Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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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
Apr 27, 2018	2018_745690_0002	023772-17, 028733-17, 028735-17, 003375-18	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Falconbridge
281 Falconbridge Road SUDBURY ON P3A 5K4

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

TRACY MUCHMAKER (690), MELISSA HAMILTON (693), MICHELLE BERARDI (679), SHANNON RUSSELL (692)

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): April 17-20, 2018.

This inspection was related to:

Follow up inspection for Compliance Order (CO) #001 that was issued during Inspection report #2017_633577_0018, related to medication administration.
Follow up inspection for Compliance Order (CO) #002 that was issued during Inspection report #2017_633577_0018, related to responsive behaviours.
Follow up inspection for Compliance Order (CO) #001 that was issued during Inspection report #2018_671684_0003, related to plan of care, specific to falls prevention.
Follow up inspection for Compliance Order (CO) #001 that was issued during Inspection report #2017_509617_0015, related to plan of care, specific to the revision of care plans.

A Complaint inspection #2018_746692_0001, and a Critical Incident System Inspection #2018_744693_0003 were conducted concurrently with this Follow Up inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support RPN, Personal Support Workers (PSWs), residents and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes, staff education records, as well as reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Responsive Behaviours

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

- **1 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 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
O.Reg 79/10 s. 131. (2)	CO #001	2017_633577_0018	690
O.Reg 79/10 s. 54.	CO #002	2017_633577_0018	693
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_671684_0003	692

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.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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During a record review of resident #008's medication orders, Inspector #690 noted that resident #008 was to receive an identified medication as prescribed by the physician.

A review of the telephone order written by RN #114 identified that part "a" of the medication order did not include the medication name or a route for administration and part "b" of the medication order did not include a route for administration.

In an interview with Inspector #690, RN #114 identified that a medication order should include the name of the medication and the route that the medication should be administered. The Inspector and RN #114 reviewed the written telephone medication order; RN #114 identified that the telephone medication order was not clear and should have contained the medication name and the route it was to be administered.

A review of policy “Physician/Nurse Practitioner Orders: RC-16-01-04”, last revised February 2017, identified the nurse had the professional responsibility to advocate for the resident’s safety and well-being by questioning a medical order that was unclear or contrary to therapeutic resident outcomes. The nurse/interdisciplinary team was to review the order for clarity, as well clearly document the telephone order on the Physician Order form.

In an interview with Inspector #690, the DOC identified that it was the expectation that a medication order should include the medication name and the route it was to be administered. The Inspector and the DOC reviewed the written telephone order and the DOC identified that the order was not clear and should have contained the medication name and the route it is to be administered. [s. 6. (1) (c)]

2. The licensee failed to shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and the preferences of that resident.

A Critical Incident System (CIS) report was submitted to the Director. The CIS report identified that resident #007 was diagnosed with an illness and was being treated with an intervention.

Inspector #690 reviewed resident #007’s care plan and identified a number of interventions related to resident #007's illness. Inspector #690 reviewed #007's health care records and could not locate documentation to support the outcomes of the care set out in the plan of care or documentation to support the effectiveness of the plan of care.

In an interview with Inspector #690, RN #129 identified that the interventions related to their diagnosis were unrealistic, and that they may have been default interventions and that those interventions should not have been included in resident #007’s care plan.

In an Interview with Inspector #690, the DOC identified that the interventions in resident #007 care plan related to their diagnosis should not have been in their care plan and that had they known that those interventions were in their care plan, they would have been removed from their care plan. [s. 6. (2)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and any other time when, the resident’s care needs changed or care set out in the plan was no longer necessary.

Compliance order CO #001 from inspection 2017_509617_0015 was served with a specified compliance date and ordered the licensee to:

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all residents assessed for the risk of falling and have fallen, their plan of care is reviewed and revised when care set out in the plan has not been effective in mitigating subsequent falls that resulted in injury.

While the licensee complied with the previous compliance order, additional findings of noncompliance were identified.

A Critical Incident System (CIS) report was submitted to the Director. The CIS report identified that resident #007 was diagnosed with an illness and was being treated with an intervention.

Inspector #690 reviewed resident #007's care plan and identified a number of interventions related to resident #007's care plan focus of their illness. Inspector #690 reviewed #007's health care records and could not locate documentation to support the outcomes of the care set out in the plan of care or documentation to support the effectiveness of the plan of care.

In an interview with Inspector #690, RN #129 identified that the interventions related to their diagnosis were unrealistic, and that they may have been default interventions and that those interventions should not have been included in resident #007's care plan.

In an Interview with Inspector #690, the DOC identified that the interventions in resident #007 care plan related to their diagnosis should not have been in their care plan and that had they known that those interventions were in their care plan, they would have been removed from their care plan. [s. 6. (10) (b)]

4. A Critical Incident System (CIS) report was submitted to the Director for an incident with injury/hospital transfer that resulted in a significant change in status. The CIS report identified that resident #004 sustained a fall resulting in an injury.

The care plan for resident #004 was reviewed by Inspector #690. The care plan identified that staff were to apply an identified fall intervention device.

During multiple observations, Inspector #690 observed resident #004 without the

presence of the identified fall intervention device in place.

In an interview with Inspector #690, PSW #127 confirmed that resident #004 did not have the identified fall intervention device in place and that it had not been in use by resident #004 for approximately two weeks.

In an interview with Inspector #690, RPN #102 confirmed that the identified fall intervention device was not in place and identified that the fall intervention device should have been resolved from the care plan. .

In an interview with Inspector #690, the DOC confirmed that care plans were to be revised with any change in a resident condition and at minimum quarterly. The DOC reviewed the care plan and confirmed that the intervention for resident #004 should have been removed from the care plan. [s. 6. (10) (b)]

5. A Critical Incident System (CIS) report was submitted to the Director for an incident with injury/hospital transfer that resulted in a significant change in status for resident #012. The CIS report identified that resident #012 had fallen and sustained an injury.

The care plan for resident #012 was reviewed by Inspector #693. The care plan identified that the staff were to provide resident #012 with an specified device.

During multiple observations, Inspector #693 observed resident #012 without the presence of the specified device.

In an interview with Inspector #693, PSW #127 identified that if a resident used a specified device, it would be identified in their care plan. PSW #127 and Inspector #693 reviewed the electronic care plan, which identified that resident #012 used a specified device. PSW #127 confirmed that resident #012 had used a specified device in the past, however, they no longer used it.

A review of the policy entitled “Care Planning: RC-05-01-01”, last revised: April 2017, identified that as the resident’s status changed, members of the interdisciplinary team were to update the plan of care so that it was reflective of the current needs and preferences of the resident.

In an interview with Inspector #693, RPN #107 identified that resident #012 had used a specified device but no longer did as the resident frequently removed it. RPN #107

reviewed the electronic care plan with Inspector #693 and confirmed that the use of a specified device was identified and that the care plan should have been updated.

In an interview with Inspector #693, the DOC stated that if resident #012 used a specified device, it would be indicated in their care plan. The DOC confirmed to Inspector #693 that the current care plan identified the use of a specified device. The DOC identified to Inspector #693 that if resident #012 no longer used a specified device, then the care plan should have been updated to reflect the change. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 10th day of May, 2018

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

Original report signed by the inspector.

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 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Aux termes de l'article 153 et/ou

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) : TRACY MUCHMAKER (690), MELISSA HAMILTON (693), MICHELLE BERARDI (679), SHANNON RUSSELL (692)

Inspection No. / No de l'inspection : 2018_745690_0002

Log No. / No de registre : 023772-17, 028733-17, 028735-17, 003375-18

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Apr 27, 2018

Licensee / Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 700, MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : Extendicare Falconbridge
281 Falconbridge Road, SUDBURY, ON, P3A-5K4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Laura Halloran

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To Extendicare (Canada) 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)

Linked to Existing Order / Lien vers ordre existant: 2017_509617_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6. (10) of the LTCHA.

Specifically, the licensee shall ensure:

a) Residents #012, and #004 are reassessed and their plan of care is reviewed and revised to reflect the current care needs and;

b) All other residents are reassessed and their plan of care is reviewed and revised at the following times; at least every six months, when a goal in the care plan is met, the resident's needs change or when care in the plan is no longer necessary.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Compliance order CO #001 from inspection 2017_509617_0015 was served on September 22, 2017, with a compliance date of November 10, 2017 and ordered

the licensee to:

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all residents assessed for the risk of falling and have fallen, their plan of care is reviewed and revised when care set out in the plan has not been effective in mitigating subsequent falls that resulted in injury.

While the licensee complied with the previous compliance order, additional findings of noncompliance were identified.

A Critical Incident System (CIS) report was submitted to the Director. The CIS report identified that resident #007 was diagnosed with an illness and was being treated with an intervention.

a) Inspector #690 reviewed the electronic progress notes which identified that, RPN #130 documented that an identified intervention for resident #007's illness was maintained. The inspector did not observe any documentation to indicate when the identified intervention was initiated.

Inspector #690 reviewed the electronic care plan and was unable to identify a focus related to the identified intervention.

A review of policy: IC-03-01-12, last revised: September 2017, identified that the care plan was used to indicate the reason for the identified intervention and the alternate plan of care for the duration of the intervention. The policy further indicated that registered staff were to ensure that the care plan and progress notes were updated accordingly once it was determined that a resident required the identified intervention.

In an interview with RPN #123 they confirmed that when a resident required the identified intervention, it should be indicated on the care plan. RPN #123 and Inspector #690 reviewed resident #007's care plan and confirmed that the care plan did not indicate that resident #007 required the identified intervention related to resident 007's illness and that it should have been updated to state this. RPN #123 further identified it would be the responsibility of the registered staff to update the care plan on the shift that the identified intervention was initiated.

In an interview with ADOC #115 they identified that it would be the expectation

that when a resident required the identified intervention, it would be indicated in the care plan. Inspector #690 and ADOC #115 reviewed resident #007's electronic care plan and ADOC #115 identified that the intervention was not on the care plan and that it should have been. (690)

2. A Critical Incident System (CIS) report was submitted to the Director for an incident with injury/hospital transfer that resulted in a significant change in status. The CIS report identified that resident #004 sustained a fall resulting in an injury.

The care plan for resident #004 was reviewed by Inspector #690. The care plan identified that staff were to apply an identified fall intervention device.

During multiple observations, Inspector #690 observed resident #004 without the presence of the identified fall intervention device.

In an interview with Inspector #690, PSW #127 confirmed that resident #004 did not have the identified fall intervention device in place and identified that the identified fall intervention device had not been in use by resident #004 for approximately two weeks.

In an interview with Inspector #690, RPN #102 confirmed that the identified fall intervention device was not in place and identified that the fall intervention device should have been resolved from resident 004's care plan.

In an interview with Inspector #690, the DOC confirmed that care plans were to be revised with any change in a resident condition and at minimum quarterly. The DOC reviewed the care plan and confirmed that the identified fall intervention device should have been removed from resident 004's care plan. (690)

3. A Critical Incident System (CIS) report was submitted to the Director for an incident with injury/hospital transfer that resulted in a significant change in status in resident #012. The CIS identified that resident #012 sustained a fall resulting in an injury.

The care plan for resident #012 was reviewed by Inspector #693. The care plan identified that the staff were to provide resident #012 with a specified device.

During multiple observations, Inspector #693 observed resident #012 without the presence of the specified device.

In an interview with Inspector #693, PSW #127 identified that if a resident used a specified device, it would be identified in their care plan. PSW #127 and Inspector #693 reviewed the electronic care plan, which identified that resident #012 used a specified device. PSW #127 confirmed that resident #012 had used a specified device in the past, however, they no longer used it.

In an interview with Inspector #693, RPN #107 identified that resident #012 had used a specified device, but no longer did. RPN #107 reviewed the electronic care plan with Inspector #693 and confirmed that the use of a specified device was identified and that the care plan should have been updated.

In an interview with Inspector #693, the DOC stated that if resident #012 used a specified device, it would be indicated in their care plan. The DOC confirmed to Inspector #693 that the current care plan identified the use of a specified device. The DOC identified to Inspector #693 that if resident #012 no longer used a specified device, then the care plan should have been updated to reflect the change.

The severity of this issue was determined to be level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to three of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• Compliance Order (CO) made under s. 6. (10) of the LTCHA, September 22, 2017, (#2017_509617_0015) with a compliance date of November 10, 2017.
 (690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 11, 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 27th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Tracy Muchmaker

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