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

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

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
Feb 17, 2022	2021_627004_0004 (A1)	012255-21, 012735-21, 012927-21, 013173-21, 013347-21, 013629-21, 013692-21, 013808-21, 014106-21, 014253-21, 014571-21, 015661-21, 015818-21	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Granite Ridge Care Community
5501 Abbott Street East Stittsville ON K2S 2C5

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

Amended by GURPREET GILL (705004) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Executive Director of the Long-term care home requested 2 week extension to their compliance due date as they are currently experiencing an outbreak. The new compliance due date is March 4, 2022.

Issued on this 17th day of February, 2022 (A1)

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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Licensee/Titulaire de permis

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302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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Granite Ridge Care Community
5501 Abbott Street East Stittsville ON K2S 2C5

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

Amended by GURPREET GILL (705004) - (A1)

Amended 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): October 26, 27, 28, 29, November 1, 2, 3, 4,5, 8, 9, and 15, 2021.

The following intakes were inspected in this Critical Incident System (CIS) inspection:

Log #: 012255-21 (CI: 2879-000026-21), #: 013347-21(CI: 2879-000030-21), 013629 -21(CI: 2879-000025-21) related to alleged resident to resident physical abuse.

Log #: 012735-21 (CI: 2879-000027-21), 012927-21 (CI: 2879-000028-21), 013808-21 (CI: 2879-000033-21), 014571-21 (CI: 2879-000037-21), 015661-21 (CI: 2879-000040-21) related to alleged resident to resident sexual abuse.

Log # 013173-21(CI: 2879-000029-21), 013692-21(CI: 2879-000032-21), 014106-21 (CI: 2879-000034-21), 014253-21(CI: 2879-000035-21), 015818-21(CI: 2879-000042-21) regarding a fall incident that caused injury to resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director(ED), the Director of Care (DOC), the Associate Directors of Care (ADOC), the Infection Prevention & Control (IPAC) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Support Attendant (CSA) housekeeping staff, Dietary Aide (DA), COVID screener, Psychogeriatric outreach RN and residents.

During the course of the inspection, the inspector(s) reviewed the resident health care records, licensee policies and other pertinent documents. The

Inspector(s) observed residents, resident home areas, infection control practices, the provision of care and services to resident, staff to resident interactions, resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **2 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. 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 licensee has failed to ensure that a resident was provided care as per the plan of care.

An identified resident was involved with five separate incidents of inappropriate behaviour involving three residents, including two incidents that occurred when the resident had a 1:1 sitter due to their sexual behaviours.

On a day in 2021, the staff member who was assigned 1:1 sitter witnessed an identified resident had inappropriate contact with another resident. According to the report, the 1:1 sitter was eight feet away from the resident and unable to stop it from happening.

On another day in 2021, another staff member who was assigned 1:1 sitter witnessed the identified resident approach another resident and had inappropriate behaviours towards them.

Interviews with two Registered Practical Nurses (RPNs), indicated that when some staff are assigned as 1:1 sitter for the identified resident, they do not report to the nurses station before their shift for report on the resident, this included two staff members who did not receive report on two separate days in 2021, when two incidents occurred while the resident had a 1:1 sitter in place.

Interviews with the two staff members indicated that neither were aware of the resident's sexual responsive behaviours and did not receive any direction as 1:1 for the resident until after the incidents on two separate days in 2021 occurred. One staff member further added that they were not even aware that the resident was not supposed to touch any other residents until after the incident on their shift occurred.

As per the resident's documented plan of care, the resident had a 1:1 sitter in place at the time of the inspection due to responsive behaviours of a sexual nature.

Observations during the inspection found that on two occasions on a specific day in 2021, the identified resident's assigned 1:1 sitter, the staff was not with the resident in the home area for approximately five minutes. On both occasions, the resident was observed to leave their room and walk the corridors of the home area alone. The resident was observed to interact with other residents including during this time.

Interviews with the ADOC and three Registered Practical Nurses (RPNs), indicated that the 1:1 sitter was always to stay with the resident and redirect if necessary, to prevent the resident from getting close to other residents. Furthermore, when the resident was in their room, the 1:1 should be sitting by the doorway, so they are aware if the resident leaves. They also indicated that direction was supposed to be given to staff assigned as 1:1 before they started

their shift with the resident. Such information included how to redirect the resident, not leaving the resident's side, keeping the resident away from other residents and using the behaviour mapping tools to chart behaviours. As such, the resident was not provided care as per their plan of care which lead to incidents of responsive behaviours of a sexual nature.

Sources: Residents Health Care Record, Critical Incident Reports, Observations and interviews with identified staff members. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.
An identified resident was involved with five separate incidents of inappropriate behaviour involving three residents, including two incidents that occurred when the resident had a 1:1 sitter in place due to their sexual behaviours.

As per the resident's documented plan of care, the resident had a 1:1 sitter in place on two separate days in 2021 due to sexually inappropriate behaviours. On a day in 2021, the staff member who was assigned 1:1 sitter witnessed the resident had inappropriate contact with resident another resident. According to the report, the 1:1 sitter was eight feet away from the resident and unable to intervene between the residents.

On another day in 2021, another staff member who was assigned 1:1 sitter witnessed the identified resident approach another resident and had inappropriate behaviours towards them.

Interviews with two Registered Practical Nurses (RPNs), indicated that when some staff are assigned as 1:1 sitter for the resident, they do not report to the nurses station before their shift for report on the resident, this included both staff members who did not receive report on two separate days in 2021, when two incidents occurred while the resident had a 1:1 sitter in place.

Interviews with the two staff members indicated that neither were aware of the resident's sexual responsive behaviours and did not receive any direction regarding sitting with the resident until after the incidents on two separate days in 2021 occurred. One of the staff members further added that they were not aware that the resident was not supposed to touch any other residents until after the incident on their shift occurred.

Sources: Residents Health Care Record, Critical Incident Reports, Observations and interviews with identified staff members. [s. 55. (b)]

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 direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #3: 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 staff participate in the implementation of the infection prevention and control program, specifically related to assisting residents to perform hand hygiene before and after meals.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals.

On a specific day in 2021, it was observed that residents were not assisted to perform hand hygiene before the lunch service. The home's Infection Prevention Control Lead (IPAC) staff indicated that they encourage residents to complete hand hygiene before and after meals however lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Observations of meal service, Public Health Ontario document –Infection Prevention and Control for Long-Term Care Homes Summary of Key Principles and Best Practices Dec 2020, interview with IPAC lead. [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 infection prevention and control program, to be implemented voluntarily.

Issued on this 17th day of February, 2022 (A1)

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

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by GURPREET GILL (705004) - (A1)
Inspection No. / No de l'inspection :	2021_627004_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012255-21, 012735-21, 012927-21, 013173-21, 013347-21, 013629-21, 013692-21, 013808-21, 014106-21, 014253-21, 014571-21, 015661-21, 015818-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 17, 2022(A1)
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Granite Ridge Care Community 5501 Abbott Street East, Stittsville, ON, K2S-2C5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Suzy Gardner

To The Royale Development GP Corporation as general partner of The Royale Development LP, 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

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. 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 / Ordre :

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:
a) Ensure 1:1 monitoring is provided to residents as per their plan of care
b) Ensure that the assigned 1:1 staff member:
-does not leave the resident to assist other staff or residents.
- report to the nurse's station before their shift for report on residents' responsive behaviours that require heightened monitoring and that there is documentation that the assigned staff has been informed of the resident's monitoring needs by registered staff at the start of every shift while the resident is on 1:1 monitoring.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was provided care as per the plan of care.

An identified resident was involved with five separate incidents of inappropriate behaviour involving three residents, including two incidents that occurred when the resident had a 1:1 sitter due to their sexual behaviours.

On a day in 2021, the staff member who was assigned 1:1 sitter witnessed an identified resident had inappropriate contact with another resident. According to the report, the 1:1 sitter was eight feet away from the resident and unable to stop it from happening.

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Interviews with the two staff members indicated that neither were aware of the resident's sexual responsive behaviours and did not receive any direction as 1:1 for the resident until after the incidents on two separate days in 2021 occurred. One staff member further added that they were not even aware that the resident was not supposed to touch any other residents until after the incident on their shift occurred.

As per the resident's documented plan of care, the resident had a 1:1 sitter in place at the time of the inspection due to responsive behaviours of a sexual nature.

Observations during the inspection found that on two occasions on a specific day in 2021, the identified resident's assigned 1:1 sitter, the staff was not with the resident in the home area for approximately five minutes. On both occasions, the resident was observed to leave their room and walk the corridors of the home area alone. The resident was observed to interact with other residents including during this time.

Interviews with the ADOC and three Registered Practical Nurses (RPNs), indicated that the 1:1 sitter was always to stay with the resident and redirect if necessary, to prevent the resident from getting close to other residents. Furthermore, when the resident was in their room, the 1:1 should be sitting by the doorway, so they are aware if the resident leaves. They also indicated that direction was supposed to be given to staff assigned as 1:1 before they started their shift with the resident. Such information included how to redirect the resident, not leaving the resident's side, keeping the resident away from other residents and using the behaviour mapping tools to chart behaviours. As such, the resident was not provided care as per their plan of care which lead to incidents of responsive behaviours of a sexual nature.

Sources: Residents Health Care Record, Critical Incident Reports, Observations and interviews with identified staff members.

An order was made by taking the following factors into account:
Severity: An identified resident was involved with five separate incidents of inappropriate behaviour involving three residents resulted in actual risk of harm to the residents.
Scope: This non-compliance was widespread as three residents were identified to be affected by the incidents.
Compliance History: Two written notification (WN) and two voluntary plans of correction (VPCs) were issued to the home related to s. 6 (7) of the Long-Term Care Homes Act, 2007 in the past 36 months.

(593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2022(A1)

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.

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 17th day of February, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by GURPREET GILL (705004) - (A1)

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

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