Ontario

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

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

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

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


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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 13, 2018 | 2018_703625_0006 | 003025-18, 005578-18 | Critical Incident System |

### Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

KATHERINE BARCA (625)

### 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): April 9, 10 and 11, 2018.**

**Two intakes completed during this inspection were related to two Critical Incident System (CIS) reports regarding complaints of improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident.**

**During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Resident Assessment Instrument (RAI) Coordinator, a Registered Dietitian (RD), the Director of Care (DOC) and the Administrator.**

**The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspector also reviewed resident health care records, the home's investigation files and related documents.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director regarding alleged improper or incompetent treatment or care of resident #001 that resulted in harm or a risk of harm to the resident. The report detailed that, on a date in the winter of 2018, resident #001 experienced an incident and their plan of care was not followed. The report also identified that the resident had experienced other similar incidents. Specific direction had been provided with respect to an intervention related to the incident, which did not include a component that was a factor in the incident. The report also referenced a written complaint the home received as a result of the incident.

Inspector #625 reviewed the written complaint submitted to the home from resident #001's family member #110, which indicated the resident had a specific intervention in place, an error had been made, and the resident had experienced multiple incidents where they required staff intervention. The complaint stated that it appeared staff were "not listening – following plans or receiving proper directions".

The Inspector reviewed resident #001's health care record, including:
- the care plan in place at the time of the incident, which identified interventions in place related to the incident, but did not include a specific component which was a factor during

the incident; and
- the current dining room dietary list, current care plan and current Kardex which contained conflicting information related to the assistance the resident required.

The Inspector reviewed the home's investigation file into the incident which included:
- an Internal Complaint Documentation Form that identified the resident had a specific intervention in place and engaged in an activity not identified in the intervention which resulted in an incident. The form also indicated that the resident had experienced several similar incidents and the home had updated the care plan to be more clear, to address the incident; and
- notes of a meeting with RD #111 that identified changes required to the care plan for clarity with respect to a particular intervention.

During an interview with Inspector #625, Registered Dietitian (RD) #111 identified that the incident involving resident #001's occurred because they engaged in an activity not identified in their intervention. They stated that, in response to a previous incident that occurred in the fall of 2017, the former RD had made a note with the intention of identifying specific intervention details, but the note was not clear in that other activities should not have been included in the intervention. The RD acknowledged that the care plan in place at the time of the incident was not clear to the staff in that the resident was not to engage in another activity. The RD also acknowledged resident #001's current plan of care was unclear regarding whether the assistance the resident required and the care plan needed to be updated.

During an interview with the Administrator, they stated that the home's investigation into the incident involving resident #001 determined that the orders related to the intervention were not clear to the PSW staff who could misinterpret it. The Administrator commented that the orders were not as clearly written as they could have been. They acknowledged the plan of care had not provided clear direction to the PSWs with respect to the interventions in place at the time of the incident involving resident #001. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

The following is further evidence to support Compliance Order #001 issued on March 26, 2018, during RQI #2018_703625_0001, with  a compliance due date of April 30, 2018.

A CIS report was submitted to the Director regarding an allegation of improper or

incompetent treatment or care of resident #002 that resulted in harm or a risk of harm to the resident. A written complaint, from resident #002's family member #102, was also submitted by the home related to the CIS report and alleged that a safety device that was required, had not been in use during an incident that occurred in the winter of 2018.

A review of resident #002's care plan in place at the time of the incident identified the resident required a particular safety device in place, to be safe.

Resident #002's Treatment Administration Records (TARs) for March and April 2018, did not list any interventions related to the safety device in place.

Inspector #625 reviewed the home's investigation file related to the incident which included staff interview notes detailing PSW #104's statement that they had used a safety device when providing care to resident #002. The notes also identified that PSW #108 stated they were not sure if a safety device was in place as they didn't notice and didn't know it was present when they provided care to the resident during a shift.

During an interview with Inspector #625, the Administrator stated during the home's investigation it was discovered that PSW #108 did not recall the use of a particular safety device when they provided care to resident #002.

During an interview with Inspector #625, the Director of Care (DOC) acknowledged that resident #002's care plan in place at the time of the incident included the use of a safety device as an intervention. The DOC stated that the investigation identified that PSW #104 stated they had used the safety device with resident #002 during a shift, but that PSW #108 who worked the following shift, did not recall if the safety device was present. The DOC stated staff were required to sign for the use of the safety device on the TAR and, upon reviewing the TARs, identified to the Inspector the April 2018 TAR did not list the use of the specific safety device as an intervention. The DOC acknowledged that some staff had reported seeing and/or using the safety device but that staff had not signed for it's use. [s. 6. (9) 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 O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

A CIS report was submitted to the Director regarding an allegation of improper or incompetent treatment or care of resident #002 that resulted in harm or a risk of harm to the resident. The report indicated, in addition to other allegations, resident #002 was found to be dressed inappropriately.

Inspector #625 reviewed a written complaint submitted to the home by resident #002's family member #102 which identified that, on multiple dates in the winter of 2018, resident #002 was inappropriately dressed by the home's staff. Specific details and evidence of the inappropriate dress were included in the written complaint.

A review of resident #002's care plan in place at the time of both incidents identified that the resident was to be dressed appropriately at all times, and that staff were to ensure the resident was "dressed appropriately" and provided specific details related to appropriate attire for the resident.

Inspector #625 reviewed the home's investigation file related to the two incidents which included:
- An Internal Complaint Documentation Form that indicated the complaint involved a lack of appropriate dress;
- Interview notes with staff that identified, with respect to the first incident, PSWs #104 and #105 had dressed the resident in the manner detailed in the complaint and PSW #104 stated that they had not known the resident well with respect to the specifics of their care; and

- Interview notes with staff that identified, with respect to the second incident, resident #002's family member #103 observed the resident to be dressed in an inappropriate manner and reported this to the home's staff.

During an interview with Inspector #625, the DOC acknowledged that resident #002's care plan in place at the time of the two incidents indicated the resident was to be dressed appropriately at all times, the resident was to be dressed in a specific manner. The DOC acknowledged the home's investigation determined the resident had not been dressed appropriately during the two incidents, had not been dressed in the manner specified in the care plan for either incident, and the care provided to the resident with respect to dressing had not been provided as detailed in their care plan.

During an interview with Inspector #625, the Administrator stated that the results of the investigation identified that, with respect to the two incidents, resident #002 was dressed inappropriately and provided specific details of the inappropriate attire.[s. 40.]

***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 that ensures that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director**

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

**s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, when having received a written complaint with respect to a matter that the licensee reported to the Director under section 24 of the Act, that a copy of the complaint was submitted to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

A CIS report was submitted to the Director regarding alleged improper or incompetent treatment or care of resident #001 that resulted in harm or a risk of harm to the resident. The report referenced a written complaint the home received as a result of a specific incident.

Inspector #625 reviewed the documentation related to the written complaint the home had submitted to the Director. Although the incident had occurred months prior, the Inspector was not able to locate a written report documenting the response the licensee made to the complainant which the home had submitted to the Director.

During a review of documentation related to the incident, the Inspector noted an email dated several days after the incident from the Administrator to Administrative Assistant #112 that read "We need to follow whatever process that needs to be followed in terms of finalizing this with the Ministry."

During an interview with Inspector #625, the Administrator stated that they had completed their investigation and responded to the complainant in writing several days after the incident had occurred. The Administrator also stated that Administrative Assistant #112 would have additional information regarding the distribution of the home's response to the complainant.

During an interview with Administrative Assistant #112, they stated to the Inspector that, due to a miscommunication, the Director had not been forwarded the response made by the home to the complainant. [s. 103. (1)]

**Issued on this 16th day of April, 2018**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KATHERINE BARCA (625) |
| **Inspection No. / No de l'inspection :** | 2018_703625_0006 |
| **Log No. / No de registre :** | 003025-18, 005578-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Apr 13, 2018 |
| **Licensee / Titulaire de permis :** | St. Joseph's Care Group<br>35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7 |
| **LTC Home / Foyer de SLD :** | Bethammi Nursing Home<br>63 Carrie Street, THUNDER BAY, ON, P7A-4J2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Janine Black |

To St. Joseph's Care Group, 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 :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

**Order / Ordre :**

The licensee must be compliant with s. 6 (1) of the Long-Term Care Homes (LTCHA), 2007.

The licensee shall ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident

The licensee shall specifically:
- Conduct a review of resident #001's plan of care with a focus on specific interventions. Ensure the plan of care is clear with respect to the interventions;
- Identify the residents in the home who are at risk of experiencing a specific type of incident and require related interventions. Ensure the plans of care for those residents are clear with respect to the interventions the residents require; and
- Maintain written records of the plans of care reviewed, the findings, and the actions taken to address any inconsistencies, or lack of clarity, in the plans.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director regarding alleged improper or incompetent treatment or care of resident #001 that resulted in harm or a risk of harm to the resident. The report detailed that, on a date in

the winter of 2018, resident #001 experienced an incident and their plan of care was not followed. The report also identified that the resident had experienced other similar incidents. Specific direction had been provided with respect to an intervention related to the incident, which did not include a component that was a factor in the incident. The report also referenced a written complaint the home received as a result of the incident.

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The Inspector reviewed resident #001's health care record, including:
- the care plan in place at the time of the incident, which identified interventions in place related to the incident, but did not include a specific component which was a factor during the incident; and
- the current dining room dietary list, current care plan and current Kardex which contained conflicting information related to the assistance the resident required.

The Inspector reviewed the home's investigation file into the incident which included:
- an Internal Complaint Documentation Form that identified the resident had a specific intervention in place and engaged in an activity not identified in the intervention which resulted in an incident. The form also indicated that the resident had experienced several similar incidents and the home had updated the care plan to be more clear, to address the incident; and
- notes of a meeting with RD #111 that identified changes required to the care plan for clarity with respect to a particular intervention.

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another activity. The RD also acknowledged resident #001's current plan of care was unclear regarding whether the assistance the resident required and the care plan needed to be updated.

During an interview with the Administrator, they stated that the home's investigation into the incident involving resident #001 determined that the orders related to the intervention were not clear to the PSW staff who could misinterpret it. The Administrator commented that the orders were not as clearly written as they could have been. They acknowledged the plan of care had not provided clear direction to the PSWs with respect to the interventions in place at the time of the incident involving resident #001.

During RQIs #2018_703625_0001 and #2015_333577_0016, commencing on October 5, 2015, and January 28, 2018, respectively, two VPCs were issued.

The decision to issue a compliance order was based on the severity which indicated the potential for actual harm or risk to occur. Although the scope was isolated to one resident, the resident experienced multiple incidents of choking and the home's compliance history identified a history of noncompliance specific to this area of the legislation. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2018

## 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, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  13th  day of April, 2018**

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

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

**Name of Inspector / Nom de l'inspecteur :** Katherine Barca

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