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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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Bureau régional de services de London
130 avenue Dufferin 4ème étage
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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
Oct 6, 2017	2017_605213_0020	016027-17, 016032-17, 016037-17, 020863-17, 020864-17, 020865-17	Follow up

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213), ALI NASSER (523), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 2, 3, 4, 2017.

This follow up inspection was completed related to six compliance orders:
Log #016027-17 related to complying with the home's prevention of abuse policy, issued in Inspection #2016_229213_0039 with a compliance date of June 30, 2017.
Log #016032-17 related to skin and wound assessments, issued in Inspection #2017_605213_0007 with a compliance date of July 28, 2017.
Log #016037-17 related to immediately investigating abuse, taking appropriate actions and reporting the results to the Director, issued in Inspection #2017_605213_0007 with a compliance date of July 28, 2017.
Log #020863-17 related to medication incidents, issued in Inspection #2017_605213_0015 with a compliance date of September 8, 2017.
Log #020864-17 related to complying with the home's medication reconciliation policy, issued in Inspection #2017_605213_0015 with a compliance date of September 8, 2017.
Log #020865-17 related to medication administration, issued in Inspection #2017_605213_0015 with a compliance date of September 8, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Vice President of Quality Improvement, Resident Care Coordinators, Resident Assessment Instrument (RAI) Coordinators, the Food and Nutrition Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Administrative Assistants and Scheduling Clerks.

The Inspectors also made observations and reviewed policies and procedures, quality improvement plans, education records, health records, incident reports, internal investigation records and other relevant documentation.

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

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

- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2016_229213_0039	213
LTCHA, 2007 S.O. 2007, c.8 s. 23.	CO #002	2017_605213_0007	213
O.Reg 79/10 s. 50. (2)	CO #001	2017_605213_0007	563
O.Reg 79/10 s. 8. (1)	CO #002	2017_605213_0015	563

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

This inspection was a follow-up to compliance order #003, issued in follow-up inspection #2017_605213_0015 on August 24, 2017. The order stated in part: The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Specifically, the licensee will:
1. Ensure that all registered staff have received training related to medication administration and the best practices, policies and procedures of the home and pharmacy provider related to medication administration.

A review of Medication Incidents in Risk Management in Point Click Care was completed for the period of September 8, 2017 to October 2, 2017. There were seven medication incidents documented for this period of time. Review of those reports showed three incidents involved medication given to the wrong resident and four incidents involved missed doses.

In interviews with the Vice President (VP) of Quality Improvement (QI) #101 and the Administrator #102 on October 3, 2017, they reviewed the above medication incidents with Inspector #523 and acknowledged that for the incidents noted above, the medications were not administered as prescribed. They said that the expectation was for nurses to review physician orders, ensure they were transcribed to the electronic medication administration record (eMAR), and then administered to residents as per the directions in the eMAR.

The Administrator #102 acknowledged that at least four of the seven above medication incidents (57 per cent) were committed by agency registered staff. The Administrator also said that there was no record that the agency staff received training related to medication administration and the best practices, policies and procedures of the home and pharmacy provider related to medication administration.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

The severity of this non-compliance is potential for actual harm and the scope is isolated. The home does have a history of non-compliance in this subsection of the legislation as it was issued as an Immediate Order on January 25, 2017, with a compliance date of January 27, 2017 in Critical Incident Inspection #2016_229213_0035, and it was re-issued as a Compliance Order on June 29, 2017, with a compliance date of July 28, 2017 when it was followed up in Complaint Inspection #2017_605213_0008 and

reissued as a Compliance Order on August 24, 2017 in Follow-Up Inspection #2017_605213_0015 with a compliance date of September 8, 2017. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

This inspection was a follow-up to compliance order #001, issued in follow-up inspection #2017_605213_0015 on August 24, 2017. The order stated in part: The licensee will ensure that for medication incidents and adverse drug reactions:
a) Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health.
c) All medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action will be taken as necessary and a written record kept of this.

A review of Medication Incidents in Risk Management in Point Click Care was completed

for the period of September 8, 2017, to October 2, 2017. There were seven medication incidents documented for this period of time. Review of those reports showed that for six of the seven incidents, there was no record of review, analysis or actions taken related to this incident.

The home's plan for quality improvement related to medication administration and the reduction of medication incidents in the home included: "The Director of Nursing is the designated 'Lead' for Medication Management within the site" and "DON continues to review all Medication Incidents in detail and provide education/support to staff as needed, as well as take disciplinary measures as needed".

In interviews with the Vice President (VP) of Quality Improvement (QI) #101 and the Administrator #102 on October 3, 2017, they reviewed the above medication incidents with Inspector #523 and acknowledged that for the medication incidents noted above, there was no record of review, analysis and actions taken related to those incidents. They said that it was the Director of Nursing's (DON) role to complete a review and analysis of medication incidents and take appropriate actions, as well as, to ensure that the review, analysis and action taken related to those incidents was documented.

The licensee failed to ensure that six of the seven medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

The severity of this non-compliance is potential for actual harm and the scope was widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as an Immediate Order on January 25, 2017 in Critical Incident Inspection #2016_229213_0035 and reissued as a Compliance Order in Follow-Up Inspection 2017_605213_0015. [s. 135. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”. DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 6th day of October, 2017

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) :	RHONDA KUKOLY (213), ALI NASSER (523), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2017_605213_0020
Log No. / No de registre :	016027-17, 016032-17, 016037-17, 020863-17, 020864-17, 020865-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 6, 2017
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angel Roth

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_605213_0015, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Specifically, the licensee will:
1. Ensure that all agency staff have received training related to medication administration and the best practices, policies and procedures of the home and pharmacy provider related to medication administration prior to performing their duties in the home.
2. Develop and implement a tracking system related to completion of training of agency staff to ensure that all agency staff have received training before performing their duties in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

This inspection was a follow-up to compliance order #003, issued in follow-up inspection #2017_605213_0015 on August 24, 2017. The order stated in part:
The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Specifically, the licensee will:
1. Ensure that all registered staff have received training related to medication administration and the best practices, policies and procedures of the home and pharmacy provider related to medication administration.

A review of Medication Incidents in Risk Management in Point Click Care was

completed for the period of September 8, 2017 to October 2, 2017. There were seven medication incidents documented for this period of time. Review of those reports showed three incidents involved medication given to the wrong resident and four incidents involved missed doses.

In interviews with the Vice President (VP) of Quality Improvement (QI) #101 and the Administrator #102 on October 3, 2017, they reviewed the above medication incidents with Inspector #523 and acknowledged that for the incidents noted above, the medications were not administered as prescribed. They said that the expectation was for nurses to review physician orders, ensure they were transcribed to the electronic medication administration record (eMAR), and then administered to residents as per the directions in the eMAR.

The Administrator #102 acknowledged that at least four of the seven above medication incidents (57 per cent) were committed by agency registered staff. The Administrator also said that there was no record that the agency staff received training related to medication administration and the best practices, policies and procedures of the home and pharmacy provider related to medication administration.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

The severity of this non-compliance is potential for actual harm and the scope is isolated. The home does have a history of non-compliance in this subsection of the legislation as it was issued as an Immediate Order on January 25, 2017, with a compliance date of January 27, 2017 in Critical Incident Inspection #2016_229213_0035, and it was re-issued as a Compliance Order on June 29, 2017, with a compliance date of July 28, 2017 when it was followed up in Complaint Inspection #2017_605213_0008 and reissued as a Compliance Order on August 24, 2017 in Follow-Up Inspection #2017_605213_0015 with a compliance date of September 8, 2017. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_605213_0015, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee will ensure that:
a) Every medication incident and adverse drug reaction is documented with a record of the immediate and corrective actions taken to maintain the resident's health.
b) Every medication incident and adverse drug reaction is reviewed and analyzed, corrective action is taken as necessary and a written record kept of this.

Grounds / Motifs :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

This inspection was a follow-up to compliance order #001, issued in follow-up inspection #2017_605213_0015 on August 24, 2017. The order stated in part:
The licensee will ensure that for medication incidents and adverse drug reactions:
a) Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health.

c) All medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action will be taken as necessary and a written record kept of this.

A review of Medication Incidents in Risk Management in Point Click Care was completed for the period of September 8, 2017, to October 2, 2017. There were seven medication incidents documented for this period of time. Review of those reports showed that for six of the seven incidents, there was no record of review, analysis or actions taken related to this incident.

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In interviews with the Vice President (VP) of Quality Improvement (QI) #101 and the Administrator #102 on October 3, 2017, they reviewed the above medication incidents with Inspector #523 and acknowledged that for the medication incidents noted above, there was no record of review, analysis and actions taken related to those incidents. They said that it was the Director of Nursing's (DON) role to complete a review and analysis of medication incidents and take appropriate actions, as well as, to ensure that the review, analysis and action taken related to those incidents was documented.

The licensee failed to ensure that six of the seven medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

The severity of this non-compliance is potential for actual harm and the scope was widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as an Immediate Order on January 25, 2017 in Critical Incident Inspection #2016_229213_0035 and reissued as a Compliance Order in Follow-Up Inspection 2017_605213_0015. (523)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

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 6th day of October, 2017

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 : RHONDA KUKOLY

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