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
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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_796754_0029 (A1)	013592-21, 015565-21, 016889-21, 016896-21, 018170-21	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street Collingwood ON L9Y 4X1

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

Amended by SHARON PERRY (155) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date for Compliance Order #001 changed to December 30, 2021.

Issued on this 13th day of December, 2021 (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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Dec 13, 2021	2021_796754_0029 (A1)	013592-21, 015565-21, 016889-21, 016896-21, 018170-21	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street Collingwood ON L9Y 4X1

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

Amended by SHARON PERRY (155) - (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): On-site November 3-5, 8 -10, and off-site November 15, 2021.

The following intakes were completed during this Critical Incident Inspection:

Log #016889-21, follow up to Compliance Order (CO) #001 from inspection #2021_739694_0022, regarding s. 19 (1), with a compliance due date (CDD) of October 26, 2021;

Log #016896-21, follow up to CO #007 from inspection #2021_739694_0022, regarding r. 131 (2), with a CDD of October 26, 2021;

Log #013592-21, related to falls prevention and management at the home; and

Log #015565-21, related to alleged improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (ED), Director of Care (DOC), Universal Care Canada Incorporated (UCCI) management staff, Infection Prevention and Control Lead (IPAC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aides (HAs), Dietary Supervisory, Social Worker, Pharmacy Consultant, and residents.

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, policies and procedures,

internal investigation and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)
0 VPC(s)
1 CO(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_739694_0022	754

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. 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 comply with Compliance Order (CO) #007 from inspection 2021_739694_0022 served on October 7, 2021, with a compliance due date of October 26, 2021.

The licensee failed to ensure that all medication incidents were reported through the home's Medication Incident Reporting System (MIRS) process.

During the inspection, a Medication Administration Audit Report was run in Point Click Care (PCC) for a two-week period. The report documented that registered staff had signed for medication as administered to residents two hours outside the prescribed medication administration time.

The two-week report showed that in different home areas and on different shifts, 62 residents were administered multiple medications that were documented as administered outside the prescribed medication administration time.

Some medications were time sensitive medications, such as medications for certain disease processes, controlled substances for pain control, and medications ordered to be given prior to care.

Pharmacy Consultant #114 and Registered Staff #104 stated that a medication should be given within a one-hour window before and after the prescribed medication administration time.

MIRS types included a wrong time incident, which was defined as a medication administered at a time other than what was prescribed, and a delivery incident which was when a medication was late.

The home had provided recent training to registered staff that when a medication was administered late, they should seek physician instructions and approval.

The MediSystem Medication Administration policy stated that medications were to be administered according to registered staff’s provincial College regulations, administer to one resident at a time, and to document in the electronic Medication Administration Record (eMAR) at the time the medication was administered.

DOC #101 stated that the registered staff were to sign and save their documentation to the eMAR when the medication was administered to the resident.

There were two reasons for the residents to be on the Medication Administration Audit Report. If the registered staff were documenting later in the eMAR, after having given the medication during the prescribed time to the resident, or if the registered staff had administered the medications to the residents later than the prescribed medication time. The DOC had not yet reviewed the specific

medication incidents.

Not ensuring that residents were administered medications, at the times specified by the prescriber, may have placed the residents at risk for harm.

Sources: Medication Administration Audit Report, LTC-Medication Administration policy, MIRS incident type and definitions, MIR-#29173, MediSystem presentation handout, interview with Pharmacy Consultant #114, Registered Staff #104, and DOC #102. [s. 131. (2)]

2. The licensee has failed to ensure that drugs were administered to three residents in accordance with the directions for use specified by the prescriber.

The homes Medication Incident Report System (MIRS) Types and Definitions defined an omission medication incident as a prescribed medication not being administered according to the Medication Administration Record (MAR) and prescribers orders.

A) A Medication Incident Report documented that a resident did not receive their morning medications for five days in a one month period. The reason documented was the resident was sleeping. The report documented there were high alert medications involved.

B) A Medication Incident report documented that a resident did not receive three medications over a two week period, because the resident was sleeping.

C) A Medication Incident report documented that a resident did not receive a medication, because the resident was sleeping.

RN #117 and the DOC said that residents who did not receive medications because they were sleeping would be considered a medication error.

By not ensuring that three residents received all of their medications as specified by the prescriber put them at risk of negative health effects.

Sources: CIS #M581-000053-21, MIR #29178, MIR #29174, MIR #29175, MIR #29176, MIRS incident types and definitions, interviews with RN #117, and the DOC. [s. 131. (2)]

3. The following is further evidence to support compliance order CO #007 issued on October 7, 2021, during inspection 2021_739694_0022, with a compliance due date of October 26, 2021.

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A critical incident was submitted for a resident when they were found needing medical assistance. They were transferred to hospital and later passed away.

The residents Medication Administration Record (eMAR) documented they did not receive their morning medications for eight days in a one month period, because they were sleeping.

The Director of Care (DOC) said that if medications were not given because the resident was sleeping this would be a medication error as staff would not be ensuring or trying to get the resident to take their medication.

By not ensuring that the resident received all of their medications as specified by the prescriber put them at risk of negative health effects.

Sources: CIS #M581-000039-21, progress notes and eMAR for a resident, interviews with the DOC. [s. 131. (2)]

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

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

Issued on this 13th day of December, 2021 (A1)

[redacted]

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 SHARON PERRY (155) - (A1)
Inspection No. / No de l'inspection :	2021_796754_0029 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013592-21, 015565-21, 016889-21, 016896-21, 018170-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 13, 2021(A1)
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, Collingwood, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Astrida Kalnins

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 Corporation of the County of Simcoe, 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_739694_0022, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must comply with s. 131 (2) of O. Reg. 79/10.
Specifically, the licensee must:

a) Ensure that all medication incidents, including time sensitive medications administered late, are reported through the home's Medication Incident Reporting (MIR) process.

b) Review and analyze the operational issues that may have contributed to medication incidents such as omissions, and late medications within the last 30 days. Develop a written action plan to address the identified issues.

c) Ensure a weekly auditing process is developed and implemented, starting immediately, to identify and ensure all medication incidents are reported through the home's MIR process. These audits should include ways to identify all types of medication incidents, as defined by the homes Medication Incident Report System Types and Definitions, including late medications.

A list of the audit reports used, including but not limited to the medication administration audit report on Point Click Care, and a copy of the written audits are to be completed and kept in the home.

Grounds / Motifs :

1. 1. The licensee has failed to comply with Compliance Order (CO) #007 from

inspection 2021_739694_0022 served on October 7, 2021, with a compliance due date of October 26, 2021.

The licensee failed to ensure that all medication incidents were reported through the home's Medication Incident Reporting System (MIRS) process.

During the inspection, a Medication Administration Audit Report was run in Point Click Care (PCC) for a two-week period. The report documented that registered staff had signed for medication as administered to residents two hours outside the prescribed medication administration time.

The two-week report showed that in different home areas and on different shifts, 62 residents were administered multiple medications that were documented as administered outside the prescribed medication administration time.

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MIRS types included a wrong time incident, which was defined as a medication administered at a time other than what was prescribed, and a delivery incident which was when a medication was late.

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DOC #101 stated that the registered staff were to sign and save their documentation to the eMAR when the medication was administered to the resident.

There were two reasons for the residents to be on the Medication Administration Audit Report. If the registered staff were documenting later in the eMAR, after having given the medication during the prescribed time to the resident, or if the registered staff had administered the medications to the residents later than the prescribed medication time. The DOC had not yet reviewed the specific medication incidents.

Not ensuring that residents were administered medications, at the times specified by the prescriber, may have placed the residents at risk for harm.

Sources: Medication Administration Audit Report, LTC-Medication Administration policy, MIRS incident type and definitions, MIR-#29173, MediSystem presentation handout, interview with Pharmacy Consultant #114, Registered Staff #104, and DOC #102. [s. 131. (2)]

2. The licensee has failed to ensure that drugs were administered to three residents in accordance with the directions for use specified by the prescriber.

The homes Medication Incident Report System (MIRS) Types and Definitions defined an omission medication incident as a prescribed medication not being administered according to the Medication Administration Record (MAR) and prescribers orders.

A) A Medication Incident Report documented that a resident did not receive their morning medications for five days in a one month period. The reason documented was the resident was sleeping. The report documented there were high alert medications involved.

B) A Medication Incident report documented that a resident did not receive three medications over a two week period, because the resident was sleeping.

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RN #117 and the DOC said that residents who did not receive medications because they were sleeping would be considered a medication error.

By not ensuring that three residents received all of their medications as specified by

the prescriber put them at risk of negative health effects.

Sources: CIS #M581-000053-21, MIR #29178, MIR #29174, MIR #29175, MIR #29176, MIRS incident types and definitions, interviews with RN #117, and the DOC. [s. 131. (2)]

3. The following is further evidence to support compliance order CO #007 issued on October 7, 2021, during inspection 2021_739694_0022, with a compliance due date of October 26, 2021.

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A critical incident was submitted for a resident when they were found needing medical assistance. They were transferred to hospital and later passed away.

The residents Medication Administration Record (eMAR) documented they did not receive their morning medications for eight days in a one month period, because they were sleeping.

The Director of Care (DOC) said that if medications were not given because the resident was sleeping this would be a medication error as staff would not be ensuring or trying to get the resident to take their medication.

By not ensuring that the resident received all of their medications as specified by the prescriber put them at risk of negative health effects.

Sources: CIS #M581-000039-21, progress notes and eMAR for a resident, interviews with the DOC.
(539)

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

2. An order was re-issued by taking the following factors into account:

Severity: There was potential risk of harm to residents as the residents had their medication documented as administered two hours later than prescribed.

Scope: Pattern – There were 60/135 residents on the medication audit report who were documented as receiving administered medications two hours later than prescribed.

Compliance History: This subsection was issued as a Written Notification (WN) on May 30, 2019, during inspection #2019_605213_0019. A Voluntary Plan of Correction (VPC) on July 10, 2019, during inspection #2019_773155_0010. It was issued as a Compliance Order (CO) on May 27, 2021, during inspection #2021_739694_0018, with a compliance due date (CDD) of June 24, 2021, and reissued as a Compliance Order (CO) during inspection 2021_739694_0022 with a compliance due date of October 26, 2021.

(754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 30, 2021(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 13th day of December, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SHARON PERRY (155) - (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

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