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 prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2015;	2014_270531_0024 (A3)	006490-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street COBOURG ON K9A 5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET COBOURG ON K9A 5J6

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

SUSAN DONNAN (531) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

As a result of The Director's review the report was revised.

Issued on this 30 day of January 2015 (A3)

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

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2015;	2014_270531_0024 (A3)	006490-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street COBOURG ON K9A 5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET COBOURG ON K9A 5J6

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

SUSAN DONNAN (531) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 16 and 17, 2014

During the course of the inspection, the inspector(s) spoke with Residents, Resident's family members, five Personal Support Workers, 3 Registered Practical Nurses, 3 Registered Nurses, The Assistant Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 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 LTCHA, 2007, 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 comply to with LTCHA 2007, c. 8, s. 19 (1) (a) whereby residents were not protected from sexual abuse.

Under O. Reg. 79/10, sexual abuse is defined as "any non-consensual touching,

behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member" .

This non-compliance is supported by the following findings:
On a specified date Critical Incident report M351-000019-14 was submitted to the Ministry of Health and Long-term Care by the home reporting a resident to resident alleged sexual abuse.

On October 16, 2014 during an interview with S103 (ADOC) he/she confirmed that he/she was the manager on call and in the building the day of the incident when contacted by S106 of the alleged incident. S103 interviewed S100, S104, S107, S106 and Resident #1. S103 told inspector #531 that he/she had directed all staff involved to keep the matter strictly confidential and they were not to share the details with anyone.
S103 told inspector #531 that Resident #1 had been moved and that Resident #2 was not to be advised of Resident #1's whereabouts.

As a result of the direction not to share information regarding the incident, staff reported the following:

On October 17, 2014 S108 RN, S113 RPN, and S114 PSW who were staff where Resident #1 had been moved reported they were not aware of the reason Resident #1 was moved.

S108 confirmed he/she had been instructed by S103 (ADOC) "to keep him/her safe". S108 reported not being aware of the reason or method of keeping him/her safe.
S113 confirmed that he/she was not aware that Resident #1 had been moved until he/she noticed Resident #1 in the dining room, it was not communicated at the beginning of the shift.
S114 was interviewed later in the day and confirmed he/she did not know why Resident #1 had been moved, or what had caused the move.

On October 17, 2014 during an interview with S106 RN and S111 RPN (staff on the floor of Resident #2) both confirmed that they were not aware Resident #2 was to be monitored. S111 confirmed he/she was not aware of the monitoring of Resident #2 until 10:30; therefore he/she had not instructed the day staff at the beginning of the shift to monitor Resident #2. (Both S106 and S111 were on duty when the alleged abuse had been reported.)

On October 17, 2014 S109 (RPN) who works on the floor where Resident #2 resides, reported if he/she had not obtained informal information of the reason that Resident #1 had been moved he/she probably would have informed Resident #2 when he/she approached inquiring about the whereabouts of his/her roommate.

S103 confirmed for inspector #531 that S106 was directed not to document the incident in Resident #1 or #2 health record and that S103 was the only one with documentation of the incident and of the ongoing investigation.
S103 told inspector #531 that the reason for this was that it was an alleged abuse and a very small community and she did not wish "word to get out" as there was no proof of the incident and both residents to protect.

On October 16 , 2014 Resident #1 was interviewed by inspector #531 and when asked about the alleged abuse Resident #1 welled up with tears and began weeping reluctant at first to respond then nodded yes to the alleged abuse questions.

On October 16 and 17 Resident #1 and Resident #2 health records were reviewed. There was no documentation to confirm that there was an incident or revisions in either care plan or progress notes to provide direction to direct care staff caring for the two residents.
On October 16, 2014 both S102 and S103 told inspector #531 that Resident #1 was examined by the physician on a specified date and there was no documentation of the examination.
Review of the progress notes confirmed that on a specified date, the day of the incident S106 documented the following:
"RN spoke to ADOC and she is handling the issue.

On October 17, 2014 during an interview with S105 the Director Of Care it was confirmed that the Employee Assistance Program was on site to assist staff involved in the alleged abuse, but the home had not provided any support of that nature to Resident #1. The Director of Care confirmed that management will be contacting victim services for support of Resident #1 and that both health records will be revised to provide direction to staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) n the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident and in development and implementation of the plan of care.
This non-compliance is supported by the following findings:
On a specified date Critical Incident report M351-000019-14 was submitted to the Ministry of Health and Long-Term Care by the home reporting a resident to resident alleged sexual abuse.

On October 16, 2014 both S102 and S103 told inspector #531 that Resident #1 was examined by the physician on a specified date. In review of the health record, there was no documentation of the examination. This information was not available for staff and others involved in the care of Resident #1 and Resident #2.

Review of the progress notes confirm that on the day of the incident S106 documented the following:
"RN spoke to ADOC and he/she is handling the issue.
There was no further documentation on either Resident #1 or #2's health records.

Direct care staff involved in all aspects of care was unaware of the situation and therefore did not have the information needed to assess or revise care plans or provide care in response to Residents' specific needs.
On October 16, 2014 during an interview with S102 it was confirmed that there was no documentation as "anyone could read it."
On October 16, 2014 S103 the Assistant Director of Care confirmed that he/she had instructed the staff involved to maintain strict confidentiality and "the information is on a need to know basis." [s. 6. (4) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10s. 55 (b) whereby all direct care staff were not advised at the beginning of every shift of each resident whose behaviours required heightened monitoring because those behaviours pose a potential risk to the resident or others.

On a specified date Critical Incident report M351-000019-14 was submitted to the Ministry of Health and Long-term Care by the home reporting a resident to resident alleged sexual abuse.

On October 17, 2014 during interview with S106 RN and S111 RPN, both confirmed that they were not aware Resident #2 was to be monitored. S111 confirmed he/she was not aware of the monitoring of Resident #2 until 10:30 that morning; therefore he/she had not instructed the day staff at the beginning of the shift.
S115 a Personal Support Worker working where Resident #2 resides told inspector #531 that there was no communication of the incident, or the need for heightened monitoring reported at the beginning of the shift.

On October 17, during an interview with S105 the Director of Care he/she confirmed that staff will be made aware of the need for monitoring before the end of the day. [s. 55. (b)]

Issued on this 30 day of January 2015 (A3)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SUSAN DONNAN (531) - (A3)

Inspection No. / No de l'inspection : 2014_270531_0024 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 006490-14 (A3)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jan 30, 2015;(A3)

Licensee / Titulaire de permis : THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street, COBOURG, ON, K9A-5J6

LTC Home / Foyer de SLD : GOLDEN PLOUGH LODGE
983 BURNHAM STREET, COBOURG, ON, K9A-5J6

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : CLARE BRIGGS (ACTING)

To THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND, 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. 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 :

(A3)
The licensee is required to prepare, submit and implement a plan for achieving compliance under s. 19 (1) of the LTCHA 2007. This plan is to include:

1. Strategies and interventions to effectively manage Resident #2 s behavior in order to protect other residents from potential abuse. These strategies will clearly define the responsibilities of each discipline in preventing further occurrences of alleged sexual abuse by Resident #2 towards other Residents.

2. Strategies and interventions to assist and support Resident #1 who has been abused or allegedly abused.

3. A process to continually monitor the effectiveness of the plan to ensure all Residents are protected from abuse.

The plan is to be submitted to Sue Donnan, the Long-Term Care Homes Inspector, Ministry of Health and Long- Term Care, Susan.Donnan@ontario.ca by December 20, 2014.

Grounds / Motifs :

1. The licensee has failed to comply to with LTCHA 2007, c. 8, s. 19 (1) (a) whereby residents were not protected from sexual abuse.

Under O. Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member" .

This non-compliance is supported by the following findings:
On a specified date Critical Incident report M351-000019-14 was submitted to the Ministry of Health and Long-term Care by the home reporting a resident to resident alleged sexual abuse

On October 16, 2014 during an interview with S103 (ADOC) he/she confirmed that he/she was the manager on call and in the building the day of the incident when contacted by S106 of the alleged incident. S103 interviewed S100, S104, S107,

S106 and Resident #1. S103 told inspector #531 that he/she had directed all staff involved to keep the matter strictly confidential and they were not to share the details with anyone.
S103 told inspector #531 that Resident #1 had been moved and that Resident #2 was not to be advised of Resident #1's whereabouts.

As a result of the direction not to share information regarding the incident, staff reported the following:

On October 17, 2014 S108 RN, S113 RPN, and S114 PSW who are staff where Resident #1 had been moved reported they were not aware of the reason Resident #1 was moved.
S108 confirmed he/she had been instructed by S103 (ADOC) "to keep him/her safe". S108 reported not being aware of the reason or method of keeping him/her safe.
S113 confirmed that he/she was not aware that Resident #1 had been moved until he/she noticed him/her in the dining room, it was not communicated at the beginning of the shift.
S114 was interviewed later in the day and confirmed he/she did not know why Resident #1 had been moved or what had caused the move.

On October 17, 2014 during an interview with S106 RN and S111 RPN (staff on the floor of Resident #2) both confirmed that they were not aware Resident #2 was to be

monitored. S111 confirmed he/she was not aware of the monitoring of Resident #2 until 10:30; therefore he/she had not instructed the day staff at the beginning of the shift to monitor Resident #2. (Both S106 and S111 were on duty when the alleged abuse had been reported.)

On October 17, 2014 S109 (RPN) who works where Resident #2 resides, reported if he/she had not obtained informal information of the reason that Resident #1 had been moved he/she probably would have informed Resident #2 when he/she approached her inquiring about the whereabouts of his/her roommate.

S103 confirmed for inspector #531 that S106 was directed not to document the incident in Resident #1 or #2 health record and that S103 was the only one with documentation of the incident and of the ongoing investigation.
S103 told inspector #531 that the reason for this was that it was an alleged abuse and a very small community and he/she did not wish "word to get out" as there was no proof of the incident and both residents to protect.

On October 16, 2014 Resident #1 was interviewed by inspector #531 and when asked about the alleged abuse Resident #1 welled up with tears and began weeping reluctant at first to respond then nodded yes to the alleged abuse questions.

On October 16 and 17 Resident #1 and Resident #2 health records were reviewed. There was no documentation to confirm that there was an incident or revisions in either care plan or progress notes to provided direction to direct care staff caring for the two residents.
On October 16, 2014 both S102 and S103 told inspector #531 that Resident #1 was examined by the physician on a specified date, there was no documentation of the examination.
Review of the progress notes confirm that on a specified date, the day of the

incident S106 documented the following:
"RN spoke to ADOC and he/she is handling the issue.

On October 17, 2014 during an interview with S105 the Director of Care it was confirmed that the Employee Assistance Program was on site to assist staff involved in the alleged abuse, but the home had not provided any support of that nature to Resident #1. The Director of Care confirmed that management will be contacting victim services for support of Resident #1 and that both health records will be revised to provide direction to staff.

(531)

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

Dec 31, 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) n 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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30 day of January 2015 (A3)

Signature of Inspector /
Signature de l'inspecteur :

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

Service Area Office /
Bureau régional de services : Ottawa