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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2017	2017_491647_0010	031296-16, 032567-16, 032983-16	Complaint

Licensee/Titulaire de permis

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 31, June 1, 2, 6, 7, 8, 9, 12, 13, 14, 15, 16, August 8, 9, 10, 11, 2017.

The following intakes were inspected concurrently with this inspection:
#031296-16,
#032567-16,
#032983-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), Dietary Aides, Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observations of home and resident areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A complainant contacted the Ministry of Health and Long Term Care ACTIONline on an identified date, and subsequently submitted a written concern on an identified date, indicating that resident #002 had not received care consistently.

A clinical record review indicated that resident #002 at the time of admission required extensive assistance to receive care. Additionally, resident #002 currently has no cognitive impairment.

An interview with resident #002 indicated that he/she looks forward to receiving assistance to receive care however does not always get it. Resident #002 further indicated that he/she has been informed on several occasions from direct care staff that they are working short and are unable to provide the required assistance.

A record review for resident #002 from an identified period indicated that resident #002 had not received assistance with care on seven occasions due to an insufficient staffing

mix that is consistent with residents' assessed care needs.

A record review of the staffing daily roster report for the home area that resident #002 resides on indicated the following:

-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short two direct care staff with no replacements scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short two direct care staff with no replacements scheduled. The missed care were not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.

An interview with the Administrator and record review of the performance indicator comparison report from the above mentioned identified time period, indicated there had been 546 direct care staff shifts that had not been filled. The home tracks unfilled shifts instead of unfilled hours however the Administrator confirmed that the 546 direct care staff shifts that had been unfilled had comprised of four, six, and eight hour shifts.

An interview with the Director of Care (DOC) indicated that as a result of the unfilled 546 direct care staff shifts, the home had not provided staff according to the home's staffing plan. The DOC further indicated that as a result of the 546 unfilled direct care staff shifts, residents had not received care consistent with their assessed care needs.

The severity of the non-compliance and the severity of harm and risk was minimal harm or potential for actual harm.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home had a compliance history related to sufficient staffing and had been previously issued a VPC during a Critical Incident

System Inspection on December 29, 2015 (2015_168202_0026). [s. 31. (3)]

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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complainant contacted the ACTIONline on an identified date, and subsequently submitted a written concern on an identified date, to the Ministry of Health and Long Term Care, indicating that resident #002 had not been consistently offered personal care.

A clinical record review indicated that resident #002 at the time of admission required extensive assistance to receive care. Additionally, resident #002 currently has no cognitive impairment.

An interview with resident #002 indicated that he/she looks forward to receiving assistance to receive care however does not always get it. Resident #002 further indicated that he/she has been informed on several occasions from direct care staff that they are working short and are unable to provide the required assistance.

Interviews with direct care staff #100 and Registered staff member #101 indicated that resident enjoys his/her personal care and does not refuse them when offered. Direct care staff #100 and Registered staff member #101 further indicated that staff document in Point of Care (POC) that the task had been completed and if a resident refuses it is also documented in POC.

A review of the POC documentation for personal care from an identified time frame, indicated that there had been no assistance for personal care on 38 occasions.

It had been confirmed during an interview with the Associate Director of Care (ADOC) that staff document the completion of personal care in the POC documentation. The ADOC acknowledged that resident #002 does not have any cognitive impairment and would be able to indicate if he/she received assistance with personal care. The ADOC further acknowledged that there had been no documentation on the above mentioned dates to confirm if staff had provided the required assistance to resident #002. [s. 33. (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 residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

The Ministry of Health and Long Term Care received a call into the Ministry of Health and Long Term Care ACTIONline on an identified date indicating that the food in the home was not good and often served cold.

Interview with resident #001 indicated that he/she often skips meals due to the poor quality and the temperature. He/she stated that often times when the meal reached him/her it was cold. Resident #001 further indicated during an interview that he/she frequently requests his/her meal to be heated in the microwave prior to serving to ensure it is at the correct temperature.

Record review of the server temperature form indicated that the standard holding temperature of hot food was from 60C – 76C. A further record review of the server

temperature forms from the ground floor server, from an identified time frame, from the start of meal service indicated the following:

-an identified date, hot entree recorded at 57C and hot vegetable recorded at 55C,
-an identified date, hot entree recorded at 56C,
-an identified date, hot entree recorded at 56C.

During a meal observation on an identified date, resident #009 had been served last in the table rotation. During an interview with resident #009, he/she indicated to the inspector that his/her meal was cold.

Record review of the server temperature form indicated the starting temperature of the hot entrees had been recorded as 64C for the identified entree and 67C for the mixed vegetables.

Inspector #647 and dietary aide #106 had checked the end of service food temperature and recorded the identified entree had reduced to 52.7C and the mixed vegetables had reduced to 43.6C.

Dietary aide #106 indicated at that time that he/she had been aware the temperatures were not holding and maintaining between 60C – 76C however continued to serve the meal to residents. Dietary aide #106 further indicated during an interview that the reduction in the food temperature would not make the food enjoyable or palatable for residents.

During an interview with Food Service Manager (FSM) #104 it had been indicated that it is the dietary aide's responsibility to record the food temperatures at the beginning of meal service. The FSM further indicated that there had been an additional expectation of a mid meal temperature for the ground floor server as of an identified date, due to the temporary use of chafing dishes. The FSM confirmed after a review of the server temperature form that mid meal temperatures had not been recorded to ensure the holding temperatures mentioned above remained and further confirmed that the reduction in the food temperature would not make the food palatable for residents. [s. 73. (1) 6.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #4: 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. (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 :

The Ministry of Health and Long Term Care ACTIONline had been contacted in October, 2016, indicating that resident #001 has had other residents enter his/her room.

During an interview with resident #001, he/she indicated that he/she likes to keep his/her door closed because other residents and often resident #008 enters his/her room. Resident #001 further indicated that resident #008 will often only have under garments on which has been very upsetting to him/her.

A review of the written plan of care indicated that resident #001 is to have a yellow wander guard strip in place, a stop sign to remain on his/her room door and an infrared alarm in place to be activated during the night.

Interviews with direct care staff #102 and Registered staff #109 indicate that yellow wander strips are used as a deterrent for wandering residents and placed on resident doors that they often attempt to enter. The above mentioned staff confirmed that resident #001 had a yellow wander strip, a stop sign and an infrared alarm at night to avoid residents entering room. Direct care staff #102 and Registered staff #109 indicated that a combination of visual and audio interventions are effective as all residents respond differently.

During observations by inspector on four identified dates, it had been observed that the stop sign had not been present on resident #001's door as indicated by the written plan of care.

During an interview with Registered staff it had been acknowledged the stop sign had not been present on the door of resident #001 and indicated it had remained a current intervention to minimize residents entering the room of resident #001. Registered staff #109 confirmed at the time of the above mentioned interview that the care set out in the plan of care for resident #001 had not been provided as specified in the plan. [s. 6. (7)]

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

Issued on this 22nd day of September, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647)
Inspection No. / No de l'inspection :	2017_491647_0010
Log No. / No de registre :	031296-16, 032567-16, 032983-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 1, 2017
Licensee / Titulaire de permis :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
LTC Home / Foyer de SLD :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kyla MacDonald

To MILL CREEK CARE CENTRE, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall develop and implement a staffing plan that provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation and also develop and implement a contingency plan for staffing shortages with specific strategies and direction to staff to ensure all residents receive care consistent with their assessed personal care, specific to bathing twice weekly.

The licensee shall ensure all staff receive training/education on the plan and the licensee shall monitor and ensure the plan is implemented on the shifts when staff shortages occur.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A complainant contacted the Ministry of Health and Long Term Care ACTIONline on an identified date, and subsequently submitted a written concern

on an identified date, indicating that resident #002 had not received care consistently.

A clinical record review indicated that resident #002 at the time of admission required extensive assistance to receive care. Additionally, resident #002 currently has no cognitive impairment.

An interview with resident #002 indicated that he/she looks forward to receiving assistance to receive care however does not always get it. Resident #002 further indicated that he/she has been informed on several occasions from direct care staff that they are working short and are unable to provide the required assistance.

A record review for resident #002 from an identified period indicated that resident #002 had not received assistance with care on seven occasions due to an insufficient staffing mix that is consistent with residents' assessed care needs.

A record review of the staffing daily roster report for the home area that resident #002 resides on indicated the following:

-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short two direct care staff with no replacements scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short two direct care staff with no replacements scheduled. The missed care were not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.
-an identified date, the identified home area had been short one direct care staff with no replacement scheduled. The missed care was not rescheduled.

An interview with the Administrator and record review of the performance indicator comparison report from the above mentioned identified time period, indicated there had been 546 direct care staff shifts that had not been filled. The

home tracks unfilled shifts instead of unfilled hours however the Administrator confirmed that the 546 direct care staff shifts that had been unfilled had comprised of four, six, and eight hour shifts.

An interview with the Director of Care (DOC) indicated that as a result of the unfilled 546 direct care staff shifts, the home had not provided staff according to the home's staffing plan. The DOC further indicated that as a result of the 546 unfilled direct care staff shifts, residents had not received care consistent with their assessed care needs.

The severity of the non-compliance and the severity of harm and risk was minimal harm or potential for actual harm.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home had a compliance history related to sufficient staffing and had been previously issued a VPC during a Critical Incident System Inspection on December 29, 2015 (2015_168202_0026). [s. 31. (3)] (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 20, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 1st day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

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