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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 13, Aug 21, 2018	2018_664602_0014	016520-18, 016575-18	Critical Incident System

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

Caressant Care Marmora
58 Bursthall Street P.O. Box 429 MARMORA ON K0K 2M0

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

WENDY BROWN (602)

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): July 10-13, 19, 20 & 24, 2018

The following intakes were completed in the Critical Incident System Inspection: Log# 016520-18, CIS#2718-000033-18 regarding a fall with transfer to hospital and Log# 016575-18, CIS#2718-000034-18 regarding medication incidents.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the acting Director of Care (DOC)/Executive Director (ED), the Resident Care Coordinator, RAI-Coordinator, the physiotherapist, physiotherapy assistant, ward clerks, housekeeping staff, and the Regional Director for Caressant Care.
In addition, observations of resident care, resident-staff and staff-staff interactions, medication passes and provision of physiotherapy services were completed. A review of relevant care home policies including medication administration and fall prevention was conducted. Physician Order Audit reports, staff communication documentation, the home's investigation files and mandatory meeting attendance lists were reviewed. Post instruction session interviews with registered and unregistered nursing staff were also conducted.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (3)	CO #901	2018_664602_0014	602

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

On three specified shifts Registered Nurse (RN) #108 was assisted by unregulated care providers (Personal Support Workers - PSW) to administer medications to a specified number of residents including resident #002. On a specified shift, PSW #117 gave resident #002 resident # 004's medication. The error was discovered by RN #108 who contacted the acting Director of Care (DOC)/Executive Director (ED) #100. The acting DOC/ED directed RN #108 to contact the physician who ordered resident #002 be transferred to hospital. Resident #002 was subsequently admitted to hospital.

The licensee failed to ensure that no drug was administered to resident #002 unless it had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On a specified shift, RN #108 was assisted by an unregulated care provider, PSW #117 to administer medications to a specified number of residents. RN #108 requested that the PSW "run the medications", a process described as follows: "the RN pours the medication at the cart, in the hallway, and the PSW attends the resident' s room and/or

bedside to give the resident the medication. The RN does not enter the room(s) to observe the resident taking the medication as part of the process". The medications provided were numerous and included oral tablets, narcotics, eye drops, inhaled medication and insulin.

On a specified shift, RN # 108 was assisted by PSW #116 to administer medications to a specified number of residents. The process was repeated with RN#108 pouring out the medications and the PSW entering the room to give the resident the required tablets, drops, inhaled medication and insulin.

On another specified shift, RN #108 was again assisted by PSW #117 who gave resident #002 resident #004's medication. Upon discovering the error, the RN contacted the acting DOC/ED #100 who directed that the physician be called immediately. The resident was transferred to hospital as per physician order, where they were admitted.

During the acting DOC/ED #100's post incident follow up, another PSW staff #107, advised that they had "run pills", for a different nurse; the PSW explained that this RN would ask that a PSW take a resident pills when they were in the small dining room or wanted a "when necessary" night medication. The acting DOC/ED #100 contacted the nurse; a summary of the discussion was provided as follows: the RN indicated that they had not asked PSWs to run pills in several years. The RN explained that, in the past, they asked for assistance with residents attending meals in the small dining room or when the nurse was getting behind in giving out pills. RN #106 advised that a previous Director of Care had said it was OK to have a runner. The RN was not aware of any other registered nursing staff who had PSWs "run" pills for them.

The licensee failed to ensure that no person other than a physician, dentist, registered nurse or a registered practical nurse administered resident medications.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #002. The scope of the issue was a level 3 as it related to a specified number of residents requiring medications. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
- written notifications (2) (WN) issued March 12, 2018 (2018_664602_0006);
- voluntary plan of correction (VPC) issued August 2017 (2017_589641_0027). [s. 131. (3)]

Additional Required Actions:

CO # - 901 was 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care specific to falls was provided to the resident #001.

On a specified date, resident #001, who is considered at high risk for falls, was found laying in a specified location. The resident was transferred to hospital where they were admitted with injury.

Resident #001 was admitted to the LTC home on a specified date. The resident was assessed as requiring several fall related interventions including assistance of staff.

Various staff were interviewed and confirmed that the plan of care indicated resident #001 required assistance of staff. None of those interviewed were able to explain why the resident did not have the assistance of staff when they fell.

Interventions outlined in the plan of care specific to fall risk were not provided to resident #001.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it was an isolated incident. The home had a level 3 history as they had a related previous non-compliance with this section of the LTCHA that included a voluntary plan of correction (VPC) issued April2016 (2016_270531_0014). [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Administrator works regularly in that position on site at the home as follows: in a home with a licensed bed capacity of more than 64 but fewer than 97, at least 24 hours per week.

The Caressant Care Marmora LTC home has a licensed capacity of 84 beds; therefore an Administrator is required to work regularly in that position on site at least 24 hours per week.

During a critical incident inspection, inspector #602 was alerted to the fact that the acting DOC/ED #100 was working as both the Administrator and the DOC, since a specified date.

In an interview, the acting DOC/ED #100 advised that they had been working as the acting DOC since a specified date and that the Regional Director had provided on site support as the Administrator one day (eight plus hours) a week; the Regional Director was also available for Administrator support by remote access. The acting DOC/ED #100 indicated that recruitment efforts have been successful and that a part time (three days/week) DOC will be in place on a specified date; as of another specified date, the new DOC will begin full time allowing the acting DOC/ ED #100 to resume full time Administrator duties. [s. 212. (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 the home's Administrator works regularly in that position on site at the home for the following amount of time per week: at least 24 hours per week, to be implemented voluntarily.

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 27th day of August, 2018

[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

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

Ministére 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) :	WENDY BROWN (602)
Inspection No. / No de l'inspection :	2018_664602_0014
Log No. / No de registre :	016520-18, 016575-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 13, Aug 21, 2018
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Marmora 58 Bursthall Street, P.O. Box 429, MARMORA, ON, K0K-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Brandt

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

Ministére 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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131 (3).
Specifically the licensee shall:
a) immediately cease the practice of personal support staff administering drugs except as outlined in O. Reg. 79/10, s. 131 (4) specific to administration of topicals and,
b) ensure all registered nursing staff attend re-instruction session(s) that review the College of Nurses of Ontario (CNO) practice standards specific to:
- "Medication" and,
- "Authorizing Mechanisms" – with focus on delegation, and,

c) Provide documentation indicating each registered nursing staff has:
- attended the re-instruction session and,
- indicated understanding of the practice standards specific to the the CNO "Medication" and "Authorizing Mechanisms" documents.

Grounds / Motifs :

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On three specified shifts Registered Nurse (RN) #108 was assisted by unregulated care providers (Personal Support Workers - PSW) to administer medications to a specified number of residents including resident #002. On a specified shift, PSW #117 gave resident #002 resident # 004's medication. The error was discovered by RN #108 who contacted the acting Director of Care (DOC)/Executive Director (ED) #100. The acting DOC/ED directed RN #108 to contact the physician who ordered resident #002 be transferred to hospital.

Resident #002 was subsequently admitted to hospital.

The licensee failed to ensure that no drug was administered to resident #002 unless it had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On a specified shift, RN #108 was assisted by an unregulated care provider, PSW #117 to administer medications to a specified number of residents. RN #108 requested that the PSW "run the medications", a process described as follows: "the RN pours the medication at the cart, in the hallway, and the PSW attends the resident' s room and/or bedside to give the resident the medication. The RN does not enter the room(s) to observe the resident taking the medication as part of the process". The medications provided were numerous and included oral tablets, narcotics, eye drops, inhaled medication and insulin.

On a specified shift, RN # 108 was assisted by PSW #116 to administer medications to a specified number of residents. The process was repeated with RN#108 pouring out the medications and the PSW entering the room to give the resident the required tablets, drops, inhaled medication and insulin.

On another specified shift, RN #108 was again assisted by PSW #117 who gave resident #002 resident #004's medication. Upon discovering the error, the RN contacted the acting DOC/ED #100 who directed that the physician be called immediately. The resident was transferred to hospital as per physician order, where they were admitted.

During the acting DOC/ED #100's post incident follow up, another PSW staff #107, advised that they had "run pills", for a different nurse; the PSW explained that this RN would ask that a PSW take a resident pills when they were in the small dining room or wanted a "when necessary" night medication. The acting DOC/ED #100 contacted the nurse; a summary of the discussion was provided as follows: the RN indicated that they had not asked PSWs to run pills in several years. The RN explained that, in the past, they asked for assistance with residents attending meals in the small dining room or when the nurse was getting behind in giving out pills. RN #106 advised that a previous Director of Care had said it was OK to have a runner. The RN was not aware of any other

registered nursing staff who had PSWs "run" pills for them.

The licensee failed to ensure that no person other than a physician, dentist, registered nurse or a registered practical nurse administered resident medications.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #002. The scope of the issue was a level 3 as it related to a specified number of residents requiring medications. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA. (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2018

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

Ministére 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with LTCHA s. 6 (7).

The licensee shall ensure that:
- while resident #001 is assessed as needing assistance of staff while ambulating with a four wheel walker or transferring; that this care is provided,
- nursing and personal support services staff review the contents of resident #001's, and all other resident's plans of care, assessed as at moderate to high risk for falls, to ensure that fall mitigation interventions identified in the plan of care are being provided,
- registered nursing staff monitor and communicate changes to the provision of fall mitigation interventions to direct care staff at the start of each shift; changes to be documented in the communication book for reference by staff.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care specific to falls was provided to the resident #001.

On a specified date, resident #001, who is considered at high risk for falls, was found laying in a specified location. The resident was transferred to hospital where they were admitted with injury.

Resident #001 was admitted to the LTC home on a specified date. The resident was assessed as requiring several fall related interventions including assistance of staff.

Various staff were interviewed and confirmed that the plan of care indicated resident #001 required assistance of staff. None of those interviewed were able to explain why the resident did not have the assistance of staff when they fell.

Interventions outlined in the plan of care specific to fall risk were not provided to resident #001.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it was an isolated incident. The home had a level 3 history as they had a related previous non-compliance with this section of the LTCHA that included a voluntary plan of correction (VPC) issued April 2016.
(602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 13th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : Wendy Brown

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