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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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Bureau régional de services de London
130, avenue Dufferin 4ème étage
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Téléphone: (519) 873-1200
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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
Jul 13, 2021	2021_886630_0019 (A1) (Appeal\Dir#: DR# 152)	003803-21, 004719-21, 004754-21, 004761-21, 006461-21, 007570-21	Critical Incident System

Licensee/Titulaire de permis

Ritz Lutheran Villa
4118A Road 164 R.R. #5 Mitchell ON N0K 1N0

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

Ritz Lutheran Villa
4118A Road 164, R.R. #5 Mitchell ON N0K 1N0

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

Amended by Andrew Wisdom (Director) - (A1)(Appeal\Dir#: DR# 152)

Amended Inspection Summary/Résumé de l'inspection modifié

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on July 13, 2021.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 152.
A copy of the Director Order is attached.

Issued on this 13th day of July, 2021 (A1)(Appeal\Dir#: DR# 152)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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Jul 13, 2021	2021_886630_0019 (A1) (Appeal/Dir# DR# 152)	003803-21, 004719-21, 004754-21, 004761-21, 006461-21, 007570-21	Critical Incident System

Licensee/Titulaire de permis

Ritz Lutheran Villa
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Long-Term Care Home/Foyer de soins de longue durée

Ritz Lutheran Villa
4118A Road 164, R.R. #5 Mitchell ON N0K 1N0

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

Amended by Andrew Wisdom (Director) - (A1)(Appeal/Dir# DR# 152)

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): Onsite: March 29, 30, 31, April 1, 14, 15 and May 18, 2021; Off site: April 8, 9,13,16, 21, 22 and May 14,

2021.

The following Critical Incident (CI) intakes were completed within this inspection related to the prevention of resident to resident abuse:

Log #003803-21 / CI 3007-000003-21

Log #004719-21 / CI 3007-000006-21

Log #004754-21 / CI 3007-000007-21

Log #004761-21 / CI 3007-000008-21

Log #006461-21 / CI 3007-000011-21

Log #007570-21 / CI 3007-000017-21

An Infection Prevention and Control (IPAC) inspection was also completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant the Director of Care (ADOC), the Environmental Manager, a Physician, a Registered Nurses (RN), a Registered Practical Nurse (RPN), a Housekeeper, Personal Support Workers (PSWs), the Behavioural Supports Ontario (BSO) RN, the BSO PSW, the Resident Assessment Instrument (RAI) Coordinator, a nursing student, security guards and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed IPAC practices within the home, observed residents and

the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes, reviewed CI reports and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

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

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to protect three residents from sexual abuse by another resident.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse to include "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff

member."

1.There were multiple sexually inappropriate behaviours by one resident towards other residents in the home during a two month time period. Several Critical Incident (CI) reports were submitted to the Ministry of Long-Term Care (MLTC) related to sexual responsive behaviours demonstrated by this resident towards other residents. Care plan interventions were identified and implemented but failed to be effective. Based on an assessment of the resident by an external care provider recommendations had been provided for the management of these behaviours. These recommendations were not fully implemented by the home. The home failed to clearly demonstrate that they had protected residents from non-consensual sexual contact by this resident. [569]

2. A Critical Incident (CI) report documented actions of a sexual nature by one resident to another resident on the home. There were at least four other documented incidents between these residents after this incident had occurred.

Inspector #569 asked staff if there had been leadership direction to allow sexual interactions between these residents, including the parameters for staff to follow during those interactions. Staff said they had been directed to allow sexual interactions between both residents provided both were willing, and in a public place and if the resident was safe. They also said they did not feel comfortable with the situation as they felt it contributed to one of the resident's responsive behaviours.

The Director of Care (DOC) and Administrator told Inspector #630 that the home had implemented a new policy titled "Intimacy and Sexuality" on April 27, 2021, which included direction for staff when responding to sexual interactions between residents. Prior to this policy being implemented there was not a specific process or assessment tool in place in the home to determine a residents cognitive capacity to consent to sexual activities. They said this policy was separate from the home's prevention of abuse and neglect policy, but the expectation was that the two would be used together when assessing resident to resident sexual activities or behaviours. The DOC said an assessment tool was to be used by registered staff to assess a resident's cognitive capacity to consent to a sexual activity every time resident were found to be engaging in an activity of a sexual nature with another resident. Interviews with staff and management in the home found that there were differing understanding of when to use the assessment tool as well as the meaning of consent related to sexual activities. Staff and

management in the home had inconsistent understandings of how to implement the policy.

The DOC said this "Intimacy and Sexuality" policy and assessment tool had not been implemented at the time of the sexual interactions between these two residents. The DOC said they realized, upon review of the incidents between the residents, that the resident's cognitive capacity to consent to sexual touching or behaviours should have been assessed differently. The DOC said some of the incidents, had not been reported to management and therefore they were not able to investigate or report it at the time. [630]

3. Staff witnessed an incident of a sexual nature between two residents in a common area of the home. Staff and the Director of Care (DOC) said one of the residents was not cognitively capable of consenting to these sexual actions by the other resident and therefore they considered this an incident of sexual abuse.

This resident had a history of sexually responsive behaviours that had been directed towards this resident and other residents in the home. One of the interventions that had been implemented for the resident was not in place at the time of the incident. The Critical Incident (CI) report indicated that this resident's sexual behaviours could not be managed by the resources in the home and posed a "public safety risk" to other residents. [630]

Sources: The home's Intimacy and Sexuality policy dated April 2021; the home's Zero Tolerance Abuse and Neglect policy dated August2017; Critical Incident (CI) reports; progress notes and other clinical records; interview with a Personal Support Worker (PSW) and other staff. [s. 19. (1)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 152)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written plan of care for two residents that set out their planned care and provided clear directions to staff regarding their responsive behaviours.

Staff witnessed a resident touching another resident in a sexual manner in a common area of the home. A Critical Incident (CI) was submitted to the MLTC (Ministry of Long-Term Care). The family of one of the resident had been involved in providing parameters related to the sexual activities between these two residents. There were then additional documented incidents in the progress notes of sexual interactions between these residents.

Several areas of documentation were reviewed as part of the plan of care for both residents including care plans, kardex, and hard copy documents. There was no clear direction for staff regarding this issue for either resident within their plan of care.

Staff were asked if there had been leadership direction to allow sexual interactions between these residents. One staff said they had been directed to allow sexual interactions between both residents with specific parameters. They also said they did not feel comfortable with the situation as they felt it contributed

to one of the resident's responsive behaviours.

The Director of Care (DOC) acknowledged the written plan of care for these residents did not provide clear direction for staff.

Sources: Clinical records for two residents; interview with a RN and other staff interviews. [569] [s. 6. (1)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A resident had been assessed by an external resource and recommendations had been made regarding their medications and care for responsive behaviours. The home's improper processing of the assessment recommendations resulted in the resident not having a plan of care in place for an extended time frame which adequately addressed this assessment or the determined needs of the resident. This placed the resident at risk for increased responsive behaviours and placed other residents at risk .

Sources: Physician Orders and other clinical records for the resident; interviews with a Physician and nursing leadership. [569] [s. 6. (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 there is a written plan of care for each resident that sets out their planned care and provides clear directions to staff and to ensure that the care set out in the plan of care is based on an assessment of the resident and their needs and preferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy in place in the home to promote zero tolerance of abuse and neglect of residents, was complied with for two residents related to incidents of potential sexual abuse.

Clinical records for a resident described an incident of a sexual nature between two residents. The Assistant Director of Care (ADOC) said that they were unaware of this incident and complaint from a resident. They said the registered staff should have reported it to leadership in accordance with the home's policy Zero Tolerance – Abuse & Neglect.

Clinical records for another resident described an incident an incident of a sexual nature between two residents. Staff alerted the registered staff of the incident, but this was not reported to leadership in accordance with the home's abuse policy. The Director of Care (DOC) verified that this incident should have been reported to management and staff did not follow the home's process.

There was no documented evidence to demonstrate that the home's policy had been complied with for these incidents in the following areas: contact the Charge Nurse/manager or delegate immediately; promptly investigate resident-to-resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence; assess resident capacity on a regular basis, especially if there are significant changes in the resident's condition.

The staff and leadership team's failure to comply with the home's policy placed residents at risk of harm related to sexual exploitation or abuse.

Sources: Progress notes and other clinical records for residents; the home's "Zero Tolerance – Abuse & Neglect" with a review date of October 2020; interviews with nursing leadership and other staff. [s. 20. (1)]

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 the written policy in place in the home to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 13th day of July, 2021 (A1)(Appeal/Dir# DR# 152)

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 Andrew Wisdom (Director) - (A1) (Appeal/Dir# DR# 152)
Inspection No. / No de l'inspection :	2021_886630_0019 (A1)(Appeal/Dir# DR# 152)
Appeal/Dir# / Appel/Dir#:	DR# 152 (A1)
Log No. / No de registre :	003803-21, 004719-21, 004754-21, 004761-21, 006461-21, 007570-21 (A1)(Appeal/Dir# DR# 152)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 13, 2021(A1)(Appeal/Dir# DR# 152)
Licensee / Titulaire de permis :	Ritz Lutheran Villa 4118A Road 164, R.R. #5, Mitchell, ON, N0K-1N0
LTC Home / Foyer de SLD :	Ritz Lutheran Villa 4118A Road 164, R.R. #5, Mitchell, ON, N0K-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeff Renaud

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 Ritz Lutheran Villa, 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

(A1)(Appeal/Dir# DR# 152)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

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
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:

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
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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
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 13th day of July, 2021 (A1)(Appeal/Dir# DR# 152)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Andrew Wisdom (Director) - (A1)
(Appeal/Dir# DR# 152)

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 : London Service Area Office