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 areas where drugs are stored are kept locked at all times when not in use, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

The current practice in the home is that destroyed non-controlled drugs are placed in a Daniels' Sharpsmart container that is located in each medication room. The medications are placed in this container in their pouches and are not altered or denatured to such an extent that its consumption is rendered impossible or improbable. These containers are then removed from the home by Daniels a contracted company of Classic Care Pharmacy. This was confirmed by an ADOC and the Director of Care. [s. 136. (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 when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Infection Prevention and Control lead confirmed that the Infection Prevention and Control program was not evaluated and updated for 2013. [s. 229. (2) (d)]

2. The licensee of the long term care home failed to ensure that the staff failed to participate in the implementation of the infection prevention and control program.

On a date during the month of March 2014, during the noon medication pass on a Home Area the Registered Staff Member administered medication to resident #100 and then continued on to administer medications to resident #599 and resident #102 before performing any hand hygiene. The Registered Staff Member confirmed that hand hygiene should be done between each resident.

During the month of March 2014, at 1040 hours in the Spa Room in a Home Area the following were noted:
*open shampoo and body wash container (no lid)
*2 bins containing nail clippings and no nail clipper
*4 bins containing nail clippings with nail clipper

*dirty container bin
*stained upholstered chair near the shower area
The above noted concerns were verified by PSW at 1050 hours

During the month of March 2014, at approximately 1145 hours a PSW was observed cleaning the tub in the spa room in a Home Area. Upon completion it was noted that there was feces in the tub and on the tub chair. The PSW confirmed that after each resident bath the tub was sprayed with disinfectant and the brush was used to scrub the tub. During observation the PSW did not use the brush to scrub the tub and both scrub brushes available were dry. The PSW confirmed that they did not use the scrub brush between baths and had just completed six resident baths. Interview with the Infection Prevention and Control lead indicated that the expectation was for staff to use the brush to clean the tub between resident baths.

During the month of March 2014, 12 resident nail clipper drawers contained pieces of old nail clippings in a Home Area spa. Interview with the Infection Prevention and Control lead indicated that nail clippers were to be cleaned after each resident use.

On a date during the month of March 2014, the Registered Staff Member in a Home Area was observed during the lunch meal providing resident's with medications without washing their hands inbetween residents. Interview with the Infection Prevention and Control lead confirmed that Registered staff were to wash their hands between resident contact.

On a date during the month of March 2014, a PSW was observed during the lunch meal in a Home Area to sneeze into their hands and continue to provide assistance to residents eating without washing their hands. [s. 229. (4)]

3. The licensee of the long term care home failed to ensure that any pet living in the home or visiting as part of a pet visitation program has up to date immunizations.

Interview with the Program Manager indicated that the home did not have confirmation that pets visiting the home from the St.John's Pet Therapy program had up to date immunizations. [s. 229. (12)]

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 Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and to ensure that the staff participate in the implementation of the Infection Prevention and Control program and that any pet living in the home or visiting as part of a pet visitation program has up to date immunizations, to be implemented voluntarily.

WN #17: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

During the month of March 2014, at approximately 0855 hours, resident #300 was observed in the dining room and was noted to have a strong bowel odour. The resident remained in the dining room until breakfast was completed at 1000 hours. A PSW reported that the resident was incontinent of bowels in the dining room and was changed at approximately 1030 hours. The PSW confirmed that the resident sat in the dining room with a soiled brief and was not changed for at least one and a half hours. [s. 3. (1) 4.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

During an interview with a Registered Staff Member, the staff member confirmed that resident #489 had multiple wounds with some that required dressing changes and some that required monitoring. The Registered Staff Member verified that there was missing documentation to verify the dressing changes and monitoring had occurred. The Registered Staff Member further verified that interventions and responses to these interventions were not documented. The expectation of the home was to have complete documentation. [s. 30. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

Resident #599 reported that on a date during the month of March 2014, the resident slept with their dentures in overnight and oral care was not provided. A PSW confirmed that the resident required assistance to complete oral care. The resident's plan of care for oral hygiene indicated that the resident required one staff limited assistance with mouth care and dentures were to be soaked overnight. A review of the resident's clinical health record revealed that there was no documentation on multiple occasions to indicate that oral care was completed.

Resident #606 reported during the month of March 2014 that oral care was being done once daily and sometimes not at all. Interview with the Registered Staff Member during the month of March 2014 revealed that resident #606 was to have dentures cleaned twice daily (a.m. and in the evening).

Review of the oral care documents with the Registered Staff Member during the month of March 2014, revealed that dentures were not cleaned on multiple occasions.

In addition the oral care documents revealed that dentures were cleaned once instead of twice daily on multiple occasions.

The Registered Staff Member confirmed that oral care is to be documented if completed. [s. 34. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Resident #599 reported that on some evenings after supper meal service staff would change and try to put the resident to bed. The resident indicated that sometimes they are put in bed when it suited PSW's schedule however, the resident desired to go to bed later in the evening. The Assistant Director of Care stated that the resident's bedtime and rest routines would be individualized in the resident's plan of care. The RN confirmed that the resident did not have a bedtime and rest routine developed in their plan of care that was supported and individualized to promote comfort, rest and sleep. [s. 41.]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that within 10 days of receiving Resident Council advice related to concerns or recommendations, that the Licensee responds to the Resident Council in writing.

During an interview with a Resident Council Member during the month of March 2014, at 1135 hours they stated that Resident's Council did not receive a response in writing within 10 days.

The Program Manager during the month of March 2014, at 1435 hours confirmed that written responses are taken to the next meeting and not given to the Resident Council within 10 days. [s. 57. (2)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that within 10 days of receiving Family Council advice related to concerns or recommendations, that the Licensee responds to the Family Council in writing.

During an interview with a Family Council Representative during the month of March 2014, they stated that Family Council did not receive a response in writing within 10 days.

Interview with Executive Director during the month of March 2014, at 1215 hours stated they did not respond in writing to any Family Council concerns or recommendations. The Executive Director verified that there needed to be a response in writing. The Executive Director further confirmed that a written response to Family Council was not done within 10 days. [s. 60. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that each resident was offered a minimum of a between meal beverage in the morning.

On a date during the month of March 2014, it was observed that morning beverages were not distributed in a Home Area. This was confirmed by staff. [s. 71. (3) (b)]

2. The licensee of the long term care home failed to ensure that the planned menu items were offered and available at each meal and snack.

On a date during the month of March 2014, the home ran short of mashed potatoes and it was not available for two residents in a Home Area who chose to have mashed potatoes.

On a date during the month of March 2014, the home ran short of pureed sausage and pureed carrots. The last four residents who required pureed texture did not have the planned menu items available for staff to offer. [s. 71. (4)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure to seek the advice of the Resident's Council and the Family Council, if any, in developing and carrying out the survey.

Interview with a Resident Council member during the month of March 2014, at 1036 hours revealed that they have not been consulted or asked to participate in the development or carrying out of the satisfaction survey.

Interview with a Family Council Representative during the month of March 2014, at 1345 hours revealed that they have not been consulted or asked to participate in the development or carrying out of the satisfaction survey.

Interview with the Program Manager during the month of March 2014, at 1435 hours revealed that satisfaction surveys come from the Corporate office and there is no input on development or the carrying out of the satisfaction survey from Resident or Family Council members.

Interview with the Executive Director during the month of March 2014, at 1215 hours revealed that satisfaction surveys come from the Corporate office and there is no input on development or the carrying out of the satisfaction survey from Resident or Family Council members. [s. 85. (3)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

During the month of March 2014, during the initial tour of the home a lingering offensive odour was noted in the hallway of a Home Area between two resident rooms. During the month of March 2014, at 1250 hours the lingering offensive odour was again noted in the same Home Area outside a resident room and inside this same resident room. The resident that resides in this room is using an air surface on the bed and the blue cover was noted to be soiled and dust and debris was noted between the surface unit and the foot of the bed. The Executive Director confirmed that there was a lingering offensive odour in the hallway by two resident rooms. [s. 87. (2) (d)]

Issued on this 17th day of April, 2014

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

Sally Ashby

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) :	SALLY ASHBY (520), SHARON PERRY (155), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_259520_0010
Log No. / Registre no:	L-000238-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 10, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	COLUMBIA FOREST 650 MOUNTAIN MAPLE AVENUE, WATERLOO, ON, N2V-2P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~LESLEY HARRIS~~ Dahia Burt-Gerrans.

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

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall assess all residents and evaluate their bed systems to minimize the entrapment risk in all potential entrapment zones for residents where bed rails are used.

Grounds / Motifs :

1. The licensee of the long term care home failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to the residents.

On a date during the month of March 2014, at approximately 1515 hours, resident #300 was observed sleeping on a therapeutic surface with two half side rails in the raised position and a pillow placed against each half rail. Upon observation there was approximately a five inch gap from the head of bed and there were no bolsters in place. Interviews confirmed that there was no assessment of entrapment zones completed for resident #300 who was observed using side rails.

On a date during the month of March 2014, at approximately 1000 hours, resident #306 was observed laying on their therapeutic surface with two half side rails in the raised position with side rail protectors. Upon observation there was no bolsters in place. Interviews confirmed that there was no assessment of entrapment zones completed for resident #306 who was observed using side rails.

Interviews with the Environmental Services Manager and Executive Director revealed that where bed rails were used for all residents, including for residents using therapeutic surfaces, their bed systems were not evaluated. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 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.

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

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 10th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Sally Ashby

Name of Inspector / Nom de l'inspecteur : Sally Ashby

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