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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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Télécopieur: (519) 885-2015

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
Aug 30, 2021	2021_872218_0015	010357-21, 010358-21, 010359-21	Follow up

Licensee/Titulaire de permis

Saint Luke's Place
1624 Franklin Blvd. Cambridge ON N3C 3P4

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

Saint Luke's Place
1624 Franklin Boulevard Cambridge ON N3C 3P4

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

APRIL RACPAN (218)

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): August 16-20 and 23-25, 2021.

The following intakes were completed in this Follow up inspection:
Log #010358-21/Compliance Order (CO) #001 related to infection prevention and control (IPAC) practices;
Log #010359-21/CO #002 related to mandatory reporting requirements; and
Log #010357-21/CO #003 related to the home's hand hygiene program.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC) and IPAC Lead, the Maintenance and Facility Manager, Registered staff, Housekeeping staff, Administrative staff, and Personal Support Workers (PSWs).

During the course of the inspection, the inspector conducted a tour of the resident home areas (RHAs), observed infection prevention and control practices, resident care provision, and completed resident/staff interviews. The inspector also reviewed posting of required information, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Infection Prevention and Control
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 229. (4)	CO #001	2021_792659_0012	218
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2021_792659_0012	218

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to implement a hand-hygiene program in accordance with evidence-based practices.

On June 18, 2021, CO #003 from Inspection #2021_792659_0012 was issued under s. 229 (9) of the Long-Term Care Homes Act (LTCHA) related to the home's hand hygiene program because they did not include hand hygiene procedures for residents in relation to snacks. The order specified the following:

1) The licensee was to review and revise their hand hygiene policy to include best practices for residents; including hand hygiene before and after meals and snacks.
2) All staff were to be trained on the new hand hygiene policy.
3) A documented record of the training, including who provided the training, the date of the training and staff members that attended the training was to be kept at the home.
4) At a minumum, weekly audits were to be conducted on each unit for resident hand hygiene to ensure compliance with the revised policy. The audits were to continue for a minimum of two months or until no further concerns were identified related to resident hand hygiene. The audits were to include the date/time, the person responsible, the findings and any actions taken.

The compliance due date (CDD) to comply the order was July 30, 2021.

The licensee completed step three but failed to complete steps one, two, and four of CO #001.

The home revised their policy on July 7, 2021, to include directions for staff to assist residents with hand hygiene practices before eating any food during meals and snack services. The policy was not revised to include directions for performing hand hygiene after meals and snack services, as per best practice guidelines.

During the course of the inspection, the following was observed:

During a meal service, multiple residents were not reminded, encouraged, or provided with assistance by staff to perform hand hygiene after eating their meals.

During a snack service, a staff member assisted two residents with eating their snacks and beverages and the staff member did not perform hand hygiene for themselves or provide the residents with assistance on hand hygiene practices before or after eating their snacks and beverages. They did not have a hand sanitizer at point of care access.

During a snack service, two staff members assisted multiple residents with their snacks and beverages and they did not provide residents with assistance on hand hygiene practices before or after eating their snacks and beverages.

A review of the home's education documents showed that approximately 50% of the staff members were not trained on the home's hand hygiene program and revised hand hygiene policy. A review of the home's hand hygiene auditing tool also showed that audits were not being completed for hand hygiene practices during meals and snack services.

The Administrator and IPAC Lead acknowledged that the home's revised policy remained inconsistent with best practice guidelines as it did not include guidelines for hand hygiene practices post meals and snack services.

By not following best practices for hand hygiene placed the staff and residents at risk for disease transmission.

Sources: multiple observations, Public Health Ontario (PHO): Just Clean Your Hands LTCH Implementation Guide, PHO Best Practices for Hand Hygiene in All Health Care Settings (April 2014), Hand Hygiene Policy #I-D-002 , interviews with multiple staff and the IPAC Lead. [s. 229. (9)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperatures required to be measured in one resident common area on every floor of the home and in at least two resident bedrooms in different parts of the home, were documented at least once every evening or night.

The home identified that temperatures were not being measured or documented for resident common areas and resident bedrooms in the evening or night because they had not assigned a staff member to do the task.

The failure to measure and document one of the resident common areas on every floor and at least two resident bedrooms at least once every evening or night placed residents at potential risk for developing a heat related illness.

Sources: LTCH's temperature log records and interviews with the Maintenance Manager #102. [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperatures required to be measured in one resident common area on every floor of the home and in at least two resident bedrooms in different parts of the home, were documented at least once every evening or night, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA: it was a condition of every licensee that the licensee must comply with every order made under this Act.

A) On June 18, 2021, CO #001 from Inspection #2021_792659_0012 was issued under s.229 (4) of the LTCHA to ensure that all staff participated in the implementation of the IPAC program. The order specified the following:

1) All staff, including Administrative staff, follow the IPAC guidance as set out in the Directives for donning and doffing personal protective equipment (PPE), including universal masking.
2) Re-education for six specific staff members related to Public Health (PH) best practice guidance for PPE use when providing care to residents on isolation precautions. The training at a minimum was to include the types of isolation, what/when/where to don and doff the PPE. The training was to be documented to include the date, the name of the person who provided the training, the content reviewed, and the name of the persons who received the training.
3) All staff clean and disinfect lift equipment as per PH best practice guidance.
4) A designated individual(s) to conduct, at minimum, daily audits on each RHA and every shift to ensure compliance with donning and doffing PPE in acccordance with isolation precaution signage, and cleaning and disinfecting lift equipment before and after use and as needed. The audits were to continue for one month. The dates of the audit, the person responsible for auditing, and the actions taken including disciplinary actions were to be documented.
5) Registered staff review the resident's on isolation daily and ensure that the appropriate signage was posted for the type of precaution, as required.

The CDD to comply the order was July 30, 2021.

The licensee completed steps one, three, and five of CO #001. The licensee failed to complete steps two and four of CO #001.

A review of the six staff members' education documents demonstrated that two staff members were not re-educated and the other four staff members completed parts of the education after the CDD. One of the staff members was audited by the home on a specific day in July 2021, and the results showed that they were not in compliance with proper PPE use.

A review of the home's auditing records also demonstrated that audits were not being completed during the night shifts. Audits were also not implemented for the cleaning and disinfection practices of lift equipment. IPAC Lead #101 said they missed implementing these parts of the order.

B) On June 18, 2021, CO #002 from Inspection #2021_792659_0012 was issued to the home under s. 24 (1) of the LTCHA to ensure that immediate reporting was completed as required by the Director. The order specified the following:

1) That any person who had reasonable grounds to suspect that the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: improper or incompetent treatment or care of a resident that resulted in harm or risk of harm.
2) All management staff members of the home were to review the requirements for critical incident (CI) reporting. A written record of the review was to be maintained at the home and include the date of the review and who completed the review.

The CDD to comply the order was July 30, 2021.

The licensee completed step one but failed to complete step two of CO #002.

The Administrator provided a review package that included guidelines for mandatory reporting. The review was provided to Management staff and one Manager had not completed the review. There were also 12 other management staff members who were not provided with the review.

Failure to ensure that all parts of CO #001 and CO #002 were complied with placed the residents at potential risk for improper care practices.

Sources: CO #001 and #002 from Inspection #2021_792659_0012, the LTCH’s action plan, Prevention, Reporting and Elimination of Resident Abuse - Policy #A-F-06, staff training and education records, auditing records, interviews with the IPAC Lead and other staff. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee complies with every order made under the LTCHA, to be implemented voluntarily.

Issued on this 30th day of August, 2021

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) :	APRIL RACPAN (218)
Inspection No. / No de l’inspection :	2021_872218_0015
Log No. / No de registre :	010357-21, 010358-21, 010359-21
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 30, 2021
Licensee / Titulaire de permis :	Saint Luke's Place 1624 Franklin Blvd., Cambridge, ON, N3C-3P4
LTC Home / Foyer de SLD :	Saint Luke's Place 1624 Franklin Boulevard, Cambridge, ON, N3C-3P4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Maureen Toth

To Saint Luke's Place, 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)

Linked to Existing Order / Lien vers ordre existant: 2021_792659_0012, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Order / Ordre :

The licensee must be compliant with Ontario Regulations 79/10 s. 229 (9).

Specifically, the licensee must ensure that:

1) The licensee's hand hygiene policy is reviewed and updated to include best practices for residents; including hand hygiene practices after meals and snack services.

2) All staff will be re-trained on the home's hand hygiene program, including the updated hand hygiene policy.

3) A documented record of the training is to be kept in the home, including the person responsible for providing the training, the date(s) of the training, and the names of the staff members that attended the training.

4) The licensee will review and update their hand hygiene auditing tool to include an audit process for staff and residents during meals and snack services.

5) A designated individual(s) conducts, at a minimum, daily audits on each resident home area during meals and/or snack services to ensure compliance with the revised hand hygiene policy. The audits will continue for a minimum of two months or until no further concerns are identified related to hand hygiene practices during meals and snack services. The audits should include: the date and time, the name of the individual conducting the audit, the name(s) of the individuals audited, the results of the audits, and any actions taken.

Grounds / Motifs :

1. 1. The licensee failed to implement a hand-hygiene program in accordance with evidence-based practices.

On June 18, 2021, CO #003 from Inspection #2021_792659_0012 was issued under s. 229 (9) of the Long-Term Care Homes Act (LTCHA) related to the home's hand hygiene program because they did not include hand hygiene procedures for residents in relation to snacks. The order specified the following:

1) The licensee was to review and revise their hand hygiene policy to include best practices for residents; including hand hygiene before and after meals and

snacks.
2) All staff were to be trained on the new hand hygiene policy.
3) A documented record of the training, including who provided the training, the date of the training and staff members that attended the training was to be kept at the home.
4) At a minumum, weekly audits were to be conducted on each unit for resident hand hygiene to ensure compliance with the revised policy. The audits were to continue for a minimum of two months or until no further concerns were identified related to resident hand hygiene. The audits were to include the date/time, the person responsible, the findings and any actions taken.

The compliance due date (CDD) to comply the order was July 30, 2021.

The licensee completed step three but failed to complete steps one, two, and four of CO #001.

The home revised their policy on July 7, 2021, to include directions for staff to assist residents with hand hygiene practices before eating any food during meals and snack services. The policy was not revised to include directions for performing hand hygiene after meals and snack services, as per best practice guidelines.

During the course of the inspection, the following was observed:

During a meal service, multiple residents were not reminded, encouraged, or provided with assistance by staff to perform hand hygiene after eating their meals.

During a snack service, a staff member assisted two residents with eating their snacks and beverages and the staff member did not perform hand hygiene for themselves or provide the residents with assistance on hand hygiene practices before or after eating their snacks and beverages. They did not have a hand sanitizer at point of care access.

During a snack service, two staff members assisted multiple residents with their snacks and beverages and they did not provide residents with assistance on hand hygiene practices before or after eating their snacks and beverages.

A review of the home's education documents showed that approximately 50% of the staff members were not trained on the home's hand hygiene program and revised hand hygiene policy. A review of the home's hand hygiene auditing tool also showed that audits were not being completed for hand hygiene practices during meals and snack services.

The Administrator and IPAC Lead acknowledged that the home's revised policy remained inconsistent with best practice guidelines as it did not include guidelines for hand hygiene practices post meals and snack services.

By not following best practices for hand hygiene placed the staff and residents at risk for disease transmission.

Sources: multiple observations, Public Health Ontario (PHO): Just Clean Your Hands LTCH Implementation Guide, PHO Best Practices for Hand Hygiene in All Health Care Settings (April 2014), Hand Hygiene Policy #I-D-002 , interviews with multiple staff and the IPAC Lead.

An order was made by taking the following factors into account:

Severity: The licensee not ensuring that their hygiene program was in accordance with evidence-based practices placed others at potential risk for disease transmission in the home.

Scope: This non-compliance was a pattern because hand hygiene practices were not followed for two out of four resident home areas observed.

Compliance History: The licensee continues to be in non-compliance with s. 229 (9) of O.Reg 79/10, resulting in a CO being re-issued. CO #003 was issued on June 18, 202, during Inspection #2021_792659_0012 with a compliance due date of July 30, 2021. In the past 36 months, ten other COs were issued to different sub-sections of the legislation, all of which have been complied. (218)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 29, 2021

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:

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 30th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : April Racpan

Service Area Office /
Bureau régional de services : Central West Service Area Office