Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

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
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2019	2019_746692_0016	010655-19	Complaint

Licensee/Titulaire de permis

Woods Park Care Centre Inc.
110 Lillian Crescent BARRIE ON L4N 5H7

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

Woods Park Care Centre
110 Lillian Crescent BARRIE ON L4N 5H7

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 24-26, 2019.

The Following intake was inspected upon during this Complaint Inspection:
-One log related to a complaint that was submitted to the Director regarding Infection Prevention and Control concerns, the shortage of staff, resulting in care not being provided to residents.

A Critical Incident System inspection #2019_746692_0015 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Care (ADOC), Director of Resident/Family Service (DRFS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), 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 interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, complaint logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a

minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director on an identified date, regarding infection prevention and control practices and staffing shortages occurring often in the home, resulting in residents not receiving care.

Inspector #692 interviewed residents and when asked the question, if they felt the home had enough staff to ensure that they got the care and assistance they required, the Inspector received the following responses:

- Resident #003 identified that the home often doesn't have enough staff working and they have had to wait for care to be completed. They identified that they had missed being bathed a few times, however was unable to recall specific dates. They indicated that staff told them that they couldn't bathe them but did not provide a reason;

- Resident #004 indicated that they had missed being bathed a few times recently; and

- Resident #005 identified that they had missed being bathed as few times, one recently, but could not recall the date. They indicated that the staff had not had the time to complete it.

Inspector #692 reviewed the home's complaint log for a five month period, and noted three separate concerns from families regarding the residents not being bathed at their scheduled times.

A review of the home's policy titled "Hygiene, Personal Care & Grooming – VII-G-10.60", last revised April 2019, indicated that staff were to provide the required minimum number of baths per week. The policy also identified that staff were to follow the resident specific bathing protocols as defined in their plan of care.

The Inspector selected three dates in the month the complaint was submitted and reviewed the "Follow Up Question Report", which documents the out come of care provided to all residents specific to bathing. The report indicated that on the first date reviewed for bathing four residents' had documented "Activity did not occur", on the second date three residents' had documented "Activity did not occur", and on the third date two residents' had documented "Activity did not occur".

a) In a review of the "Follow Up Question Report", for bathing, it identified that on the first date reviewed, residents #009, #010, #011 and #012 had “Activity did not occur”.

Inspector #692 reviewed the “Documentation Survey Report” for the month, which confirmed that the resident’s bathing choice was documented “Activity did not occur”. A further review of the report identified documentation of “Activity did not occur” for resident #010 on another date and on a different date for resident #012.

The Inspector reviewed the identified resident’s health care records and was unable to locate any documentation that indicated that the missed bathing choice of the resident was completed or rationale as to why they were not completed.

b) The Inspector reviewed the “Follow Up Question Report”, for bathing, which identified that on the second date reviewed, residents #014, #015 and #016 had documented “Activity did not occur”.

In a review of the “Documentation Survey Report” for the month, the Inspector identified that the resident’s bathing choice was documented “Activity did not occur”. A further review of the report identified documentation of “Activity did not occur” for residents #014 and #015's on three different dates.

The Inspector reviewed the identified resident’s health care records and was unable to locate any documentation that indicated that the missed bathing choice of the resident was completed or rationale as to why they were not completed.

c) The Inspector reviewed the “Follow Up Question Report”, for bathing, which identified that on the third date reviewed, residents #008 and #013 had documented “Activity did not occur”.

In a review of the “Documentation Survey Report” for the month, Inspector #692 identified that the resident’s bathing choice was documented “Activity did not occur”. A further review of the report identified documentation of “Activity did not occur” on another date, and there was not any documentation for a different date, for resident #008. The report identified that resident #013 had received their bathing choice for the rest of the month.

The Inspector reviewed the identified resident’s health care records and was unable to locate any documentation that indicated that the missed bathing choice of the resident

was completed or rationale as to why they were not completed.

In separate interviews with the Inspector, Personal Support Workers (PSWs) #104, #105, #106, #113, #114, #115 and #116, each identified that when the home worked short staffed the resident's bathing choice was frequently missed due to the increased workload. Each PSW identified that if the resident's scheduled bathing choice was not completed at that time they were to notify the registered staff and the bathing choice was to be completed the next shift or the next day, which they indicated rarely occurred. PSWs #105, #113, #114, and #115 indicated that the residents' scheduled bathing choice was documented as "Activity did not occur" when it was not provided to the resident.

The Inspector reviewed the "Documentation Survey Reports" for residents bathing and noted that any of the aforementioned resident's did not have their bathing choice made up prior to their next scheduled bathing time.

During separate interviews with Registered Practical Nurses (RPNs) #107, #112, and #117, as well as Registered Nurses (RNs) #103 and #109, they each indicated that if a resident's scheduled bathing choice was missed during the shift it would be rescheduled for the next shift. Each registered staff confirmed that if the PSWs documented the bathing choice as "Activity did not occur" then that meant the resident did not have their scheduled bathing choice completed. If the bathing choice was missed during the shift it would be reassigned to the next shift. Each registered staff stated that although the resident's bathing choice was rescheduled, they were not made up until the resident's next scheduled bathing day, which meant residents were not being offered to bathe twice per week, as their plan of care had indicated.

In an interview with Inspector #692, the Administrator and Associate Director of Care (ADOC) #102, stated that if a resident was not bathed at their scheduled time it was supposed to be rescheduled for the next shift or the next day. Together, the Inspector with the Administrator and ADOC #101 reviewed the "Follow Up Question Report" for bathing and the "Documentation Survey Report" for the aforementioned residents, which they confirmed that the residents were not bathed on the days they were scheduled to and were not completed on the next shift. When asked if it was acceptable the frequency of the resident not being bathed and not made up, they both indicated that it was not, and the staff should have bathed the resident. [s. 33. (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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A complaint was submitted to the Director on an identified date, regarding infection prevention and control practices and staffing shortages occurring often in the home, resulting in residents not receiving care. Please see WN #1 for details.

Inspector #692 reviewed a document titled "Staffing Evaluation Plan for Woods Park Care Centre", which indicated that the homes compliment of PSWs for the day, evening, and night shifts.

Inspector #692 reviewed the home's nursing department "Schedule Report" for a three month period. The report indicated that the home worked with less PSWs than the normal staffing compliment for the day and evening shifts. The report identified the following:

-the first month reviewed, the report identified that the home worked short: one PSW shift four of the days, two PSW shifts four of the days, three PSW shifts four of the days, and four PSW shifts one of the days. The home worked short staffed of PSWs 13 out of the 30 days (43 per cent);

-the second month reviewed, indicated that the home worked short: one PSW shift six of the days, two PSW shifts five of the days, and three PSW shifts of five of the days. The home worked short staffed of PSWs 16 out of the 31 days (52 per cent); and

-the third month reviewed, identified that the home worked short: one PSW shift two of the days, two PSW shifts on three of the days, and three PSW shifts on two of the days. The home worked short staffed of PSWs seven out of the 25 days (28 per cent).

In separate interviews with Inspector #692, PSWs #104, #105, #106, #113, #114, #115 and #116, each indicated that the home had staffing issues in the past few months, in which they work short staffed on each shift often. Each PSW stated that when they worked short staffed they ensured resident safety and "worked hard" to get the care done for all residents, but bathing residents was frequently missed.

During separate interviews with RPNs #107, #112, and #117, as well as RNs #103 and #109, they each indicated that the home has had significant staffing shortages with the nursing department for the past five to six months. They each indicated that when they worked short staffed they would prioritize care for residents, ensuring their safety and providing the essential care, such as toileting, transferring and feeding. However, they indicated that they cancelled bathing of residents to ensure that the other care was completed, as there was not enough time for the completion of all the residents scheduled to be bathed.

In an interview with the Administrator and ADOC #101, they indicated that the home had been experiencing challenges with staffing due to a variety of reasons, which they were addressing to ensure the home was at a full compliment of staff on each shift. They both stated that when they were short staffed it was difficult to complete of all of the care for each resident, therefore the bathing of residents was to be rescheduled to be completed the next shift. [s. 8. (1) (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 ensuring there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

Issued on this 10th day of July, 2019

[redacted]

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

Ministère de la Santé et 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 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) :	SHANNON RUSSELL (692)
Inspection No. / No de l'inspection :	2019_746692_0016
Log No. / No de registre :	010655-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 8, 2019
Licensee / Titulaire de permis :	Woods Park Care Centre Inc. 110 Lillian Crescent, BARRIE, ON, L4N-5H7
LTC Home / Foyer de SLD :	Woods Park Care Centre 110 Lillian Crescent, BARRIE, ON, L4N-5H7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Cotton

To Woods Park Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with s. 33 (1) of the Ontario Regulation 79/10.

The licensee shall prepare, submit and implement a plan to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice.

The plan must include, but is not limited to the following:

a) Develop and implement an auditing process to ensure that all residents who were not bathed are followed up with;

b) Maintain records of the audits, including the follow up completed; and

c) Improve the communication between staff and management to determine gaps in providing resident care, safety issues, and actions taken by providing and recording monthly staff meetings.

The plan must be emailed to the attention of LTCH Inspector Shannon Russell at SudburySAO.moh@ontario.ca. The plan is due on July 22, 2019, and the order is to be complied by August 30, 2019.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by

a medical condition.

A complaint was submitted to the Director on an identified date, regarding infection prevention and control practices and staffing shortages occurring often in the home, resulting in residents not receiving care.

Inspector #692 interviewed residents and when asked the question, if they felt the home had enough staff to ensure that they got the care and assistance they required, the Inspector received the following responses:

- Resident #003 identified that the home often doesn't have enough staff working and they have had to wait for care to be completed. They identified that they had missed being bathed a few times, however was unable to recall specific dates. They indicated that staff told them that they couldn't bathe them but did not provide a reason;

- Resident #004 indicated that they had missed being bathed a few times recently; and

- Resident #005 identified that they had missed being bathed as few times, one recently, but could not recall the date. They indicated that the staff had not had the time to complete it.

Inspector #692 reviewed the home's complaint log for a five month period, and noted three separate concerns from families regarding the residents not being bathed at their scheduled times.

A review of the home's policy titled "Hygiene, Personal Care & Grooming – VII-G-10.60", last revised April 2019, indicated that staff were to provide the required minimum number of baths per week. The policy also identified that staff were to follow the resident specific bathing protocols as defined in their plan of care.

The Inspector selected three dates in the month the complaint was submitted and reviewed the "Follow Up Question Report", which documents the out come of care provided to all residents specific to bathing. The report indicated that on the first date reviewed for bathing four residents' had documented "Activity did

not occur", on the second date three residents' had documented "Activity did not occur", and on the third date two residents' had documented "Activity did not occur".

a) In a review of the "Follow Up Question Report", for bathing, it identified that on the first date reviewed, residents #009, #010, #011 and #012 had "Activity did not occur".

Inspector #692 reviewed the "Documentation Survey Report" for the month, which confirmed that the resident's bathing choice was documented as "Activity did not occur". A further review of the report identified documentation of "Activity did not occur" for resident #010 on another date and on a different date for resident #012.

The Inspector reviewed the identified resident's health care records and was unable to locate any documentation that indicated that the missed bathing choice of the resident was completed or rationale as to why they were not completed.

b) The Inspector reviewed the "Follow Up Question Report", for bathing, which identified that on the second date reviewed, residents #014, #015 and #016 had documented "Activity did not occur".

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c) The Inspector reviewed the "Follow Up Question Report", for bathing, which identified that on the third date reviewed, residents #008 and #013 had documented "Activity did not occur".

In a review of the "Documentation Survey Report" for the month, Inspector #692 identified that the resident's bathing choice was documented "Activity did not occur". A further review of the report identified documentation of "Activity did not occur" on another date, and there was not any documentation for a different date, for resident #008. The report identified that resident #013 had received their bathing choice for the rest of the month.

The Inspector reviewed the identified resident's health care records and was unable to locate any documentation that indicated that the missed bathing choice of the resident was completed or rationale as to why they were not completed.

In separate interviews with the Inspector, Personal Support Workers (PSWs) #104, #105, #106, #113, #114, #115 and #116, each identified that when the home worked short staffed the resident's bathing choice was frequently missed due to the increased workload. Each PSW identified that if the resident's scheduled bathing choice was not completed at that time they were to notify the registered staff and the bathing choice was to be completed the next shift or the next day, which they indicated rarely occurred. PSWs #105, #113, #114, and #115 indicated that the residents' scheduled bathing choice was documented as "Activity did not occur" when it was not provided to the resident.

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In an interview with Inspector #692, the Administrator and Associate Director of Care (ADOC) #102, stated that if a resident was not bathed at their scheduled time it was supposed to be rescheduled for the next shift or the next day. Together, the Inspector with the Administrator and ADOC#101 reviewed the "Follow Up Question Report" for bathing and the "Documentation Survey Report" for the aforementioned residents, which they confirmed that the residents were not bathed on the days they were scheduled to and were not completed on the next shift. When asked if it was acceptable the frequency of the resident not being bathed and not made up, they both indicated that it was not, and the staff should have bathed the resident.

The severity of this issue was determined to be a level two, as there was minimal harm/minimal risk. The scope of the issue was a level three, as the number of residents not bathed was widespread. The home had a level two compliance history with no related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10. (692)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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
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 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)
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 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 8th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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