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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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 12, 2018	2018_505103_0024	003303-18, 007744-18, 008617-18, 008886-18, 009278-18, 009703-18, 011565-18, 020162-18, 024143-18	Critical Incident System

Licensee/Titulaire de permis

Providence Care Centre
752 King Street West KINGSTON ON K7L 4X3

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

Providence Manor
275 Sydenham Street KINGSTON ON K7K 1G7

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

DARLENE MURPHY (103)

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): September 6, 10-14, 17-20, 2018.

The following intakes were inspected:
Log #011565-18 (CIS #553-000015-18)-missing/unaccounted controlled substance,
Log #009703-18 (CIS #553-000013-18)-missing resident,
Log #008617-18 (CIS #553-000010-18), Log # 009278-18 (CIS #553-000012-18), and Log #024143-18 (CIS #553-000018-18)- alleged incidents of resident abuse,
Log #003303-18 (CIS #553-000002-18), Log # 007744-18 (CIS #553-000009-18), Log # 008886-18 (CIS # 553-000011-18) and Log # 020162-18 (CIS # 553-000016-18)-resident falls.

During the course of the inspection, the inspector(s) spoke with a resident, Staffing/Scheduler, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI coordinator, the Assistant Directors of Care (ADOC), the Acting Director of Care and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records including progress notes and resident plans of care, critical incidents submitted by the home related to the inspection and the home's abuse policy and observed resident care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **2 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	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. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The following findings relate to Log #008617-18 and #009278-18:

The licensee has failed to ensure the police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect that the licensee suspected may constitute a criminal offence.

Under O. Reg 79/10, s. 2 (1), physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Resident #009 and resident #010 both resided on the same resident unit and both had a cognitive impairment. On an identified date, residents #009 and #010 were mobilizing in the hallway with their walkers. Neither resident would move out of the others way and this resulted in a physical altercation. Resident #009 sustained an injury as a result of the incident. RN #117 was notified of the incident and according to their documentation, assessed both residents.

The home submitted a critical incident to report the altercation. The Acting DOC was interviewed and indicated the incident was not reported to the police and was unsure of the reason. They acknowledged the incident should have been immediately reported to the police. [s. 98.]

2. Resident #003 and resident #004 both resided on the same unit. On an identified date, PSW staff observed resident #004 in the doorway of resident #003's room and when the staff went to redirect the resident, they found resident #003 lying on the floor. Resident #003 reported resident #004 had struck them and the resident sustained an injury as a result of the incident.

The Acting DOC was interviewed and indicated the incident was not reported to the police because the family had requested they not be notified. Discussion was held with the Acting DOC in regards to the home's obligation to report all incidents of abuse or neglect that may constitute a criminal offence. [s. 98.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following findings relate to Log #008617-18 and #009278-18:

The person who had reasonable grounds to suspect the abuse of a resident had occurred failed to immediately report the suspicion and the information upon which it was based to the Director.

As outlined in WN #1, residents #009 and #010 were involved in a physical altercation that resulted in injury to resident #009. RN #117 was unavailable for interview, but it was noted in their documentation that an email was sent to alert the DOC of the incident.

The Acting DOC was interviewed and stated they became aware of the incident by means of an email that was received the following day when they returned to work. They stated the Director (MOHLTC) was notified of the incident for the first time by means of a critical incident which they sent on a specified date. According to the Acting DOC, RN #117 should have immediately notified the on call manager such that the appropriate notifications could have been made. [s. 24. (1)]

2. As outlined in WN #1, residents #003 and #004 were involved in a physical altercation that resulted in injury to resident #003. RPN #108 was interviewed and indicated they assessed the resident and notified RN #107 of the incident. RN #107 was interviewed and indicated they were aware of the incident, but unable to recall if they had been notified that evening.

The Acting DOC was interviewed and indicated RN #107 had been made aware of the incident at the time of the incident but failed to report it. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The following finding relates to Log #009703-18:

The licensee has failed to ensure care was provided to resident #007 as specified in the plan.

Resident #007 was admitted to the home on an identified date and had specified diagnoses. The resident mobilized with the assistance of a walker.

On an identified date, resident #007 advised PSW #105 that they would be leaving the building to go on a specified errand. Approximately three hours later, the staff noted the resident had not yet returned to the home and initiated a search of the building. The resident was subsequently found approximately one hour later by a staff member a couple of blocks away from the home. The resident indicated they became lost when trying to return to the home. Resident #007 sustained no injuries.

Resident #007's plan of care in effect at the time of this incident was reviewed. The plan indicated under, Locomotion off the unit, that the resident will be supervised when leaving the unit, and that the resident should be accompanied by staff or family whenever leaving the building.

The licensee failed to ensure care was provided to resident #007 as specified in the plan. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The following finding relates to Log #009703-18:

The licensee has failed to ensure the Director was immediately informed of a resident who went missing for three hours or more.

On an identified date, resident #007 reported to PSW #105 that they would be leaving the building to go on a specified outing. As outlined in WN #3, following search efforts, resident #007 returned to the home at a specified time.

The Director (MOHLTC) was informed of the incident by means of a critical incident report which was submitted on a specified date and time.

The licensee failed to ensure the Director was immediately informed resident #007 was missing for more than three hours. [s. 107. (1)]

Issued on this 12th day of October, 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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2018_505103_0024
Log No. / No de registre :	003303-18, 007744-18, 008617-18, 008886-18, 009278-18, 009703-18, 011565-18, 020162-18, 024143-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 12, 2018
Licensee / Titulaire de permis :	Providence Care Centre 752 King Street West, KINGSTON, ON, K7L-4X3
LTC Home / Foyer de SLD :	Providence Manor 275 Sydenham Street, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kyle Cotton

To Providence Care Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 98.

Specifically, the licensee shall:
a) ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect of residents, #003, #009, #010 and any other residents.
b) ensure RNs #107 and #117 receive abuse prevention retraining with an emphasis on mandatory reporting obligations.
c) ensure a record of the training is retained.

Grounds / Motifs :

1. The following findings relate to Log #008617-18 and #009278-18:

The licensee has failed to ensure the police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect that the licensee suspected may constitute a criminal offence.

Under O. Reg 79/10, s. 2 (1), physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Resident #009 and resident #010 both resided on the same resident unit and both had a cognitive impairment. On a specified date, residents #009 and #010 were mobilizing in the hallway with their walkers. Neither resident would move out of the others way and this resulted in a physical altercation. Resident #009 sustained an injury as a result of the incident. RN #117 was notified of the incident and according to their documentation, assessed both residents.

The Acting DOC was interviewed and indicated the incident was not reported to the police and was unsure of the reason. They acknowledged the incident should have been immediately reported to the police.

(103)

2. Resident #003 and resident #004 both resided on the same unit. On a specified date, PSW staff observed resident #004 in the doorway of resident #003's room and when the staff went to redirect the resident, they found resident #003 lying on the floor. Resident #003 reported resident #004 had struck them and the resident sustained an injury as a result of the incident.

The Acting DOC was interviewed and indicated the incident was not reported to the police because the family had requested they not be notified. Discussion was held with the Acting DOC in regards to the home's obligation to report all incidents of abuse or neglect that may constitute a criminal offence.

The decision to issue this non compliance as an order was based on the following:
The severity of the issue was determined to be a level 3 as residents were harmed/injured as a result of the incidents. The scope of the issue was determined to be a level 2 as non compliance was identified in two out of the three incidents inspected. The home had a level 4 compliance history as they had on-going non compliance with this section of the Ontario Regulations 79/10 that included:
Voluntary plan of correction (VPC) issued July 17, 2017 (2017_505103_0026) and
VPC issued October 6, 2017 (2017_520632_0032).

(103)

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 30, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with LTCHA, s. 24 (1).

Specifically the licensee shall:
a) ensure incidents of abuse involving residents #003, #009 and #010 and any other resident are immediately reported to the Director,
b) ensure RNs #107 and #117 receive abuse prevention retraining with an emphasis on mandatory reporting of abuse.
c) ensure a record of the training is retained.

Grounds / Motifs :

1. The person who had reasonable grounds to suspect the abuse of a resident had occurred failed to immediately report the suspicion and the information upon which it was based to the Director.

Resident #009 and resident #010 both resided on the same resident unit and both had a cognitive impairment. On a specified date, both residents were awake and mobilizing in the hallway with their walkers. Neither resident would move out of the others way and this resulted in a physical altercation. Resident #009 sustained an injury as a result of the incident. RN #117 was notified of the incident and assessed both residents.

RN #117 was unavailable for interview, but it was noted in their documentation that an email was sent to alert the Director of Care (DOC) of the incident. Acting DOC was interviewed and stated they became aware of the incident by means of an email that was received the following day when they returned to work. They stated the Director (MOHLTC) was notified of the incident for the first time by means of the critical incident which they sent the day following the incident. According to the Acting DOC, RN #117 should have immediately notified the on call manager so that the appropriate notifications could have been made. (103)

2. Resident #003 and resident #004 both resided on the same unit. On a specified date, PSW staff observed resident #004 in the doorway of resident #003's room and when the staff went to redirect the resident, they found resident #003 lying on the floor. Resident #003 reported resident #004 had struck them and the resident sustained an injury as a result of the incident.

RPN #108 was interviewed and indicated they assessed the resident and notified RN #107 of the incident. RN #107 was interviewed and indicated they were aware of the incident, but unable to recall if they had been notified that evening.

The Acting DOC was interviewed and indicated RN #107 had been made aware of the incident on the evening it occurred, but failed to report it.

The decision to issue this non compliance as an order was based on the following:
The severity of the issue was determined to be a level 3 as residents were harmed/injured as a result of the incidents. The scope of the issue was determined to be a level 2 as non compliance was identified in two out of the three incidents inspected. The home had a level 4 compliance history as they had on-going non compliance with this section of the Ontario Regulations 79/10 that included:
Voluntary plan of correction (VPC) issued July 17, 2017 (2017_505103_0026),
VPC issued October 6, 2017 (2017_520632_0032) and
VPC issued November 22, 2017 (2017_520622_0041).

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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 12th day of October, 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 : DARLENE MURPHY

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