Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Hamilton Service Area Office
119 King Street West 11th Floor
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 1, 2014 | 2014_265526_0027 | H-001641-14 | Critical Incident System |

### Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

HARDY TERRACE
612 Mount Pleasant Road R. R. #2 BRANTFORD ON N3T 5L5

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

THERESA MCMILLAN (526)

### 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): November 25, 2014.**

**During the course of the inspection, the inspector(s) spoke with Assistant Director of Resident Care (ADRC), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), physiotherapist.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 :**

1. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001's Resident Assessment Instrument Minimum Data Set (RAI MDS) completed in 2014, indicated that the resident required extensive assistance from two people to transfer between bed, chair, wheelchair and standing. The document the home referred to as the "care plan" for resident #001 completed one month after the RAI MDS assessment, indicated that the resident required extensive assistance from two people for transferring and for bathing. The associated Resident Assessment Protocol (RAP) sheet indicated that the resident had unsteady balance. Two falls risk assessments, indicated that the resident had not had a fall in the year prior to the RAI MDS assessment, and that the resident was a high risk for falls.

Ten weeks after the RAI MDS assessment, resident #001 fell while being transferred by one Personal Support Worker (PSW) staff from the tub chair to the resident's wheelchair. The Critical Incident submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) indicated that the resident was assisted to a standing position from the tub chair, during which time, the resident's knees buckled and the resident fell forward onto the floor. The resident was sent to hospital by ambulance and was found to have sustained fractures and internal bleeding.

During interview, the PSW caring for resident #001 at the time of the fall confirmed that the resident's care plan directed staff to transfer the resident using two staff members, and that the PSW was transferring the resident with one person. They stated that they had witnessed the resident standing with one staff person on previous occasions and thought that the resident would be safe. The PSW and Assistant Director of Resident Care (ADRC) confirmed that the staff did not provide care as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's Resident Safety Program for Lifts, Transfers and Repositioning HS-XVIII-020 last reviewed May 2013 directed staff to "adhere to the designated lift/transfer/positioning technique as identified on the resident's care plan and Logo". The PSW caring for resident #001 one a day in 2014 when the resident sustained a fall, confirmed that they used a one person transfer when working with resident #001 rather than a two person transfer and that the transfer was improper for resident #001. The ADRC confirmed that the PSW had not followed the home's policy to adhere to the designated transfer technique for resident #001.

B) The home's Fall Prevention and Management policy NM-II-F005 last reviewed on December 2009 directed staff to "use a mechanical lift to move resident to his/her bed to proceed to do a further assessment".

On a day in 2014, resident #001 sustained a fall in the tub room while being transferred from the tub chair to the resident's wheelchair. Interview with the PSW transferring the resident indicated that the resident fell forward and hit their head on the floor. A registered practical nurse (RPN) assessed the resident and found that the resident had been injured and was restless. According to staff interviews and progress notes, the resident was lifted by a PSW and RPN into their wheelchair without using a mechanical lift. An ambulance was called and the resident was taken to hospital.

Interview with the RPN who assessed the resident after the fall confirmed that a mechanical lift was not used. Interview with the Registered Nurse (RN) in the home

confirmed that the RPN and PSW had moved the resident prior to their arrival and they had not used a mechanical lift. The RN stated that the resident should have been left on the floor until the ambulance arrived. The ADRC confirmed that the policy had not been followed and confirmed the home's expectations that a lift should have been used to move the resident. The ADRC confirmed that if the lift was not appropriate, that the resident should not have been moved and kept comfortable on the floor until the ambulance arrived.

C) The home's Critical Incident Report policy ADM-VIII-011 last reviewed on May 2014 directed staff to report to the MOHLTC immediately upon becoming aware of an incident involving improper or incompetent treatment of a resident that resulted in harm or risk of harm to the resident. Staff were directed to immediately initiate the online Critical Incident System (CIS) form using the mandatory report section during working hours and to use the after hours pager number at other times.

On a day in 2014 resident #001 sustained a fall while being transferred from the tub chair to the resident's wheelchair with one staff person present. The resident's plan of care indicated that the resident required two persons to assist with the resident's transfers. The resident was sent to hospital by ambulance and was found to have sustained fractures and internal bleeding. During interview, the PSW who was caring for the resident at the time of the fall confirmed that the transfer was unsafe and the care was improper.

During interview, the RN attending the resident after the fall confirmed that they had not followed the home's policy to immediately contact the MOHLTC using the after hours pager number regarding resident #001's fall and the improper care that contributed to the fall. The home initiated the online Critical Incident System (CIS) form the day after resident #001's fall. The ARDC confirmed that the home's policy to immediately report the incident to the MOHLTC when improper or incompetent treatment resulted in harm or risk of harm to a resident was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

***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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with,, to be implemented voluntarily.***

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**WN #3: 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 failed, through inaction, to provide treatment, care, services or assistance required for health, safety or well-being that jeopardized the health, safety or well-being of a resident and by failing to do so, neglected the resident.

Resident #001's RAI MDS assessment indicated that the resident required extensive assistance from two people to transfer between bed, chair, wheelchair and standing. The associated RAP sheet indicated that the resident had unsteady balance. The document the home referred to as the "care plan" for resident #001 completed one month later indicated that the resident required extensive assistance from two people for transferring and for bathing.

Two falls risk assessments, indicated that the resident had not had a fall in the year prior to the RAI MDS assessment, and that the resident was a high risk for falls. Interviews with the physiotherapist, RN, RPN and PSW staff confirmed that the resident required two persons for transferring.

Ten weeks after the RAI MDS assessment, resident #001 sustained a fall while being transferred from the tub chair to the resident's wheelchair with one staff person present.

The resident was sent to hospital by ambulance and was found to have sustained fractures and internal bleeding.

During interview, a PSW who was working when the fall occurred indicated that they offered to assist with the transfer of resident #001 from the tub chair to the resident's wheelchair but wasn't called to assist. During interview, the PSW who was caring for the resident at the time of the fall stated that, even though the plan of care called for two persons to assist resident #001 to transfer, they had seen the resident standing with one person on previous occasions; they thought that the resident would be safe. They stated that the resident was standing by the tub chair while the PSW reached for an item of clothing, at which time the resident fell directly forward and landed face first on the floor. The PSW confirmed that the transfer was unsafe and the care was improper. They stated that they should have called for assistance with the transfer as offered.

The ARDC confirmed the resident was a high risk for falls but had not fallen in the past year since staff were following the plan of care. The ARDC confirmed that the PSW did not follow the resident's plan of care and neglected to call for assistance when transferring resident #001. This neglect in the form of inaction of not following the plan of care and not calling for assistance as offered, resulted in the resident falling and sustaining significant injury. [s. 19. (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 not neglected by the licensee or staff,, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that safe transferring and positioning devices or techniques were used when transferring residents.

Resident #001 had been assessed as needing two persons to transfer. The document the home referred to as the “care plan” for resident #001 completed in 2014 indicated that the resident required extensive assistance from two people for transferring and for bathing. Interviews with the physiotherapist, RN, RPN and PSW staff confirmed that the resident required two persons for safe transferring.

Six weeks after the care plan was completed, resident #001 fell while being transferred by one PSW staff from the tub chair to the resident’s wheelchair. The home initiated a CIS to the MOHLTC indicating that the resident had fallen and sustained significant injury when being transferred with one staff person instead of two persons as indicated in the resident's plan of care. The resident was sent to hospital by ambulance and was found to have sustained fractures and internal bleeding.

During interview, the PSW caring for resident #001 at the time of the fall stated that they transferred the resident with one person rather than two persons as stated in the resident’s plan of care. They also stated that, even though the plan of care called for two persons to assist resident #001 to transfer, they had seen the resident standing with one person on previous occasions; they thought that the resident would be safe. They stated that the resident was standing by the tub chair while the PSW reached for an item of clothing, at which time the resident fell directly forward and landed face first on the floor. The PSW confirmed that the transfer was unsafe and the care was improper. The PSW confirmed that the transfer was unsafe according to the resident’s care needs and as outlined in the resident’s plan of care.

During the interview, the ADRC confirmed that safe transferring techniques had not been used when transferring resident #001 from the tub chair to the resident’s wheelchair. [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when assisting residents,, to be implemented voluntarily.***

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**WN #5: 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 failed to ensure that any actions taken with respect to a resident under the organized program for personal support services, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

According to their plan of care, resident #001 was to receive a bath twice per week. Review of clinical records indicated that the resident had not received two baths per week on four occasions during two months in 2014. Full time PSW staff interviewed stated that they had provided the resident with the baths according to the resident's plan of care. They confirmed that the resident's health record indicated that the baths had not been received. The ADRC confirmed that the personal hygiene services provided were not documented. [s. 30. (2)]

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**Issued on this 23rd day of January, 2015**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | THERESA MCMILLAN (526) |
| **Inspection No. / No de l'inspection :** | 2014_265526_0027 |
| **Log No. / Registre no:** | H-001641-14 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Dec 1, 2014 |
| **Licensee / Titulaire de permis :** | DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC<br>2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4 |
| **LTC Home / Foyer de SLD :** | HARDY TERRACE<br>612 Mount Pleasant Road, R. R. #2, BRANTFORD, ON, N3T-5L5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | PAUL ROOYAKKERS |

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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).

**Order / Ordre :**

The licensee shall demonstrate the following:

A) All residents' care needs specific to transfers and mobility are assessed and documented

B) The care requirements regarding transfers and mobility for each resident are clearly written in each residents' plan of care

C) Direct care staff are aware of each resident's plan of care related to transfers and mobility

D) Direct care staff provide care related to transfers and mobility according to the resident's plan of care

E) All direct care staff receive immediate re-education about the home's policies for "Fall Prevention and Management" NM-II-F005, and "Resident Safety Program for Lifts, Transfers and Repositioning" HS-XVIII-020 and receive mandatory annual training on safe transfers and lifting

**Grounds / Motifs :**

1. A previous VPC was issued on August 14, 2013.

2. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001's Resident Assessment Instrument Minimum Data Set (RAI MDS) completed in 2014, indicated that the resident required extensive assistance from two people to transfer between bed, chair, wheelchair and standing. The document the home referred to as the "care plan" for resident #001 completed one month after the RAI MDS assessment, indicated that the resident required extensive assistance from two people for transferring and for bathing. The associated Resident Assessment Protocol (RAP) sheet indicated that the resident had unsteady balance. Two falls risk assessments, indicated that the resident had not had a fall in the year prior to the RAI MDS assessment, and that the resident was a high risk for falls.

Ten weeks after the RAI MDS assessment, resident #001 fell while being transferred by one Personal Support Worker (PSW) staff from the tub chair to the resident's wheelchair. The Critical Incident submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) indicated that the resident was assisted to a standing position from the tub chair, during which time, the resident's knees buckled and the resident fell forward onto the floor. The resident was sent to hospital by ambulance and was found to have sustained fractures and internal bleeding.

During interview, the PSW caring for resident #001 at the time of the fall confirmed that the resident's care plan directed staff to transfer the resident using two staff members, and that the PSW was transferring the resident with one person. They stated that they had witnessed the resident standing with one staff person on previous occasions and thought that the resident would be safe. The PSW and Assistant Director of Resident Care (ADRC) confirmed that the staff did not provide care as specified in the plan. [s. 6. (7)] (526)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 31, 2014

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

**Issued on this 1st day of December, 2014**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Theresa McMillan

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office