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
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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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
Nov 9, 2017	2017_589641_0036	011737-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

STREAMWAY VILLA
19 JAMES STREET WEST COBOURG ON K9A 2J8

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

CATHI KERR (641), DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 30, 31, November 1 and 2, 2017

Critical incident log #021599-17 related to a resident falling resulting in an injury, was inspected in conjunction with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator / Director of Care (ADMIN/DOC), the Assistant Director of Care / RAI - Coordinator (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nutritional Care Manager (NCM), Life Enrichment Coordinator (LEC), Resident Council Representative, family members, and residents.
During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident council minutes, the home's staffing plan and schedules for the registered nurses and policies and procedures related to falls prevention.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Inspector #641 reviewed the licensee's registered nurse (RN) staffing schedule from July 1, 2017 to Nov 2, 2017. It was noted that during that time there were 14 days were there wasn't a registered nurse in the home who was an employee of the licensee and a member of the regular nursing staff of the home, for the entire 24 hours. During the following days, there was no RN on duty in the home for all or part of the shifts as noted:

1. October 31, 2017 – no RN from 1500 to 2300
2. October 30, 2017 – no RN from 1500 to 1700
3. October 27, 2017 – no RN from 2300 to 0700
4. October 23, 2017 – no RN from 1500 to 1900
5. October 20, 2017 – no RN from 1500 to 2000
6. October 11, 2017 – no RN from 1500 to 2300
7. September 19, 2017 – no RN from 2300 to 0700
8. August 29, 2017 – no RN from 1500 to 2300
9. August 28, 2017 – no RN from 1630 to 2200
10. August 10, 2017 – no RN from 1500 to 2300
11. August 5, 2017 – no RN from 2300 to 0700
12. July 29, 2017 – no RN from 1500 to 1830
13. July 19, 2017 – no RN from 1500 to 1900
14. July 12, 2017 – no RN from 1500 to 1900

On November 2, 2017, Inspector #641 interviewed the Administrator / Director of Care (ADMIN/DOC). The ADMIN/DOC indicated that the staffing back up plan for replacing a RN dictated that the home would first of all contact any of the RNs who were not working and then would offer overtime to the other RNs. If there still wasn't someone available to work, then the shift was filled with a registered practical nurse (RPN) with either herself or another RN on call. The ADMIN/DOC specified that the registered nurses in the home were all employees of the licensee and a member of the regular nursing staff of the home. She indicted that the licensee did not use agency staff because her understanding was that the home would have to have a RPN in the building at the same time anyway.

The ADM/DOC indicated that she felt the home was in compliance because it had 64 beds or fewer and therefore could use an RPN when there was an emergency situation. The ADMIN/DOC specified that because they didn't have an RN available for the shift, this constituted an emergency situation.

An "emergency means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home". O.Reg.79/10,s.45.(2) None of the 14 shifts met the definition as required.

The decision to issue a Compliance order was based on the scope and severity of this non-compliance. There were a total of 14 days during the four month period reviewed that an RN was not on duty for at least part of the shift. The absence of a Registered nurse potentially poses a risk to resident safety and affects every resident living in the home.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times. [s. 8. (3)]

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitution decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The DOC was interviewed in regards to the home's process for completing medication incidents. The DOC indicated the registered staff are responsible for documenting all medication incidents on a paper form. The DOC stated she then completes an online medication incident form which is submitted to the pharmacy and to head office.

The inspector requested to see all medication incidents that had occurred in a specified three month period. A total of nine incidents occurred during that time frame. The inspector reviewed three of the nine incidents that were found to be at the level of administration and involved high risk medications.

The first incident reviewed was categorized by the home as a D. This category is used for medication incidents that reached the resident and required monitoring. This incident occurred on a specified date whereby the resident received an extra dose of medication. The medication incident report was reviewed and indicated the resident/SDM had not been notified of the error. Additionally, there was no documentation to support the immediate actions taken to assess and maintain this resident's health as a result of this medication incident.

The second incident reviewed was categorized by the home as a C. This category is used for medication incidents that reached the resident, but there was no harm. This incident occurred on a specified date whereby the resident was given a medication that had been discontinued for that resident, and therefore no longer prescribed. The medication incident report was reviewed and indicated the resident/SDM had not been notified of the error. Additionally, there was no documentation to support the immediate actions taken to assess and maintain the resident's health as a result of the medication incident.

The third incident reviewed was categorized by the home as a D (error reached the resident and required monitoring). This incident occurred on a specified date whereby the resident received another resident's medications in error. The notifications were made in accordance with the legislated requirements and there was documentation included that supported the immediate actions taken to monitor the resident following the medication incident.

The DOC was interviewed in regards to the missing resident/SDM notifications for the two medication incidents and in regards to the missing documentation to support the immediate actions taken to assess the resident as a result of the medication incidents. The DOC reviewed the medication incidents and the resident's health care records, but was unable to find supporting evidence that the resident/SDM's were notified or that the residents were assessed as a result of the errors. The DOC agreed that both the notifications and the monitoring should have been completed for the two identified medication incidents.

The licensee has failed to ensure that every medication incident involving a resident is documented along with the immediate actions to assess and maintain the resident's health and that notifications are done in accordance with the legislation. [s. 135. (1)]

2. The licensee has failed to ensure that,
(a) a quarterly review is undertaken of all medications incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review that are implemented, and
(c) a written record is kept of the above.

The DOC was interviewed in regards to the home's process for reviewing all medication incidents and adverse drug reactions on a quarterly basis. The DOC indicated to the inspector that medication incidents are reviewed during the Medical Advisory/Professional Advisory Committee (MAC/PAC) meetings that are held every three months. She stated the meetings are attended by the Medical Director, the Pharmacist and the Director of Care.

The inspector was provided with the minutes of the last meeting which was held on a specified date. The DOC stated the previous two MAC/PAC had been cancelled due to outbreaks in the home and as a result the medication incidents for an eight month period were reviewed during that meeting. Included with the minutes was a "Medication Incident Tracking Tool" which the DOC indicated was compiled by the pharmacist for that same period.

The three medication incidents that were reviewed by the inspector were discussed with the DOC. The DOC was asked to outline how these incidents are reviewed during these meetings. She stated all medication incidents are briefly highlighted at the MAC/PAC meetings and include an overview of the type of incident and the actions taken by the DOC at the time of the error. The DOC was unable to provide this inspector with any documentation to support that quarterly reviews of all medication incidents are being completed in order to reduce and prevent medication incidents. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitution decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. Further, that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review that are implemented, and a written record is kept of the above, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure medications were given to residents #027, #026 and #025 in accordance with directions for use specified by the prescriber.

The home's medication incidents were reviewed for a specified three month period. Three medication incidents involving high risk medications were inspected.

Resident #027 had a physician's order to receive a specific medication once daily. On a specified date, the resident was given an additional dose of the same medication. The RPN gave the extra dose because the medication administration record appeared to have been erroneously signed on the wrong date. The resident had already received the medication as indicated in the medication administration record, and the resident was given a second dose in error.

On a specified date, resident #026 was given a specific medication by the RN. When the RN went to sign for the medication on the administration record, she noted that the medication had been discontinued. The medication card containing the medication had not been removed from the medication cart for destruction and the RN had failed to check the order for that medication prior to administering the medication.

On a specified date, resident #025 was given another resident's medications in error. The physician was notified and directed the staff to monitor the resident.

All of the above noted resident health care records were reviewed and there was no evidence of any adverse effects to the residents as a result of these errors.

The licensee failed to ensure drugs were administered to resident #027, #026 and #025 in accordance with directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 10th day of November, 2017

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) :	CATHI KERR (641), DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2017_589641_0036
Log No. / No de registre :	011737-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 9, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	STREAMWAY VILLA 19 JAMES STREET WEST, COBOURG, ON, K9A-2J8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kylie Szczebonski

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 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. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee is ordered to ensure that
1. at least one registered nurse who is an employee of the licensee or works at the home pursuant to a contract with the licensee and is a member of the regular nursing staff of the home is on duty and present at all times.
2. the back-up plan for nursing and personal care staffing addresses situations when a registered nursing staff cannot come to work and nursing coverage under subsection 8 (3) of the LTCH Act, 2007 is required.

Grounds / Motifs :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Inspector #641 reviewed the licensee's registered nurse (RN) staffing schedule from July 1, 2017 to Nov 2, 2017. It was noted that during that time there were 14 days were there wasn't a registered nurse in the home who was an employee of the licensee and a member of the regular nursing staff of the home, for the entire 24 hours. During the following days, there was no RN on duty in the home for all or part of the shifts as noted:

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12. July 29, 2017 – no RN from 1500 to 1830
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14. July 12, 2017 – no RN from 1500 to 1900

On November 2, 2017, Inspector #641 interviewed the Administrator / Director of Care (ADMIN/DOC). The ADMIN/DOC indicated that the staffing back up plan for replacing a RN dictated that the home would first of all contact any of the RNs who were not working and then would offer overtime to the other RNs. If there still wasn't someone available to work, then the shift was filled with a registered practical nurse (RPN) with either herself or another RN on call. The ADMIN/DOC specified that the registered nurses in the home were all employees of the licensee and a member of the regular nursing staff of the home. She indicted that the licensee did not use agency staff because her understanding was that the home would have to have a RPN in the building at the same time anyway.

The ADM/DOC indicated that she felt the home was in compliance because it had 64 beds or fewer and therefore could use an RPN when there was an emergency situation. The ADMIN/DOC specified that because they didn't have an RN available for the shift, this constituted an emergency situation.

An "emergency means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home". O.Reg.79/10,s.45. (2) None of the 14 shifts met the definition as required.

The decision to issue a Compliance order was based on the scope and severity of this non-compliance. There were a total of 14 days during the four month period reviewed that an RN was not on duty for at least part of the shift. The absence of a Registered nurse potentially poses a risk to resident safety and affects every resident living in the home.

The licensee failed to ensure that at least one registered nurse who was both an

employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times. [s. 8. (3)] (641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2017

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 9th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathi Kerr

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