Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

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

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
May 6, 2019	2019_792659_0007	028946-18, 033245-18, 006679-19	Follow up

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Cambridge Country Manor
3680 Speedsville Road, R.R. #1 CAMBRIDGE ON N3H 4R6

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

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, 14, 19 and 20, 2019

The following intakes were completed:
Log #028946-18\ Follow-up to CO #001 from Inspection 2018_755728_0007 related to s.20(1) with compliance due date of November 30, 2018.
Log #033245-18\ Critical Incident # 2651-000016-18 related to staff to resident verbal abuse.
Log #006679-19\ Critical Incident #2651-000006-19 related to resident to resident abuse.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (10)(b) was identified in this inspection and has been issued in Inspection Report 2019_792659_0008, dated Mar 25, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered nurses (RN), Registered Practical Nurses (RPN), Behavioural Support lead/RAI Coordinator (BSO/RC), Food and Nutrition Service Manager, Dietary Aides (DA), Personal Support Workers(PSW), Ward clerk , Physiotherapy Aid (PA) and residents.

The inspector toured resident home areas and common areas, observed resident care provision, resident staff interaction, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, and investigation notes.

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

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

4 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. 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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

1. A Critical Incident was reported to the Ministry of Health and Long Term Care (MOHLTC) on a specified date for an incident which occurred two days earlier.

An identified resident needed assistance with care. They called to a PSW, who came to assist them but it was reported that they were rough while providing care.

A PSW stated they were working the night of this incident but they had not witnessed anything. They were aware that the identified resident was upset about a situation and that names were being called between people. The PSW stated they had not reported the incident but that they had told the resident they should tell someone about it.

The charge RN working at the time of the incident did not recall being notified of the incident.

The DOC stated they first became aware of the incident when the identified resident spoke to them two days following the incident.

Review of the home's investigation showed an identified PSW told an RPN that the identified resident accused them of abuse. The RPN had not investigated further and had not reported this to the charge nurse. A second entry in the home's investigation file stated that the RPN had overheard a conversation in the hall between two PSW. The RPN was in the middle of a treatment and the RN was on break. The RPN told the RN they overheard the conversation but had not spoken to the resident about it.

The licensee's written policy: Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff, reviewed September 2018, stated that "all cases of suspected or actual abuse must be reported immediately to the DOC/ED. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call".

2. A Critical Incident was amended to include staff to resident verbal abuse and rough handling for a second identified resident.

One PSW said they overheard a second PSW speak to a resident inappropriately. The PSW said they had not done anything about this incident.

The DOC stated they became aware of this incident when investigating an incident for another identified resident. The DOC stated that there was no formal paper work or separate investigation completed, as it had been rolled into the prior investigation for the other identified resident.

3. During the inspection, an alleged incident of sexual abuse of a resident by a co-resident resident was found recorded in the hard copy of an identified resident's chart. This incident had not been reported the MOHLTC.

The licensee's written policy: Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff, dated reviewed September 2018, stated:

Resident to Resident Abuse:
The ED/DOC will immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence. Measures such as heightened monitoring and behaviour supports (BSO) will be employed to ensure residents involved in abuse of other residents will be hindered from entering other resident rooms unattended.

A hand written progress note in the identified resident's chart stated the resident told a staff member that they witnessed a resident exhibit responsive behaviours toward a co-resident. The staff member reported the concern to the charge RN.

The charge RN stated they had spoken to the resident about the alleged incident and the

resident confirmed the incident had taken place. The RN stated they were not certain if they immediately notified management of the incident or if they completed an assessment of the co-resident.

BSO lead stated that the a referral to BSO had not been made for the resident that exhibited the responsive behaviours.

The DOC stated that they were notified the day after the report of the alleged incident was received. The DOC stated that when there was an allegation of abuse/neglect, the expectation was that the charge nurse contacts the manager on call for further direction. The manager on call would notify the Ministry of Health and Long Term Care (MOHLTC). The DOC acknowledged the home's policy of abuse had not been followed for notification of management.

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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. 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 :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The definition of "abuse" in subsection 2(1) of the Act, defines sexual abuse is defined as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member; or any nonconsensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The clinical record showed an identified resident had a severe cognitive impairment which the RN said would lend them incapable of providing consent.

The clinical record showed that on a specified date, a resident told a staff member that they witnessed another resident exhibit responsive behaviours toward a co-resident. The staff member reported the concern to the charge RN.

The plan of care for the identified resident documented that the resident had a history of responsive behaviours towards staff. There were no interventions in the resident's plan of care to manage the identified responsive behaviours.

The progress notes for a specified date showed documentation that the charge RN had spoken to the resident, who acknowledged the incident had taken place. The charge RN told the resident not to do this again and the resident said they would not.

At the time of the inspection, the identified resident acknowledged the incident of responsive behaviours.

The charge RN stated they were not certain if they completed an assessment of the co-resident. The RN also stated that they made the PSWs aware of the incident and told staff to make sure it did not happen again.

The licensee failed to protect resident #003 from abuse by anyone. [s. 19. (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 resident #003 and all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On a specified date, a resident reported a witnessed incident where another resident exhibited responsive behaviours toward a co-resident.

The DOC stated that the charge RN had reported the incident to them the day after it occurred. The DOC acknowledged that the Director had not been notified of the incident of alleged abuse and a critical incident was not completed.

The licensee had failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (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 person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect or a resident that the licensee suspects may constitute a criminal offence.

On a specified date, a resident informed staff that they had witnessed another resident exhibit responsive behaviours towards a co-resident, which may constitute a criminal offence.

The clinical record showed the co-resident had a severe cognitive impairment. The RN stated the co-resident was not capable of providing consent.

The RN stated they had spoken to resident who exhibited the responsive behaviours about the alleged incident and the resident confirmed the incident had taken place.

The DOC acknowledged police had not been notified of this incident.

The licensee had failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect or a resident that the licensee suspects may constitute a criminal offence. [s. 98.]

Issued on this 9th day of May, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659)
Inspection No. / No de l'inspection :	2019_792659_0007
Log No. / No de registre :	028946-18, 033245-18, 006679-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 6, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Cambridge Country Manor 3680 Speedsville Road, R.R. #1, CAMBRIDGE, ON, N3H-4R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Richardson

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_755728_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licencee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must ensure that all staff comply with home's abuse and neglect policy/procedures in relation to immediate reporting of alleged, suspected or witnessed incidents of abuse.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance order #001 from inspection 2018_755728_0007, issued September 27, 2018, with a compliance due date of November 30, 2018.

Specifically, the licensee was ordered to :
a) comply with their home's abuse and neglect policy and related procedures for reporting incidents of alleged, suspected, or witnessed abuse.
b) ensure that all staff are aware and follow the reporting process as outlined in their policy.

The licensee did not complete steps (a) and (b). The licensee did not comply with their home's abuse and neglect policy and related procedures for reporting incidents of alleged, suspected, or witnessed abuse; nor did they ensure that all staff follow the reporting process as outlined in their policy.

1. A Critical Incident was reported to the Ministry of Health and Long Term Care

(MOHLTC) on a specified date for an incident which occurred two days earlier.

An identified resident needed assistance with care. They called to a PSW, who came to assist them but it was reported that they were rough while providing care.

A PSW stated they were working the night of this incident but they had not witnessed anything. They were aware that the identified resident was upset about a situation and that names were being called between people. The PSW stated they had not reported the incident but that they had told the resident they should tell someone about it.

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Review of the home's investigation showed an identified PSW told an RPN that the identified resident accused them of abuse. The RPN had not investigated further and had not reported this to the charge nurse. A second entry in the home's investigation file stated that the RPN had overheard a conversation in the hall between two PSW. The RPN was in the middle of a treatment and the RN was on break. The RPN told the RN they overheard the conversation but had not spoken to the resident about it.

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inappropriately. The PSW said they had not done anything about this incident.

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3. During the inspection, an alleged incident of sexual abuse of a resident by a co-resident resident was found recorded in the hard copy of an identified resident's chart. This incident had not been reported the MOHLTC.

The licensee's written policy: Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff, dated reviewed September 2018, stated:

Resident to Resident Abuse:
The ED/DOC will immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence. Measures such as heightened monitoring and behaviour supports (BSO) will be employed to ensure residents involved in abuse of other residents will be hindered from entering other resident rooms unattended.

A hand written progress note in the identified resident's chart stated the resident told a staff member that they witnessed a resident exhibit responsive behaviours toward a co-resident. The staff member reported the concern to the charge RN.

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BSO lead stated that the a referral to BSO had not been made for the resident that exhibited the responsive behaviours.

The DOC stated that they were notified the day after the report of the alleged incident was received. The DOC stated that when there was an allegation of abuse/neglect, the expectation was that the charge nurse contacts the manager

on call for further direction. The manager on call would notify the Ministry of Health and Long Term Care (MOHLTC). The DOC acknowledged the home's policy of abuse had not been followed for notification of management.

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The severity of this issue was one, minimal risk. The scope of this issue was widespread as it related to three of three residents. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued October 16, 2017 (2017_607523_0023)
- WN was issued August 16, 2018 (2018_539120_0037)
- WN and Compliance Order (CO), issued September 27, 2018 (2018_755728_0007)

(659)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 07, 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 6th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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