Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 20, 2020	2020_788721_0014	012646-20	Complaint

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Heron Terrace Long Term Care Community
11550 McNorton Street WINDSOR ON N8P 1T9

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

MEAGAN MCGREGOR (721), CHERYL MCFADDEN (745)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 2 and 3, 2020.

The following Complaint intake was completed within this inspection:

Log #012646-20 related to concerns about restraining residents.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a RAI Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Life Activities staff and residents.

The Inspectors also observed residents and the care provided to them, reviewed clinical records and plans of care for the identified residents and reviewed the home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that prior to including restraining by a physical device in a residents plan of care alternatives to restraining the resident had been considered and tried.

A) The Ministry of Long-Term Care (MLTC) received a complaint related to concerns about a specific device being used to restrain resident #001 during an outbreak in the home. Photos were provided by the complainant which showed resident #001 in the home with this specific device applied.

A review of resident #001's Orders section in PointClickCare (PCC) showed a physician written order from a specific date related to a restraint scheduled as needed (PRN).

A review of resident #001's Progress Notes in PCC showed the following:
- A note from a specific date stating resident occasionally exhibited specific behaviours and the behaviour was easily altered.
- A note from a specific date documenting a discussion with resident #001's family related to COVID-19 outbreak planning. The family was informed that the home may need to apply this specific device for the resident during outbreak related to specific behaviours exhibited by the resident and this would be considered a restraint.
- A note from a specific date stating that an outbreak was confirmed in the home and notes from seven subsequent dates stating that resident was exhibiting specific behaviours and the specific device was applied. On one of these dates it was documented that while the specific device was applied the resident was agitated and stating they wanted the device removed.

A review of resident #001's Care Plan in PCC showed an intervention to apply restraint as ordered by the physician related to a focus of potential for injury from restraint usage and interventions indicating to allow a specific behaviour exhibited.

A review of resident #001's Documentation Survey Report v2 in PCC showed a task to monitor behaviours scheduled daily. It was documented that resident #001 exhibited the specific behaviour on seven days and that this behaviour was easily altered on six out of the of seven days it was documented as exhibited.

During an interview when asked about resident #001's specific device, Registered Practical Nurse (RPN) #105 said that resident #001 had the specific device applied

during the homes COVID-19 outbreak because they exhibited a specific behaviour. RPN #105 stated that the purpose of the device was to prevent this behaviour. When asked if they would consider the specific device to be a restraint for resident #001, RPN #105 said yes. When asked if alternatives to restraining the resident were tried prior to implementing the specific device for resident #001 for the purpose of preventing this behaviour, RPN #105 stated if there was enough staff someone would sit with the resident and talk to them in their room but there were times they were unable to accommodate this and applied the specific device.

During an interview with Director of Care (DOC) #101 and RAI Coordinator #106 when asked what steps were taken prior to implementing a restraint for a resident, they stated a checklist for alternatives would be completed initially and then consent and a physician's order must be obtained. They said the checklist for alternatives would look at alternatives to see if there was something that could be effective before implementing a restraint and that this checklist would be kept in the resident's physical chart. RAI Coordinator #106 stated implementing the specific device was a building wide initiative that was part of the homes outbreak management planning for the COVID-19 pandemic. They said the families of all residents who exhibited a specific behaviour were contacted prior to the homes COVID-19 outbreak to obtain consent for the use of the specific device in the event there was an outbreak. When asked about resident #001's specific device, RAI Coordinator #106 said the purpose of the device was to prevent a specific behaviour and the spread of infection during the COVID-19 outbreak and they would consider this to be a restraint. When asked if alternatives to restraining the resident were tried prior to implementing the specific device for resident #001 for the purpose of preventing this specific behaviour, RAI Coordinator #106 said if there were alternatives tried it would be indicated on the checklist for alternatives in the resident's physical chart and they didn't think alternatives were tried.

Inspectors reviewed resident #001's Physical Chart with DOC #101 and RAI Coordinator #106 which included one "Alternatives to Restraints/PASDs Assessments Form" completed on a specific date one month prior to when the specific device was ordered and did not indicate that any alternatives were tried for the purpose of preventing this specific behaviour.

A review of the S&R Nursing Homes Ltd. policy titled "RCM 10-08 Least Restraints", last revised October 26, 2017, stated in part the following:
- "The minimizing of restraining program will be initiated to ensure that any restraining that is necessary is done in accordance to the Long Term Care Homes Act (LTCHA) and

Ontario Regulations to enhance the quality of life for our residents".
- "A restraint is a practice, physical device, pharmaceutical (drug) or product that limits or prevents a resident's range of motion or restricts his/her freedom to access an area when not used to support activities of daily living".
- An example of a restraining by a physical device may include this specific device when not used for activities of daily living.
- The Alternatives to Restraints Assessment form will be completed by a registered team member before application, unless in the event of an emergency situation (see Definition of Emergency Situation)
- "Emergency Situation: A physical restraint may be applied to a resident on the direction of a Registered Nurse (RN) without a Physician/RNEC's order in the event that the resident has been assessed and determined that the resident is at immediate serious risk of injury to him/herself or others. Emergency situations are time limited and will be reported to the physician within 24 hours". (721)

B) During the course of the inspection the Inspectors observed the following:
- On a specific date and time resident #003 was in their room with a specific device applied.
- On a specific date and time resident #003 was in their room and the specific device was not applied. Resident #003 proceeded to leave their room and enter the hallway at which time they were met by two staff members who returned them to their room and told them they were to remain in isolation and needed to stay in their room. A staff member then applied the specific device to resident #003.
- On a specific date and time resident #003 was in a common area with the specific device applied.

A review of resident #003's Orders section in PCC showed a physician written order from a specific date related to a restraint scheduled PRN.

A review of resident #003's Progress Notes in PCC showed the following:
- A note from a specific date documenting a discussion with resident #003's family related to COVID-19 outbreak planning. The family was informed that the home may need to apply this specific device for the resident during outbreak related to specific behaviours exhibited by the resident and this would be considered a restraint.
- A note from a specific date stating that resident was exhibiting specific behaviours and was trying to remove the specific device. They had to be monitored at all times due to safety issues.
- A note from a specific date stating that resident exhibited specific behaviours and was

placed in the nurse's station with the specific device applied and wanted to remove the specific device.

During an interview when asked about resident #003's specific device, Life Activities staff #104 stated the specific device was applied daily and the purpose was to keep them safe and help with performing activities. When asked if resident #003 would be able to remove the device themselves, Life Activities staff #104 said no.

During an interview with DOC #101 and RAI Coordinator #106 when asked about resident #003's specific device, they stated it was put in place for safety and to help stop the spread of infection during the homes COVID-19 outbreak. When asked if they would consider the specific device to be a restraint for resident #003, they stated they would. RAI Coordinator #106 said resident #003 exhibited specific behaviours and the specific device was applied for resident #003 when they required specific interventions in place for a specific period of time related to the homes COVID-19 outbreak. They stated resident #003 was exhibiting some behaviours during a specific period of time and their behaviours have since settled. DOC #101 and RAI Coordinator #106 both stated they were unaware staff were using the specific device for resident #003 at the time of the inspection and when asked why they were using the specific device for the resident staff told them they saw the device in the residents room and applied it because they thought it was part of a specific type of equipment.

Inspectors reviewed resident #003's Physical Chart with DOC #101 and RAI Coordinator #106 which did not show any completed "Alternatives to Restraints/PASDs Assessments Form". (745)

The licensee failed to ensure that prior to including restraining by a specific device in the plan of care for resident #001 and #003 that alternatives to restraining the resident had been considered and tried. [s. 31. (2) 2.]

Additional Required Actions:

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

Issued on this 23rd day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MEAGAN MCGREGOR (721), CHERYL MCFADDEN (745)
Inspection No. / No de l'inspection :	2020_788721_0014
Log No. / No de registre :	012646-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 20, 2020
Licensee / Titulaire de permis :	S & R Nursing Homes Ltd. 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	Heron Terrace Long Term Care Community 11550 McNorton Street, WINDSOR, ON, N8P-1T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amy Sworik

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To S & R Nursing Homes Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 31(2)2.

Specifically, the licensee must:
a) Ensure that resident #001 and #003 and any other resident is not restrained by a physical device unless alternatives to restraining the resident have been considered and tried where appropriate.
b) Ensure that a documented record is maintained of alternatives considered and tried prior to including restraining by a physical device in any residents plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that prior to including restraining by a physical device in a residents plan of care alternatives to restraining the resident had been considered and tried.

A) The Ministry of Long-Term Care (MLTC) received a complaint related to concerns about a specific device being used to restrain resident #001 during an outbreak in the home. Photos were provided by the complainant which showed resident #001 in the home with this specific device applied.

A review of resident #001's Orders section in PointClickCare (PCC) showed a physician written order from a specific date related to a restraint scheduled as needed (PRN).

A review of resident #001's Progress Notes in PCC showed the following:
- A note from a specific date stating resident occasionally exhibited specific behaviours and the behaviour was easily altered.
- A note from a specific date documenting a discussion with resident #001's family related to COVID-19 outbreak planning. The family was informed that the home may need to apply this specific device for the resident during outbreak related to specific behaviours exhibited by the resident and this would be considered a restraint.
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A review of resident #001's Care Plan in PCC showed an intervention to apply restraint as ordered by the physician related to a focus of potential for injury from restraint usage and interventions indicating to allow a specific behaviour exhibited.

A review of resident #001's Documentation Survey Report v2 in PCC showed a task to monitor behaviours scheduled daily. It was documented that resident #001 exhibited the specific behaviour on seven days and that this behaviour was easily altered on six out of the of seven days it was documented as exhibited.

During an interview when asked about resident #001's specific device, Registered Practical Nurse (RPN) #105 said that resident #001 had the specific device applied during the homes COVID-19 outbreak because they exhibited a specific behaviour. RPN #105 stated that the purpose of the device was to prevent this behaviour. When asked if they would consider the specific device to be a restraint for resident #001, RPN #105 said yes. When asked if alternatives to restraining the resident were tried prior to implementing the specific device for resident #001 for the purpose of preventing this behaviour, RPN #105 stated if there was enough staff someone would sit with the resident and talk to them in their room but there were times they were unable to accommodate this and applied the specific device.

During an interview with Director of Care (DOC) #101 and RAI Coordinator #106 when asked what steps were taken prior to implementing a restraint for a resident, they stated a checklist for alternatives would be completed initially and then consent and a physician's order must be obtained. They said the checklist for alternatives would look at alternatives to see if there was something that could be effective before implementing a restraint and that this checklist would be kept in the resident's physical chart. RAI Coordinator #106 stated implementing the specific device was a building wide initiative that was part of the homes outbreak management planning for the COVID-19 pandemic. They said the families of all residents who exhibited a specific behaviour were contacted prior to the homes COVID-19 outbreak to obtain consent for the use of the specific device in the event there was an outbreak. When asked about resident #001's specific device, RAI Coordinator #106 said the purpose of the device was to prevent a specific behaviour and the spread of infection during the COVID-19 outbreak and they would consider this to be a restraint. When asked if alternatives to restraining the resident were tried prior to implementing the specific device for resident #001 for the purpose of preventing this specific behaviour, RAI Coordinator #106 said if there were alternatives tried it would be indicated on the checklist for alternatives in the resident's physical chart and they didn't think alternatives were tried.

Inspectors reviewed resident #001's Physical Chart with DOC #101 and RAI Coordinator #106 which included one "Alternatives to Restraints/PASDs Assessments Form" completed on a specific date one month prior to when the specific device was ordered and did not indicate that any alternatives were tried

for the purpose of preventing this specific behaviour.

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B) During the course of the inspection the Inspectors observed the following:
- On a specific date and time resident #003 was in their room with a specific device applied.
- On a specific date and time resident #003 was in their room and the specific device was not applied. Resident #003 proceeded to leave their room and enter the hallway at which time they were met by two staff members who returned them to their room and told them they were to remain in isolation and needed to stay in their room. A staff member then applied the specific device to resident #003.
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- A note from a specific date stating that resident exhibited specific behaviours and was placed in the nurse's station with the specific device applied and wanted to remove the specific device.

During an interview when asked about resident #003's specific device, Life Activities staff #104 stated the specific device was applied daily and the purpose was to keep them safe and help with performing activities. When asked if resident #003 would be able to remove the device themselves, Life Activities staff #104 said no.

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Inspectors reviewed resident #003's Physical Chart with DOC #101 and RAI Coordinator #106 which did not show any completed "Alternatives to Restraints/PASDs Assessments Form". (745)

The licensee failed to ensure that prior to including restraining by a specific device in the plan of care for resident #001 and #003 that alternatives to restraining the resident had been considered and tried.

The severity of the issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was determined to be level 2 as it related to two of three (67%) of residents reviewed. The home had a level 2 compliance history as they had previous noncompliance with a different sub-section in the last 36 months. (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2020

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 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:

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 20th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Meagan McGregor

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