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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2021	2021_745690_0024	012764-21, 015367-21, 016474-21, 017114-21, 017455-21, 017829-21	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

Trillium Manor Home for the Aged
12 Grace Avenue Orillia ON L3V 2K2

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

TRACY MUCHMAKER (690), SHANNON RUSSELL (692)

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): November 22-26, 2021, and November 29, 2021.

The following intakes were inspected upon during this Critical Incident System inspection:

-One intake, related to a choking episode;
-Two intakes, related to falls that resulted in a transfer to hospital and significant change in health status; and
-Three intakes, related to allegations of resident to resident abuse.

A Complaint inspection #2021_745690_0023 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behaviour Supports Services (BSS) staff, Personal Support Workers (PSWs), Home Support Assistants, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

5 WN(s)
3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Falls Prevention and Management policies and procedures included in the required Falls Prevention Program were complied with, for a resident.

Ontario Regulation (O.Reg) 79/10, s. 48 (1) 1, requires an organized program for Falls Prevention to reduce the incidence of falls and the risk of injury, and O. Reg. 79/10, s. 49 (1) requires that the program includes strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches.

Specifically, staff did not comply with the home's policy and procedure "Falls Management Program", dated September 2019. The home's Falls policy indicated that the Falls Prevention Program would include that registered staff were to initiate a written plan of care within 24 hours of admission and that after a resident sustained a fall, staff were to review fall prevention interventions and modify the plan of care as indicated.

A resident sustained a fall, was transferred to the hospital resulting in a significant change in their health status. The resident's care plan identified they were at risk for falls, but there were no interventions identified to mitigate the risk for falls.

Direct care staff identified that the resident had been a fall risk; however, when they reviewed the resident's care plan, there were no strategies identified. The failure to have falls prevention strategies in place posed an actual risk of harm to the resident.

Sources: A Critical Incident System (CIS) report; a resident's health care records; the home's policy titled, "Falls Management Program", #NPC D-25, dated September 2019; interviews with a Personal Support Worker (PSW), a Registered Practical Nurse (RPN), a Registered Nurse (RN), and the Administrator. [s. 8. (1)]

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 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 any person that had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the suspicion to the Director.

Pursuant to the Long-Term Care Homes Act (LTCHA) 2007, c. 8, s.152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A progress note, described an incident in which a resident demonstrated a responsive behaviour towards another resident causing pain and an injury. Another progress note, described a separate incident in which the same resident demonstrated a responsive behaviour towards a different resident causing an injury.

A review of the Long Term Care Homes CIS reporting portal failed to identify a CIS report for either incident. The Administrator verified that neither of the incidents were reported to the Director.

Sources: Three resident's progress notes, Long Term Care Homes Reporting Portal, Interviews with an RN, and the Administrator.

2. A CIS report was submitted to the Director, related to an allegation of resident to resident abuse that occurred the day prior. An RN, and the Administrator verified that they were not made aware of the incident until the day after it had occurred and that the incident was not immediately reported to the Director.

Sources: A CIS report, two residents progress notes, interviews with an RN, and the Administrator. [s. 24. (1) 2.]

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 any person that has reasonable grounds to suspect that abuse of a resident has occurred, immediately report the suspicion to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls when a resident fell.

A resident sustained an unwitnessed fall, was transferred to the hospital, where they were diagnosed with injuries. There was no post fall assessment completed for the fall that had occurred. A progress note documented by an RN indicated that a post fall assessment was not applicable, as the resident went to the hospital.

The Administrator indicated that a post fall assessment must be completed by a registered staff member for every fall, even if the resident was transferred to the hospital.

Sources: A CIS report; a resident's health care records; the home’s policy titled, “Falls Management Program”, #NPC D-25, dated September 2019; interviews with PSW staff, Registered staff, and the Administrator. [s. 49. (2)]

2. A Resident sustained an unwitnessed fall, and they were transferred to the hospital, where they were diagnosed with an injury. The resident had sustained multiple falls in a three month period; however, there were no post fall assessments completed for two of the falls, including the fall that resulted in a transfer to hospital.

The Administrator indicated that a post fall assessment must be completed by a registered staff member for every fall. The home's failure to complete a post fall assessment after the two falls, posed an actual risk of harm to the resident.

Sources: A CIS; a resident’s health care records; the home’s policy titled, “Falls Management Program”, #NPC D-25, dated September 2019; interviews with PSW staff, Registered staff and the Administrator. [s. 49. (2)]

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 a post fall assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for falls when a resident has fallen, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to take steps to minimize the risk of altercations and potentially harmful interactions between a resident and other residents by implementing interventions.

An incident occurred where a resident exhibited responsive behaviours towards another resident. The CIS report indicated that an intervention was being utilized to manage the responsive behaviour and to prevent a recurrence.

Progress notes for the resident identified other incidents of responsive behaviours towards co-residents that occurred after the date of the incident. The resident's care plan did not include any interventions related to altercations with co-residents. Documentation by a staff member from an external agency, stated that they recommended an identified intervention at specified times to prevent a recurrence.

PSW and Registered staff stated that the resident was supposed to have the intervention in place at specified times but that most days, they did not have enough staff to provide it, which presented a risk to other residents.

Sources: Three Critical Incident System (CIS) reports; a resident's progress notes, documents from an external agency, and care plan; interviews with staff, the DOC, and the Administrator. [s. 54. (b)]

2. Another resident had a history of responsive behaviours towards other residents. The DOC had requested an intervention be put in place for a specified time period. Other incidents occurred afterwards in which the resident demonstrated responsive behaviours towards other residents.

A consult note from an external agency described the incidents and stated that the resident was meant to have the intervention in place, although it was not always possible due to staffing challenges.

PSW and Registered staff stated that the resident had responsive behaviours towards other residents, and that, at times, there was an identified intervention in place for the resident, but not always. The Administrator and DOC stated that the intent was to have the intervention in place for the resident but it was not always possible due to staffing constraints.

Sources: Two Resident's progress notes, an external agencies consult notes, interviews with staff, the DOC, and the Administrator. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident, for which they were taken to the hospital, resulting in a significant change in their health status.

A resident sustained a fall, in which they were transferred to the hospital where they were diagnosed with an injury. A review of the resident's progress notes indicated that the home was aware of the injury and subsequent significant change in the resident's health status, a day after the fall occurred. A review of the CIS report identified that the home had not submitted the report until three days later.

Sources: A CIS report; a resident's health care records; the homes internal investigation notes; and interviews with the Administrator and other staff. [s. 107. (3) 4.]

Issued on this 23rd day of December, 2021

[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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY MUCHMAKER (690), SHANNON RUSSELL (692)
Inspection No. / No de l'inspection :	2021_745690_0024
Log No. / No de registre :	012764-21, 015367-21, 016474-21, 017114-21, 017455-21, 017829-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 22, 2021
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Trillium Manor Home for the Aged 12 Grace Avenue, Orillia, ON, L3V-2K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tanya Devries-Porter

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that fall prevention strategies are implemented for all residents that are at risk of falling or that have fallen;
b) Ensure that Registered staff initiate a written plan of care within 24 hours of admission and update the plan of care as necessary to include strategies to prevent further falls or injuries from falls for any resident that has been identified as being at risk of falling.

Grounds / Motifs :

1. The licensee has failed to ensure the Falls Prevention and Management policies and procedures included in the required Falls Prevention Program were complied with, for a resident.

Ontario Regulation (O.Reg) 79/10, s. 48 (1) 1, requires an organized program for Falls Prevention to reduce the incidence of falls and the risk of injury, and O. Reg. 79/10, s. 49 (1) requires that the program includes strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches.

Specifically, staff did not comply with the home's policy and procedure "Falls

Management Program", dated September 2019. The home's Falls policy indicated that the Falls Prevention Program would include that registered staff were to initiate a written plan of care within 24 hours of admission and that after a resident sustained a fall, staff were to review fall prevention interventions and modify the plan of care as indicated.

A resident sustained a fall, was transferred to the hospital resulting in a significant change in their health status. The resident's care plan identified they were at risk for falls, but there were no interventions identified to mitigate the risk for falls.

Direct care staff identified that the resident had been a fall risk; however, when they reviewed the resident's care plan, there were no strategies identified. The failure to have falls prevention strategies in place posed an actual risk of harm to the resident.

Sources: A Critical Incident System (CIS) report; a resident's health care records; the home's policy titled, "Falls Management Program", #NPC D-25, dated September 2019; interviews with a Personal Support Worker (PSW), a Registered Practical Nurse (RPN), a Registered Nurse (RN), and the Administrator.

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

Severity: There was actual risk identified, specifically related to a resident being identified as being at risk of falling, and having no fall prevention strategies identified on the plan of care.

Scope: The scope of this non-compliance was isolated as it affected one out of three residents reviewed.

Compliance History: One Voluntary Plan of Correction (VPC) was issued to the home related to the same subsection of the legislation in the last 36 months. (692)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 04, 2022

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:

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

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 22nd day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tracy Muchmaker

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