell. PSW #113 answered the bell. Resident #21 was told PSW #113 would come right back and provide care; however PSW #113 did not come back.

DOC indicated that during internal investigation Staff #113 reported that on both identified dates the toileting care needs for Resident #20 and Resident #21 were not completed because it was the end of the shift.

The Administrator has indicated that both incidents of Resident neglect described above where brought forward to RN#114 after the second incident, RN#114 reported the incidents to the DOC. The Administrator has indicated that the Director was not immediately notified, an immediate investigation into the allegations of Resident neglect was not initiated and immediate actions were not taken related to the allegations of Resident neglect.

The PSW's did not report an allegation of Resident neglect to their supervisor after the initial incident when Resident #20 identified concern.

The licensee failed to comply with:
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to

suspect that any
of the following has occurred shall immediately report the suspicion and the information upon which
it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN#4)
- LTCHA, 2007, s. 23 (1) (a)(b), by ensuring that every alleged, suspected or witnessed incident of
abuse and or neglect of a resident, that the licensee knows of is immediately investigated, and appropriate action is taken.
(WN#3)
-The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the home's policy to promote zero tolerance of abuse is complied with. (WN#2) [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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's policy "Resident Abuse" # V-B-30.00 is complied with.

Log # O-001893-15

Review of the licensee's Resident Abuse Policy # V-B-30.00 dated October 2014 directs:

-"In ALL cases of alleged/witnessed abuse all persons in the home are obligated and required to immediately report their observations/suspicion to the Director of Care or

other Registered Staff on duty. All cases of alleged/witnessed abuse will be immediately reported to the Ministry of Health and Long Term Care."
-The DOC immediately requests and/or obtains written signed and dated (including time) statements from staff member reporting incident, the resident, the alleged abuser.
-If the alleged abuser is a staff member, the person will be sent home immediately pending investigation

On an identified date, Resident #19 informed RN #114 that PSW #112 had been physically abusive during care. RN #114 did not immediately notify the Director of the allegations of physical abuse by staff. RN#114 left a message for the DOC of the incident as reported by the resident. The DOC completed the Critical Incident Report and submitted the report the following afternoon.

On an identified date, Resident #20 reported to PSW's #115 and #116 that PSW #113 had been asked to provide continence care. Resident #20 reports that PSW #113 promised to return but never did.

Four days later, Resident #21 reported to PSW's #115 and #116 of being incontinent and rang the call bell. PSW #113 answered the bell. Resident #21 was told PSW #113 would come right back and provide care; however PSW #113 did not come back.

The Administrator has indicated that both incidents of Resident neglect described above where brought forward to RN#114 after the second incident, RN#114 reported the incidents to the DOC. The Administrator has indicated that the Director was not immediately notified, an immediate investigation into the allegations of Resident neglect was not initiated and immediate actions were not taken related to the allegations of Resident neglect.

The PSW's did not report an allegation of staff neglect to their supervisor after the initial incident when Resident #20 identified concern. [s. 20. (1)]

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

Log # O-001893-15

On an identified date, Resident #20 reported to PSW's #115 and #116 that PSW #113 had been asked to provide continence care. Resident #20 reports that PSW #113 promised to return but never did.

Four days later, Resident #21 reported to PSW's #115 and #116 of being incontinent and rang the call bell. PSW #113 answered the bell. Resident #21 was told PSW #113 would come right back and provide care; however PSW #113 did not come back.

The Administrator has indicated that both incidents of Resident neglect described above where brought forward to RN#114 after the second incident, RN#114 reported the incidents to the DOC. The Administrator has indicated that an immediate investigation into the allegations of Resident neglect was not initiated. [s. 23. (1) (a)]

2. The licensee has failed to ensure that appropriate action is taken in response to every such incident.

Log # O-001893-15

On an identified date, Resident #20 reported to PSW's #115 and #116 that PSW #113 had been asked to provide continence care. Resident #20 reports that PSW #113 promised to return but never did.

Four days later, Resident #21 reported to PSW's #115 and #116 of being incontinent and rang the call bell. PSW #113 answered the bell. Resident #21 was told PSW #113 would come right back and provide care; however PSW #113 did not come back.

An investigation into the allegations of Resident neglect and action was not taken by the home until eight days after becoming aware of the allegations of neglect to Resident's #20 and #21. [s. 23. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Definitions:
2(1)For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means,
the use of physical force by anyone other than a resident that causes physical injury of pain

5. "Neglect" means the failure to provide a resident with the treatment, care, services 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.

Log # O-001893-15

On an identified date the DOC retrieved a telephone message from the RN supervisor #114, describing concerns from Resident #19 that Staff #112 had been physically abusive during care.

During an interview RN #114 indicated that allegations of abuse would be reported to the DOC and Administrator via e-mail/telephone Monday to Friday, so they could review the information when they arrived the following day. RN #114 indicated that allegations of abuse would be forwarded immediately to DOC and Administrator on the weekends for direction.

The Director was notified by Critical Incident Report 17 hours after the home became aware of the physical abuse.

Log # O-001893-15

On an identified date, Resident #20 reported to PSW's #115 and #116 that PSW #113 had been asked to provide continence care. Resident #20 reports that PSW #113 promised to return but never did.

Four days later, Resident #21 reported to PSW's #115 and #116 of being incontinent and rang the call bell. PSW #113 answered the bell. Resident #21 was told PSW #113 would come right back and provide care; however PSW #113 did not come back.

The Administrator has indicated that both incidents of Resident neglect described above where brought forward to RN#114 after the second incident, RN#114 reported the incidents to the DOC. The Director was notified by Critical Incident eight days after becoming aware of the allegations of neglect to residents. [s. 24. (1)]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.

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

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 :	2015_365194_0011
Log No. / Registre no:	O-001234-14, 001235-14, 001893-15, 001421-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 11, 2015
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	STRATHAVEN LIFECARE CENTRE 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_293554_0028, CO #002;

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 :

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.

-by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon whichit is based to the Director:
- Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
- by ensuring that every alleged, suspected or witnessed incident of abuse and or neglect of a resident, that the licensee knows of is immediately investigated, and appropriate action is taken.
- by ensuring the home's policy to promote zero tolerance of abuse is complied with.

Grounds / Motifs :

1. Definitions:
2(1)For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means,
the use of physical force by anyone other than a resident that causes physical injury of pain

5. "Neglect" means the failure to provide a resident with the treatment, care, services 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

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-The DOC immediately requests and/or obtains written signed and dated (including time) statements from staff member reporting incident, the resident, the alleged abuser.
-If the alleged abuser is a staff member, the person will be sent home immediately pending investigation

Log #O-001893-15

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The licensee failed to comply with:
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of the following has occurred shall immediately report the suspicion and the information upon which
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or staff that resulted in harm or risk of harm. (WN#4)

Log#O-001893-15

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incontinent and rang the call bell. PSW #113 answered the bell. Resident #21 was told PSW #113 would come right back and provide care; however PSW #113 did not come back.

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The PSW's did not report an allegation of Resident neglect to their supervisor after the initial incident when Resident #20 identified concern.

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- LTCHA, 2007, s. 23 (1) (a)(b), by ensuring that every alleged, suspected or witnessed incident of
abuse and or neglect of a resident, that the licensee knows of is immediately investigated, and appropriate action is taken.
(WN#3)
-The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the home's policy to promote zero tolerance of abuse is complied with. (WN#2) [s. 19. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 22, 2015

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

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

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.

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.

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.

Issued on this 11th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

Service Area Office /
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