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

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

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
Oct 25, 2021	2021_872218_0016 (A1)	009863-21, 009888-21	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Columbia Forest
650 Mountain Maple Avenue Waterloo ON N2V 2P7

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

Amended by APRIL RACPAN (218) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Rescinded CO #001 related to O. Reg 79/10 s.9 and revoked associated NC finding. Please refer to Inspection #2021_872218_0021 for update of CO #001.

Issued on this 25th day of October, 2021 (A1)

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*

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Columbia Forest
650 Mountain Maple Avenue Waterloo ON N2V 2P7

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

Amended by APRIL RACPAN (218) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 31, September 1, 7-10, 2021

The following intakes were completed in this inspection:

-Log #009863-21/Critical Incident System (CIS) Report and a Complaint/Log #009888-21 related to an elopement incident.

CI Inspection #2021_872218_0017 was completed concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Infection Prevention and Control (IPAC) Lead, the Environmental Services Manager, the Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeeping staff, Behavioural Supports of Ontario (BSO) staff, Surveillance Screeners, and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors conducted a tour of the resident home areas (RHAs), observed IPAC practices, resident care provision, resident/staff interactions, and completed resident and staff interviews. The inspectors also reviewed clinical health records, posting of required information, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Responsive Behaviours
Safe and Secure Home

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

4 WN(s)
3 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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policies related to wandering and elopement were complied with.

Ontario Regulations 79/10 s. 9 (2) states that a written policy is required that deals with the security of doors and access to those areas by residents.
The Long-Term Care Homes Act (LTCHA), s.5 requires every licensee to ensure that the home is a safe and secure environment for its residents.

The home's policies titled "LTC - Door Alarms", "LTC – Wandering and Elopement" and "Code Yellow" provided guidance to ensure the safety and security of doors and residents with wandering, exit-seeking, and elopement behaviours. They required the following:

- a process to identify and communicate the residents at risk for wandering, exit-seeking and elopement, by placing their names on the "High-Risk identification form"
- all occurrences of elopement will be investigated and following every missing resident event, the home's leadership team will undergo a review of the incident to determine the root cause of the situation

Three residents were considered at risk for wandering, exit-seeking and elopement. They all experienced elopement episodes over a four month period. One of the residents sustained an injury when they eloped from the home.

The home had not implemented a process for identifying and communicating residents at risk for elopement until after the above incidents occurred. Prior to the incidents, the home implemented a binder titled "Only these residents may leave

the building", and it included pictures of residents that were not permitted to leave the building because they were at risk for elopement. The binder did not include the three residents' pictures until after they experienced elopement episodes. A RN said they were not familiar with the home's policies, specifically with the use of a "high-risk identification form".

Two registered staff members were responsible for following up on one of the incidents that resulted in an injury to one of the residents, but had not interviewed the designated screener who was responsible for door surveillance that day. An investigation was not completed to determine the root cause of the incident and how the resident was able to exit the building.

By not complying with the home's polices related to wandering and elopement, residents were placed at risk of harm.

Sources: LTC – Door Alarms (Policy CARE10.O010.07 last reviewed March 31, 2019), LTC – Wandering and Elopement (Policy CARE-O10.02) last reviewed March 31, 2021, Code Yellow (EMP2-O20.06) last reviewed March 31, 2021, resident identification binder, progress notes, staff interviews with DOC #101, and others. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policies related to wandering and elopement are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plans of care for resident #001, #002, and #003, were based on, at a minimum, an interdisciplinary assessment with respect to their specific behavioural patterns.

The home had a policy that required residents to be screened upon admission to determine their risk with specific behavioural patterns. Some of the criteria for identifying a resident to be of risk was if they had a diagnoses of Demenita and if they had a history of these behaviours. An individualized plan of care for managing the resident's behaviour risk was required to be developed by the Interdisciplinary team.

A) Resident #001 had a diagnosis of Dementia upon their admission to the home. Their admission papers included information that identified them to have a specified behaviour. An individualized plan of care related to the specified behaviour was not developed when they were admitted to the home. Multiple staff members did not know that resident #001 had these specific behaviours when they were admitted to the home.

In June 2021, resident #001 sustained an injury related to a specified behaviour. An assessment was completed by the interdisciplinary team and the resident's plan of care was reviewed and updated after this incident occurred.

B) Resident #002 had a diagnosis of Dementia upon their admission to the home and was considered to have a history of specific behavioural patterns. In July 2021, resident #002 had a behavioural episode. An interdisciplinary assessment was not completed for the resident until after this incident. Following the initial incident, resident #002 had four additional documented episodes of the same behavioural pattern. Their plan of care did not specify that resident #002 experienced this pattern of behaviours.

C) Resident #003 had a diagnosis of Dementia upon their admission to the home. Their admission assessment records documented that they had a specified behaviour. An individualized plan of care was not developed by the interdisciplinary team for resident #003 when they were admitted to the home. Resident #003 experienced a total of 15 behavioural episodes over a six month period. A behavioural assessment tool was completed following one of these incidents, and resident #003 remained at risk and continued to exhibit this same behavioural pattern. Their plan of care did not include a focus of the resident's specified behaviour or any interventions related to their risk.

Failure to ensure that the residents' plans of care were, at a minimum, based on an interdisciplinary assessment with respect to their specific behaviours, placed them at risk for experiencing additional behavioural incidents.

Sources: resident observations, LTC (Policy CARE-O10.02) last reviewed March 31, 2021, behavioural assessment tools for resident #001 and #003, progress notes, residents' electronic health and admission records, plans of care for resident #001, #002, and #003, interviews with management and other staff. [s. 26. (3) 5.]

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 plans of care for residents #001, #002, and #003 are based on, at a minimum, an interdisciplinary assessment with respect to their specific behavioural patterns, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the home's hand hygiene program.

Public Health Ontario (PHO) Best Practice Guidelines and the home's policies and procedures for hand hygiene practices emphasized that hand hygiene indications were required before preparing, handling, or serving food to a resident. The home's expectations required that all staff remind, encourage and assist residents with hand hygiene practices during meals and snack services.

During the course of the inspection the following was observed:

- during a lunch meal service on Eby House RHA, multiple residents were not reminded, encouraged, or provided with assistance to perform hand hygiene after they had finished eating.
- during a snack service on Schneider House RHA, PSW #105 provided snacks and beverages to multiple residents and they did not remind, encourage, or provide residents with assistance on performing hand hygiene before eating their snack or drinking their beverages.

Not following best practices for hand hygiene placed the staff and residents at risk for disease transmission.

Sources: multiple observations, PHO: Just Clean Your Hands Long Term Care Home Implementation Guide, PHO Best Practices for Hand Hygiene in All Health Care Settings (April 2014), the home's hand hygiene policy, interviews with multiple staff and the IPAC Lead. [s. 229. (4)]

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 staff participate in the implementation of the home's hand hygiene program, to be implemented voluntarily.

(A1)
The following Non-Compliance has been Revoked / La non-conformité suivante a été révoquée: WN #1

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Issued on this 25th day of October, 2021 (A1)

[redacted]

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 APRIL RACPAN (218) - (A1)
Inspection No. / No de l'inspection :	2021_872218_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009863-21, 009888-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 25, 2021(A1)
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Columbia Forest 650 Mountain Maple Avenue, Waterloo, ON, N2V-2P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lilibeth Medina

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 AXR Operating (National) LP, by its general partners, 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)
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 :

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

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 25th day of October, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by APRIL RACPAN (218) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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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 : Central West Service Area Office