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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée 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
Dec 13, 2021	2021_598570_0020 (A2) (Appeal\Dir#: DR# 156)	003858-21, 011388-21, 014859-21	Complaint

Licensee/Titulaire de permis

Shepherd Village Inc.
3758/3760 Sheppard Avenue East Toronto ON M1T 3K9

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

Shepherd Lodge
3760 Sheppard Avenue East Toronto ON M1T 3K9

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

Amended by TAMMY SZYMANOWSKI (Director) - (A2)(Appeal\Dir#: DR# 156)

Amended Inspection Summary/Résumé de l'inspection modifié

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on December 13, 2021.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 156.
A copy of the Director Order is attached.

Issued on this 13th day of December, 2021 (A2)(Appeal\Dir#: DR# 156)

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

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

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

Amended by TAMMY SZYMANOWSKI (Director) - (A2)(Appeal/Dir# DR# 156)

Amended 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): September 21-24, 27-29, October 1, 4 -6, 13-15, 2021

The following intakes were inspected during this Complaint and Follow up Inspection:

- Log #003858-21 related follow-up to CO#001 from inspection #2021_595110_0001 (A2) regarding s. 6. (7), with CDD Aug 31, 2021(A2).

- Log #011388-21 related to a complaint regarding concerns related to laundry, responsive behaviours, continence care and nutrition and hydration.

- Log #014859-21 related to a complaint regarding concerns related to responsive behaviours, skin and wounds and medication administration.

A Critical Incident System (CIS) inspection #2021_598570_0019 was conducted concurrently with this Complaint inspection.

NOTE: Findings of noncompliance related to section s.6. (7) and s.24. (1) of the LTCHA, 2007, identified in concurrent CIS inspection #2021_598570_0019, were issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Quality and Compliance Manager (QCM), Nurse Practitioner (NP), Registered Dietician (RD), Facility Department Coordinator, Nurse Manager (NM), IPAC Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker (SW), Housekeeper, Physiotherapist (PT), Physiotherapy Assistant (PTA), Dietary Aide, Senior Safety Consultant, Family members and residents.

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed video recordings, investigation notes and relevant policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **4 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 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. 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 :

(A1)
1. The home was issued a compliance order (CO) #001 within report #2021_595110_0001 (A2), related to LTCH Act s. 6 (7), with a compliance due date of August 31, 2021. A follow-up inspection was conducted, and staff were found to be non-compliant with providing care as set out in the plan of care resulting in a third re-issue of CO #001 and a Director's Referral (DR) as follows:

The licensee has failed to ensure that the care set out in the plan of care was

provided to resident #009 as specified in the plan.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to care concerns for resident #009. The complainant provided the Inspector with video recordings for two specified dates. The complainant indicated staff were rough with the resident during care and the resident sustained an injury.

Inspectors #570 and #706026 reviewed video recordings for a specified date. The video recordings revealed PSW #126 was holding resident’s arms while PSW #127 was providing personal care to the resident.

Resident #009's plan of care identified staff were not to hold the residents' hand or arm during care. The plan of care directed staff to use gentle approach when touching the resident due to risk of injury.

A progress note by RPN #112, revealed that resident #009 was exhibiting behaviours and did not want to be touched. PSW #126 held resident’s hand as the resident exhibited behvaiours and the resident sustained an injury.

Interview with PSW #126 indicated they continued with care as resident #009 exhibited behaviours and held resident's hand where resident sustained an injury while PSW #127 continued to provide personal care to the resident.

Interviews with RPN-BSO #111, the home's lead of Responsive Behaviors program and Quality and Compliance Manager (QCM) #102, and the Assistant Director of Care, ADOC #129, they acknowledged resident #009's plan of care had not been followed when PSW staff held resident’s arms and continued to provide care while resident was exhibiting behaviours.

Failing to implement the interventions identified in resident #009’s plan of care as it relates to managing the resident’s responsive behaviours has resulted in actual harm to the resident.

Sources: Video recordings, progress notes, resident #009's plan of care and interviews with PSWs #126, #127, RPN.#111, ADOC #129 and Quality Compliance Manager. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #006 and #007 as specified in the plan.

The home submitted a Critical Incident System (CIS) report to the MLTC regarding alleged neglect of residents #006 and #007, related to PSW #108 was seen on multiple occasions not feeding two residents their supplement and juice.

A review of the plan of care for residents #006 and #007 indicated that they were to receive nutritional supplements.

Interview with RPN #113 indicated that they delegated the task of administering the nutritional supplement to PSW staff during meals. The RPN indicated they were not aware the nutritional supplement was not given to residents.

Interviews with PSWs #106 and #118, they indicated that they witnessed PSW #108 threw away residents #006 and #007's nutritional supplement.

Interview with PSW #108 indicated during an identified month, they dumped out the nutritional supplement on one occasion for resident #006.

Interview with the Director of Care (DOC) indicated that PSW #108 admitted withholding residents' supplements. The PSW did not report that to the registered staff who documented that the supplements were given.

Failing to ensure resident #006 and #007's plans of care was provided to the residents as specified in the plan, the residents were placed at risk of not having their care needs met as required.

Sources: Plans of care and clinical records for residents #006 and #007, interviews with PSWs #106, 108, 118, RPN #113, and DOC. [s. 6. (7)]

3. The licensee has failed to ensure that resident #003's plan of care was provided to the resident as specified in the plan.

The MLTC received a Critical Incident System (CIS) report regarding resident #003's fall with injury.

A review of the plan of care for resident #003 identified that the resident was at risk for falls and directed that an intervention to be in place at a specified time.

Resident #003 was observed seated in their room in a wheelchair. PSW #106 and

RPN #112 confirmed that resident did not have the specified intervention at the time of observation.

Interview with Physiotherapist (PT) #134, indicated that resident #003 required the use of the specified intervention when transferred out of bed.

Interview with RN # 135, Falls Prevention Program Lead, acknowledged that the plan of care for resident #003 was not followed.

Failing to ensure resident #003's plan of care was provided to the resident as specified in the plan, the resident was placed at risk of not having their care needs met as required.

Sources: Plan of care and clinical records for resident #003, interviews with Physiotherapist, PSW #106, RPN #112, and RN #135. [s. 6. (7)]

Additional Required Actions:

(A2)(Appeal/Dir# DR# 156)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #131 followed the home's infection prevention and control (IPAC) practices related to resident #009's care.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to care concerns for resident #009.

Inspectors #570 and #706026 reviewed the video recordings of a specified date with QCM #101 and ADOC #102. PSW #131 was noted performing personal care for resident #009 and continued to use the same gloves after completing care and noted to touch clean items/surfaces in resident's room including bed controls, and assisting the resident in dressing and transfer to the wheelchair while using the same gloves.

Interview with PSW #131 indicated that they put on gloves when they enter resident's room and remove gloves prior to leaving the room.

Interview with QCM #102, and ADOC #129, they indicated that touching clean areas with the same gloves used for personal care was not best practice.

Failing to follow IPAC best practices could increase the risk of the spread of infectious disease.

Sources: Video recordings, and interviews with PSW #131, ADOC #129 and QCM #102. [s. 229. (4)]

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 all staff participate in the implementation of the home's infection prevention and control (IPAC) program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

An email with concerns related to the care of resident #009 was received by the LTC home. The complainant requested the LTC home to deal with the concerns as a complaint.

Interviews with QCM #102, and ADOC #129, they indicated an investigation to the concerns is being completed and they acknowledged the written complaint was not forwarded to the Director.

Sources: Email communication to the LTC home and interviews with ADOC #129 and QCM #102. [s. 22. (1)]

WN #4: 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged improper or incompetent treatment or care of a resident, was immediately reported to the Director.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to care concerns for resident #009.

A progress by RN #130, revealed that the substitute decision-maker (SDM) of resident #009 had called with concerns of aggressive care and improper transfer by two staff. The note indicated that RN #130 notified the ADOC.

Interviews with CQM #102, and ADOC #129, indicated RN #130 should have immediately reported the allegation to the MLTC using the after hours call number. The ADOC indicated they received a call from RN #130 about concerns from the SDM of resident #009 but was not aware of the details of those concerns at the time of the call.

Sources: Progress notes for resident #009 and interviews with ADOC #129 and QCM #102. [s. 24. (1)]

2. The licensee has failed to ensure that an alleged abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, was immediately reported to the Director.

The home submitted a Critical Incident System (CIS) report to the MLTC regarding alleged neglect of residents #006 and #007.

Interview with Nurse Manager (NM) #125 acknowledged they did not immediately report the allegation to the MLTC.

Sources: CIS report; and interview NM #125. [s. 24. (1) 2.]

Issued on this 13th day of December, 2021 (A2)(Appeal/Dir# DR# 156)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TAMMY SZYMANOWSKI (Director) - (A2)(Appeal/Dir# DR# 156)
Inspection No. / No de l'inspection :	2021_598570_0020 (A2)(Appeal/Dir# DR# 156)
Appeal/Dir# / Appel/Dir#:	DR# 156 (A2)
Log No. / No de registre :	003858-21, 011388-21, 014859-21 (A2)(Appeal/Dir# DR# 156)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 13, 2021(A2)(Appeal/Dir# DR# 156)
Licensee / Titulaire de permis :	Shepherd Village Inc. 3758/3760 Sheppard Avenue East, Toronto, ON, M1T-3K9
LTC Home / Foyer de SLD :	Shepherd Lodge 3760 Sheppard Avenue East, Toronto, ON, M1T-3K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Fiore

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

To Shepherd Village Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

(A2)(Appeal/Dir# DR# 156)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001

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

Linked to Existing Order/ Lien vers ordre existant : 2021_595110_0001, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 13th day of December, 2021 (A2)(Appeal/Dir# DR# 156)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by TAMMY SZYMANOWSKI (Director) - (A2)(Appeal/Dir# DR# 156)

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

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