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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
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Bureau régional de services de Toronto
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, Aug 12, 2014	2014_159178_0012	T-563-14/T-587-14/T-555-14	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

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

SUSAN LUI (178), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 5, 6, 7, 8, 9, 12, 14, 15, 16, June 12, July 25, 29, August 11, 2014.

This Inspection Report has been amended to reflect a change in findings, which resulted in removal of Written Notification # 3, related to section 23 (2) of the LTCHA.

The following Critical Incident Logs were inspected as part of this inspection:T-563-14, T-587-14, T-555-14, T-446-14, T-424-14, T-273-14, T-450-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Nursing, Nurse Managers, registered staff, personal care assistants (PCAs), residents.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home records, observed staff resident interactions.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend 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 resident # 1 was protected from financial abuse by anyone.

Review of Critical Incident System (CIS) report # M510-000032-14 and interviews with the home's Administrator confirm that resident # 1 had funds in the form of a cheque

stolen from his/her room by an identified staff member, and cashed by that same employee. Interviews with the accused employee and the home's Administrator confirm that the employee took seven cheques from the resident over a period of one year, totaling $13,000. The cheques arrived for the resident by mail, and were stolen from the resident's room. The home's Administrator stated that the theft was discovered by the resident's power of attorney (POA) for finances, who notified Toronto Police Services, who in turn notified the home.
According to the home's Administrator, the employee has since been dismissed by the home and has made restitution to the resident for the stolen funds. Toronto Police Services have informed the home that the employee will be charged. [s. 19. (1)]

2. The licensee has failed to ensure that resident # 7 was not neglected by the staff in the home.

Interview with an identified nurse manager and review of CIS report # M510-000009-14 confirm that the power of attorney (POA) for resident # 7 reported to the home in writing that during the night on an identified date, the resident called out for help for over an hour after a co-resident wandered into the resident's room, woke him/her and tried to move him/her out of bed, thereby frightening resident # 7.
Review of the written complaint submitted by the POA confirms that resident # 7 stated that the incident occurred at approximately 1:30 am, and that the resident called for help until 3:00 am. The complaint states that no staff attended to the resident until approximately 5:00 am the following morning. Interview with an identified nurse manager confirms that resident # 9, who lives in a nearby room, verbalized to home's staff that he/she overheard resident # 7 calling out for help for quite some time during the night in question. The nurse manager stated that it is the expectation that staff monitor residents at least every two hours during the night, and that it would be expected that a staff member would have heard resident # 7 calling out, and would have attended to the resident sooner. [s. 19. (1)]

3. The licensee has failed to ensure that resident # 8 was not neglected by the staff in the home.

Interviews with resident # 8, an identified nurse manager, and an identified registered staff member as well as resident record review confirm the following:
The plan of care for resident #8 includes the fact that the resident is not to be provided physical care by registered staff A, after a prior incident when resident # 8 alleged that registered staff A had handled him/her roughly. Registered staff A continued to work

on resident # 8's unit, therefore when the resident required assistance with physical care, registered staff A would have another staff member assist the resident instead. During the night on an identified date, resident # 8 rang the call bell and when registered staff A answered, the resident requested assistance from an alternate staff member to provide the care which required a registered staff member. Registered staff A asked registered staff B to assist the resident, however registered staff B was unable to assist the resident at that time. Registered staff A relayed this information to the resident, and at the resident's request provided the resident with supplies to attempt to provide the care to him/herself, but the resident was unsuccessful in his/her attempts to do so. Registered staff A did not proceed to obtain assistance from another registered staff member. Registered staff B never did attend to the resident, and no other registered staff member assisted the resident with the care for the remainder of the shift. The resident had to wait until the day shift to have a registered staff member assist him/her with the care.

Non-compliance with section 19.(1) of the Long Term Care Homes Act has been identified previously in the following inspections:
Inspection # 2013_109153_0027, conducted on November 14, 2013, with a Written Notification (WN) and a Compliance Order (CO) issued.
Inspection # 2013_159178_0022, conducted on September 30, 2013, with a WN and a Voluntary Plan of Correction (VPC) issued.
Inspection # 2013_103193_0002, conducted on March 19, 2013, with a WN and CO issued, which was subsequently complied on May 27, 2013. [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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 5 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Resident interview, staff interview and record review confirm that on the evening of an identified date, the staff member caring for resident # 5 spoke to the resident in a disrespectful manner and tone, leaving the resident feeling scolded. [s. 3. (1) 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 all residents are treated with courtesy and respect and in a way that fully recognizes the residents' individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: 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 neglect of a resident by the staff that resulted in harm or risk of harm has occurred, immediately reported the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).

Staff interview and record review confirm that on an identified date, a letter was received by the home from the power of attorney (POA) for resident # 7, stating that the resident called out for help for over an hour during the night on an identified date when a co-resident wandered into the resident's room and tried to get him/her out of bed, thereby frightening resident # 7. The resident was woken at 1:30 a.m. and called for help until 3:00 a.m., but no staff came to assist. This allegation of neglect was reported to the Director under the LTCHA two days later, when a Critical Incident System (CIS) report was submitted reporting the allegation. The nurse manager who submitted the CIS report no longer works for the home, and an identified nurse manager from another unit was unable to locate any documentation to indicate that the Director under the LTCHA was informed of the incident prior to submission of the CIS report on January 23, 2014. [s. 24. (1)]

2. Resident interview, staff interviews and record review confirm that on an identified date, resident # 8 provided the home with a letter alleging that he/she was neglected during the night on an identified date. Staff interviews and record review confirm that this allegation was not reported to the Director under the LTCHA. [s. 24. (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 any person who has reasonable grounds to suspect that neglect of a resident by the staff that resulted in harm or risk of harm has occurred, immediately reported the suspicion and the information upon which it was based to the Director under the LTCHA, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 8 was notified of the results of the investigation into the alleged incident of neglect occurring on an identified date, immediately after the completion of the investigation.

Resident interview and record review confirm that resident # 8 was not informed about the results of the alleged neglect investigation immediately after the investigation was completed. The alleged neglect occurred on an identified date, and was reported to the home in writing by the resident, eleven days later. An investigation was conducted by the home and a staff member was issued a suspension beginning one month later. However, the resident was not informed about the results of the investigation until approximately three months after the investigation was completed, when the nurse in charge informed the resident only that registered staff A had been suspended. [s. 97. (2)]

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 and their substitute decision makers are notified of the results of the investigations required under subsection 23 (1) of the Act, immediately upon completion of the investigation, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident of financial abuse of resident # 1.
Record review and staff interview confirms that Critical Incident Report # M510-000032-14 was submitted by the home to the Director under the Long Term Care Homes Act (LTCHA) to report the alleged financial abuse of resident # 1 by a staff member. This report did not contain the name of the staff member involved and accused in the incident. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the names of any staff members present at the time of an incident of neglect were named in the report to the Director.
Record review confirms that Critical Incident Report # M510-000009-14, describing the alleged neglect of resident # 7, does not contain the name of the staff member working on the resident's unit at the time of the alleged neglect, and suspended as a result of the resident's complaint. [s. 104. (1) 2.]

Issued on this 3rd day of September, 2014

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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) :	SUSAN LUI (178), JOANNE ZAHUR (589)
Inspection No. / No de l'inspection :	2014_159178_0012
Log No. / Registre no:	T-563-14/T-587-14/T-555-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 29, Aug 12, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CASTLEVIEW WYCHWOOD TOWERS 351 CHRISTIE STREET, TORONTO, ON, M6G-3C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Lew

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To TORONTO LONG-TERM CARE HOMES AND SERVICES, 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) (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 the following:

a) resident # 1 is protected from financial abuse by any staff member who has access to the resident's personal funds.
b) residents in the home are not neglected by staff, particularly during the night.

The plan shall be submitted via email to susan.lui@ontario.ca by August 29, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that resident # 1 was protected from financial abuse by anyone.
Review of Critical Incident System (CIS) report # M510-000032-14 and interviews with the home's Administrator confirm that resident # 1 had funds in the form of a cheque stolen from his room by an identified staff member, and cashed by that same employee. Interviews with the accused employee and the home's Administrator confirm that the employee took seven cheques from the resident over a period of one year, totaling $13,000. The cheques arrived for the resident by mail, and were stolen from the resident's room. The home's Administrator stated that the theft was discovered by the resident's power of attorney (POA) for finances, who notified Toronto Police Services, who in turn notified the home. According to the home's Administrator, the employee has since been dismissed by the home and has made restitution to the resident for the stolen funds. Toronto Police Services have informed the home that the employee will be charged. (178)

2. The licensee has failed to ensure that resident # 7 was not neglected by the

staff in the
home.
Interview with an identified nurse manager and review of CIS report # M510-000009-14 confirm that the power of attorney (POA) for resident # 7 reported to the home in writing that during the night on an identified date, the resident called out for help for over an hour after a co-resident wandered into the resident's room, woke the resident and tried to move him/her out of bed, thereby frightening resident # 7.
Review of the written complaint submitted by the POA confirms that resident # 7 stated that the incident occurred at approximately 1:30 am, and that the resident called for help until 3:00 am. The complaint states that no staff attended to the resident until approximately 5:00 am the following morning.
Interview with an identified nurse manager confirmed that resident # 9, who lives in a nearby room, verbalized to home's staff that he/she overheard resident # 7 calling out for help for quite some time during the night in question. The nurse manager stated that it is the expectation that staff monitor residents at least every two hours during the night, and that it would be expected that a staff member would have heard resident # 7 calling out, and would have attended to the resident sooner. (178)

3. The licensee has failed to ensure that resident # 8 was not neglected by the staff in the home.

Interviews with resident # 8, an identified nurse manager, and an identified registered staff member as well as resident record review confirm the following:
The plan of care for resident #8 includes the fact that the resident is not to be provided physical care by registered staff A, after a prior incident when resident # 8 alleged that registered staff A had handled the resident roughly. Registered staff A continued to work on resident # 8's unit, therefore when the resident required assistance with physical care, registered staff A would have another staff member assist the resident instead. During the night on an identified date, resident # 8 rang the call bell and when registered staff A answered, the resident requested assistance from an alternate staff member to perform a task which requires a registered staff member. Registered staff A asked registered staff B to assist the resident, however registered staff B was unable to assist the resident at that time. Registered staff A relayed this information to the resident, and at the resident's request, provided him/her with supplies to attempt to provide the care to him/herself, but the resident was unsuccessful. Registered staff A did not proceed to obtain assistance from another registered staff member. Registered

staff B never did attend to the resident, and no other registered staff member assisted the resident with the care for the remainder of the shift. The resident had to wait until the day shift to have a registered staff member assist him/her with the care.

Non-compliance with section 19.(1) of the Long Term Care Homes Act has been identified previously in the following inspections:
Inspection # 2013_109153_0027, conducted on November 14, 2013, with a Written Notification (WN) and a Compliance Order (CO) issued.
Inspection # 2013_159178_0022, conducted on September 30, 2013, with a WN and a Voluntary Plan of Correction (VPC) issued.
Inspection # 2013_103193_0002, conducted on March 19, 2013, with a WN and CO issued, which was subsequently complied on May 27, 2013. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

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 29th day of July, 2014

Signature of Inspector / Signature de l'inspecteur : (178)

Name of Inspector / Nom de l'inspecteur : SUSAN LUI

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