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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie 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
Sep 15, 2021	2021_828744_0016	005679-21, 006075-21, 007188-21, 007686-21, 009117-21, 010299-21, 011202-21, 011608-21	Complaint

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

STEVEN NACCARATO (744), CHAD CAMPS (609), RYAN GOODMURPHY (638)

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): July 19-23, 26-30, 2021.

The following intakes were inspected on during this Complaint inspection:

- One intake was related to staffing shortages;
- One intake was related to staffing shortages and diet concerns of residents;
- One intake was related to skin and wound care of a resident;
- One intake was related to nutrition concerns of a resident;
- One intake was related to care concerns for a resident;
- One intake was related to Infection Prevention and Control (IPAC) practices; and
- Two intakes were related to medication administration concerns for a resident.

Critical Incident System Inspection #2021_828744_0015 and Follow Up Inspection #2021_828744_0017 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Staff Educators, Environmental Services Manager, Housekeeping Supervisor, Infection Prevention and Control (IPAC) Lead, Food Services Manager, Dietitian, Behavioural Supports Ontario (BSO) staff, Life Enrichment Coordinator, Restorative Care Coordinator, Restorative Care Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, Activity Aides, Dietary Aides, Companion workers and residents.

The Inspector(s) also conducted a daily tour of the home, reviewed relevant resident records, internal investigations, policies and procedures of the home and observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of this 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 #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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was administered a medication in

accordance with the directions for use specified by the prescriber.

A RN administered a medication to a resident after failing to check if the timing of the medication was correct. The medication order had specific directions on when and under which circumstances the medication was to be administered.

The home's failure to ensure that the resident was administered the medication in accordance with the directions for use specified by the prescriber, presented minimal risk to the resident.

Sources: Complaint intake; Medication Incident report; Physician Medication review for the resident; The home's policy titled Resident Rights, Care and Services – Medication Management – Administration of Medications including PRN Medications, revised June 30, 2020; Electronic Medication Administration Record (eMAR) for the resident; Interviews with the Substitute Decision Maker (SDM) of the resident, an RN and the DOC. [s. 131. (2)]

2. The licensee has failed to ensure that two residents received their medication in accordance with the directions for use specified by the prescriber after readmission from the hospital.

a) One resident returned from the hospital and required multiple medication changes, which included new medication orders as well as the discontinuation of previously prescribed medications. These required medication changes prescribed from the hospital, were not processed by the home until four days after the resident had returned from hospital.

b) Another resident returned from hospital and required a new medication order. This order was not processed by the home until five days after the resident had returned from hospital. Registered staff did not ensure that the re-admission, medication reconciliation and order processing procedures were followed. Registered staff were required to have completed the nursing re-admission checklist and were to follow-up on any outstanding items on the checklist.

There was actual risk to the residents, as their new medication orders were not provided as specified by the prescriber for multiple days after their return from hospital. There was no harm identified.

Sources: Complaint intake; Medication incident reports; The two resident's medical records including: progress notes, eMAR, hospital discharge papers and physician's orders; The home's policy titled "Operation of Homes – Admission of Residents – Admission and Readmission Checklist", effective date September 16, 2013; The home's investigation notes; and interviews with the Staff Educator and other staff. [s. 131. (2)]

3. The licensee has failed to ensure that a resident received their medication in accordance with the directions for use specified by the prescriber.

a) A resident was not administered their scheduled evening medications. The resident's electronic medication administration record (eMAR) was signed by an RPN to indicate the medications were given. On the following shift, another RPN found the resident's evening medications that had not been administered.

b) In a separate incident, the same resident was administered a different medication as opposed to the medication that was required at the time.

There was actual risk to the resident, as their medications were not provided as specified by the prescriber. There was no harm identified.

Sources: Complaint intake; Medication incident reports; The resident's medical records including: progress notes, eMAR, and physician's orders; and interviews with an RPN and other staff. [s. 131. (2)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident’s plan of care set out clear directions to staff and others who provide direct care to the resident.

A resident's care plan outlined that the resident required specific care; however, the resident's Electronic Medication Administration Record (eMAR) and another area of the resident's plan of care, each provided staff differing direction on how to perform that care.

Direct care staff identified that they referred to the residents’ care plan and Kardex for specific details regarding resident care and that registered staff would update the plan whenever the care needs changed. The Inspector reviewed the three different directives in the resident’s plan of care with the DOC who acknowledged that it did not provide clear direction to staff. There was a risk to the resident due to staff not having clear direction on how to care for the resident based on their needs and preferences.

Sources: The resident’s care plan, Kardex and eMAR; Inspector’s observations; Interviews with the DOC and other staff. [s. 6. (1) (c)]

2. The licensee shall ensure that a resident’s plan of care was reviewed and revised when their care needs changed.

Three separate incidences had occurred in which the resident displayed a specific unsafe behaviour. The resident’s plan of care did not outline that the resident had displayed this behaviour, nor was there any intervention outlined to manage the safety risk.

Sources: The resident’s care plan, progress notes; BSO binder; Interviews with BSO, the DOC and other staff. [s. 6. (10) (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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was able to easily access and use the resident-staff communication and response system.

On four separate occasions, a resident was observed not being able to easily access and use the resident-staff communication and response system. The resident's plan of care required them to use the system to alert staff for assistance. When the Inspector approached the resident, they stated they required assistance..

The resident was at risk of harm for not being able to call for assistance when they required assistance, given the resident-staff communication and response system was not within their reach.

Sources: Inspector observations; The resident's Care Plan; Assessment of Continence; Interviews with the resident, DOC and other staff. [s. 17. (1) (a)]

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 is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents identified as lactose intolerant had their planned menu items, offered and available at each meal and snack.

A lactose intolerant resident was supplied a food item containing lactose. Staff confirmed that the home had no supply of the lactose free food item that was on the planned menu for the resident. The Dietitian verified that all residents regardless of the severity of their lactose intolerance should have had lactose free yogurt available to them.

There was minimal risk to the resident for being provided the food item containing lactose.

Sources: Complaint intake; Inspector observations; The home's policy titled "Resident Rights, Care and Services – Nutrition Care and Hydration Programs – Food Supplies" last revised March 24, 2021; The home's Master Diet List; Interviews with a PSW, a Dietary Aide (DA), a RPN, the Food Service Manager (FSM) and Dietitian. [s. 71. (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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

Issued on this 21st day of September, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEVEN NACCARATO (744), CHAD CAMPS (609), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2021_828744_0016
Log No. / No de registre :	005679-21, 006075-21, 007188-21, 007686-21, 009117-21, 010299-21, 011202-21, 011608-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 15, 2021
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Katie Ede

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 Valley East Long Term Care Centre Inc., 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 131 (2).

Specifically, the licensee shall:

a) Ensure that drugs are administered to identified residents in accordance with the directions for use as specified by the prescriber; and

b) Ensure that drugs are administered to residents who are returning from hospital, with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was administered a medication in accordance with the directions for use specified by the prescriber.

A RN administered a medication to a resident after failing to check if the timing of the medication was correct. The medication order had specific directions on when and under which circumstances the medication was to be administered.

The home's failure to ensure that the resident was administered the medication in accordance with the directions for use specified by the prescriber, presented minimal risk to the resident.

Sources: Complaint intake; Medication Incident report; Physician Medication review for the resident; The home's policy titled Resident Rights, Care and Services – Medication Management – Administration of Medications including PRN Medications, revised June 30, 2020; Electronic Medication Administration Record (eMAR) for the resident; Interviews with the Substitute Decision Maker

(SDM) of the resident, an RN and the DOC. [s. 131. (2)]
(609)

2. The licensee has failed to ensure that two residents received their medication in accordance with the directions for use specified by the prescriber after readmission from the hospital.

a) One resident returned from the hospital and required multiple medication changes, which included new medication orders as well as the discontinuation of previously prescribed medications. These required medication changes prescribed from the hospital, were not processed by the home until four days after the resident had returned from hospital.

b) Another resident returned from hospital and required a new medication order. This order was not processed by the home until five days after the resident had returned from hospital. Registered staff did not ensure that the re-admission, medication reconciliation and order processing procedures were followed. Registered staff were required to have completed the nursing re-admission checklist and were to follow-up on any outstanding items on the checklist.

There was actual risk to the residents, as their new medication orders were not provided as specified by the prescriber for multiple days after their return from hospital. There was no harm identified.

Sources: Complaint intake; Medication incident reports; The two resident's medical records including: progress notes, eMAR, hospital discharge papers and physician's orders; The home's policy titled "Operation of Homes – Admission of Residents – Admission and Readmission Checklist", effective date September 16, 2013; The home's investigation notes; and interviews with the Staff Educator and other staff. [s. 131. (2)]
(744)

3. The licensee has failed to ensure that a resident received their medication in accordance with the directions for use specified by the prescriber.

a) A resident was not administered their scheduled evening medications. The resident's electronic medication administration record (eMAR) was signed by an

RPN to indicate the medications were given. On the following shift, another RPN found the resident's evening medications that had not been administered.

b) In a separate incident, the same resident was administered a different medication as opposed to the medication that was required at the time.

There was actual risk to the resident, as their medications were not provided as specified by the prescriber. There was no harm identified.

Sources: Complaint intake; Medication incident reports; The resident's medical records including: progress notes, eMAR, and physician's orders; and interviews with an RPN and other staff. [s. 131. (2)]

An order was made by taking the following factors into account:

Severity: Actual risk was identified related to the staff not administering resident #010 and #012's medications as per the directions specified by the prescriber.

Scope: The scope of this non-compliance was a pattern, as it affected four out of nine residents reviewed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with Ontario Regulation 79/10 s. 131 (2), and two Voluntary Plan of Correction (VPCs) were issued to the home.
(744)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2021

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:

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

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 15th day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Steven Naccarato

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