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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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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
Sep 11, 2018	2018_641665_0009	019844-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Castleview Wychwood Towers
351 Christie Street TORONTO ON M6G 3C3

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

JOY IERACI (665), ARIEL JONES (566), NATALIE MOLIN (652), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 2, 3, 8, 9, 10, 13, 14, 15, 17, 21, 22, 23, 24, 27, 28 and 29, 2018.

During the course of the inspection, Follow Up Log #007567-18 was inspected concurrently with this Resident Quality Inspection (RQI)

The following critical incident system reports (CIS) were inspected concurrently with this RQI:
Log #002116-18, CIS #M510-000005-18
Log #007379-18, CIS #M510-000011-18
Log #008580-18, CIS #M510-000018-18
All related to infection prevention and control.

The following complaints were inspected concurrently with this RQI:
Log #021802-17 related to prevention of abuse and neglect
Log #026704-17 related to plan of care and duty to protect
Log #004720-18 related to communication and response system

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator (AA), Director of Nursing (DON), Nurse Managers (NMs), Registered Dietitian (RD), Social Worker (SW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aide (HA), residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home including resident home areas, observed delivery of resident care and services, observed staff to resident interactions, observed infection prevention and control practices, observed medication administration, reviewed residents' health records, reviewed meeting minutes, training records, relevant home policies and procedures and other pertinent documents and conducted resident and family interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **3 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	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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

The licensee failed to comply with compliance order #001 from inspection #2018_420643_0004 served on April 11, 2018, with a compliance date of May 28, 2018.

The licensee was ordered to:

1. Ensure that for resident #001 and all other residents who require assistance with transferring with a mechanical lift; staff use safe transferring techniques to assist the resident.

2. Develop an auditing system in the home to ensure staff are assisting residents with transferring using safe techniques according to the home's written policies.

3. Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

The licensee completed steps two and three. The licensee failed to complete step one regarding ensuring staff use safe transferring techniques to assist resident #001 who required assistance with transferring with a mechanical lift.

Record review of the home's minimum data set (MDS) assessment on a specified date in 2018, specified resident #001's balance ability and required assistance for transfers and toileting.

Record review of the resident's written plan of care indicated the same information and that the resident was to be transferred using an identified mechanical lift with a specified type of sling and did not indicate the sling size. A review of the home's staff assignment sheet listed the resident as requiring a specified sling size during transfers.

On an identified date in August 2018, Inspector #665 observed resident #001 being transferred from the wheelchair back to bed, as indicated in the resident's written care plan, by personal support workers (PSWs) #113 and #114. The resident was transferred from the wheelchair using the identified mechanical lift; however, the resident was placed on the specified type of sling, but the size of the sling used was not as indicated on the assignment sheet.

During an interview, PSW #113 confirmed that they were the primary caregiver, and was aware that resident #001 used an identified sling size. The PSW acknowledged that they did not check the size of the sling before transferring the resident from bed to wheelchair in the morning; and, again from wheelchair back to bed. The PSW indicated the correct

sling size was to be used to ensure safety of the resident.

During an interview, nurse manager (NM) #107 confirmed that PSWs are to check the size of the sling to be used for residents as per the plan of care prior to transferring the resident. The NM acknowledged that the incorrect sling size was used to transfer resident #001 and PSW #113 used unsafe transferring devices and techniques while assisting resident #001.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that the following rights of residents were fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Resident #004 was triggered from stage one of the resident quality inspection (RQI) for

staff to resident abuse through resident interview.

During stage one of the RQI, interview with resident #004 on an identified date in August 2018, indicated that they were yelled at by a PSW during provision of care eight days ago.

A review of the home's staffing schedule and the resident's identified care schedule indicated that PSW #111, worked on an identified date in August 2018, and provided care to the resident.

During another interview with the resident, the resident confirmed that PSW #111 was providing care on the identified date. The resident indicated that the PSW screamed at them when they requested the PSW to perform an identified task during the care. When the resident was asked how the incident made them feel, the resident stated that they felt very sad and nervous.

During an interview, PSW #111 indicated they provided care to the resident on the identified date in August 2018, but denied yelling and screaming at the resident.

A review of the home's investigation notes indicated that PSW #111 stated they raised their voice at resident #004, during the provision of care.

During an interview, NM #125 confirmed PSW #111 is loud with everyone, including residents and they have spoken to the PSW previously to speak with a soft voice to residents.

During an interview, the Administrator, also indicated that PSW #111 speaks in a loud tone and the home expects staff to speak in a calm voice with residents. The home failed to ensure that resident #004 was treated with courtesy and respect by PSW #111.

2. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: every resident has the right to designate a person to receive information concerning any transfer of the resident and to have that person receive that information immediately.

During the RQI, resident #006 was triggered for no notice of transfer.

During an interview, resident #006's substitute decision-maker (SDM) indicated that the

resident was moved to another room, and that they were not notified and had no idea what the reason was for the room transfer.

A record review for resident #006 indicated that the resident was transferred into a different room on an identified date in June 2016. The resident's progress notes indicated resident #006's family visited the home six days after the transfer, could not locate the resident, and were surprised to find out from staff that the resident's room had been changed.

An interview with registered practical nurse (RPN) #129 indicated that the resident's room was changed due to an identified reason.

In interviews, RPN #129, NM #127, social worker (SW) #128, and the Administrator indicated that when residents are transferred internally, it is the home's process to notify SDMs and obtain consent prior to the transfer. NM #127 and the Administrator confirmed that there was no evidence that the SDM had been notified prior to resident #006's room transfer on the identified date in June 2016, and that the resident's right to have their designate receive information immediately concerning any transfer was not respected.

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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and that every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

Resident #003 was triggered in stage one as a result of observations of unclean ambulation equipment.

Resident #003's wheelchair was observed to be unclean on three identified dates in August 2018. Observations conducted indicated one of the wheelchair wheels and one side of the wheelchair frame to have a moderate amount of brown coloured debris.

On an identified date in August 2018, PSW #102 and RN #103, observed resident #003's wheelchair with the inspector. When asked if the wheelchair was clean, both staff indicated the wheelchair was dirty.

A record review of the wheelchair cleaning schedule binder indicated residents' mobility aids are cleaned every six weeks. The schedule indicated that resident #003's wheelchair was cleaned on an identified date in July 2018.

In interviews, PSWs #100 and #102, RPN #101 and RN #103 indicated the home has a cleaning schedule for residents' mobility aids which is done by the heavy duty housekeeping staff on the night shift. They all indicated that if mobility aids are dirty in between the scheduled cleaning, it is the home's expectation that unit staff cleans the equipment. RN #103 indicated it is important for wheelchairs to be kept clean as residents have the right to sit in a clean wheelchair.

The sample was expanded to resident #008 as a result of the unclean wheelchair of

resident #003.

Observations conducted on an identified date in August 2018, at 1050 hours (hrs) indicated that resident #008's wheelchair had a moderate amount of spillage debris and white debris around the seat of the wheelchair.

The physiotherapist (PT) #108 and PSWs #105 and #106, observed resident #008's wheelchair with the inspector on the same day as the observation above and indicated the resident's wheelchair was not clean.

In interviews, PSWs #105 and #106 and RPN #107 indicated there is a schedule for wheelchairs to be cleaned by the heavy duty housekeeping staff on the night shift. They indicated that it is expected for staff to clean the wheelchairs if they are dirty in between the cleaning schedule. They also indicated that if a resident spills anything on their wheelchair, the staff are to clean the spill right away.

A review of the wheelchair cleaning schedule indicated that resident #008's wheelchair was cleaned on an identified date in June 2018, and was scheduled to be cleaned on an identified date in August 2018.

In an interview, NM #107, indicated the home has a six week cycle for cleaning of residents' mobility aids. The cleaning is done by the heavy duty housekeeper on the night shift. The NM stated it is expected for wheelchairs to be cleaned by the unit staff in between the cleaning schedule, or if required, arrangements are made for housekeeping to deep clean the equipment. The NM indicated since the wheelchairs of residents #003 and #008 were observed to be unclean, staff did not ensure that the personal items of the residents were cleaned when required.

Issued on this 25th day of September, 2018

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) :	JOY IERACI (665), ARIEL JONES (566), NATALIE MOLIN (652), VERON ASH (535)
Inspection No. / No de l'inspection :	2018_641665_0009
Log No. / No de registre :	019844-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 11, 2018
Licensee / Titulaire de permis :	City of Toronto 55 John Street, Metro Hall, 11th Floor, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	Castleview Wychwood Towers 351 Christie Street, TORONTO, ON, M6G-3C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nelson Ribeiro

To City of Toronto, 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_420643_0004, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.36.

Specifically, the licensee must:

1) Ensure that for resident #001 and all other residents who require assistance with transferring with a mechanical lift; staff use safe transferring techniques to assist the resident.

2) Ensure PSW #113 receives re-education on safe transferring and positioning techniques and on the use of the proper sling based on the assessment of resident #001 and other residents. The home is required to maintain a documentation record of the education, including the dates education was provided, who provided the education and the content of the education session (s).

3) Develop an on-going auditing process to ensure PSW #113 or other PSWs uses safe transferring and positioning techniques with resident #001 and other residents. The home is required to maintain records of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

The licensee failed to comply with compliance order #001 from inspection #2018_420643_0004 served on April 11, 2018, with a compliance date of May 28, 2018. The licensee was ordered to:

1. Ensure that for resident #001 and all other residents who require assistance with transferring with a mechanical lift; staff use safe transferring techniques to assist the resident.

2. Develop an auditing system in the home to ensure staff are assisting residents with transferring using safe techniques according to the home's written policies.

3. Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

The licensee completed steps two and three. The licensee failed to complete step one regarding ensuring staff use safe transferring techniques to assist resident #001 who required assistance with transferring with a mechanical lift.

Record review of the home's minimum data set (MDS) assessment on a specified date in 2018, specified resident #001's balance ability and required assistance for transfers and toileting.

Record review of the resident's written plan of care indicated the same information and that the resident was to be transferred using an identified mechanical lift with a specified type of sling and did not indicate the sling size. A review of the home's staff assignment sheet listed the resident as requiring a specified sling size during transfers.

On an identified date in August 2018, Inspector #665 observed resident #001 being transferred from the wheelchair back to bed, as indicated in the resident's written care plan, by personal support workers (PSWs) #113 and #114. The resident was transferred from the wheelchair using the identified mechanical lift; however, the resident was placed on the specified type of sling, but the size of

the sling used was not as indicated on the assignment sheet.

During an interview, PSW #113 confirmed that they were the primary caregiver, and was aware that resident #001 used an identified sling size. The PSW acknowledged that they did not check the size of the sling before transferring the resident from bed to wheelchair in the morning; and, again from wheelchair back to bed. The PSW indicated the correct sling size was to be used to ensure safety of the resident.

During an interview, nurse manager (NM) #107 confirmed that PSWs are to check the size of the sling to be used for residents as per the plan of care prior to transferring the resident. The NM acknowledged that the incorrect sling size was used to transfer resident #001 and PSW #113 used unsafe transferring devices and techniques while assisting resident #001.

The severity of this issue was determined to be a level two as there was a risk or potential for actual harm to resident #001. The scope of the issue was a level one as it was isolated to resident #001 who were reviewed. The home had a level four history, as they had on-going non-compliance with this section of the Long Term Care Homes Act (LTCHA) that included:
1) 2018_420643_0004 CIS - Compliance Order #001
2) 2017_635600_0008 CIS - Compliance Order #001
(535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 07, 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 11th day of September, 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 : Joy Ieraci

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