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

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 9, 2021	2021_823653_0022	012350-21	Complaint

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street Walkerton ON N0G 2V0

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

Gateway Haven Long Term Care Home
671 Frank Street P.O. Box 10 Wiarton ON N0H 2T0

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

ROMELA VILLASPIR (653)

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 25-27, 30-31, 2021.

The following intake was completed in this complaint inspection:
Log #012350-21 was related to an allegation of neglect, management of responsive behaviours, hospitalization, and the home's complaint procedures.

During the course of the inspection, the inspector(s) spoke with the Resident Support Assistants (RSAs), Housekeeper (HK), Screener, Personal Support Workers (PSWs), Agency PSWs, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Recreation and Leisure Aides (RLA), Recreation and Leisure Manager (RLM), Behavioural Support Ontario (BSO) RPN, Attending Physician (AP), Former Social Worker (FSW), Former Administrator, Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, reviewed clinical health records, staffing schedules, the home's air temperature records, complaint records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for a resident who was demonstrating responsive behaviours, actions were taken to respond to their needs, including reassessments and documentation of their responses to interventions.

A resident was admitted to the home with dementia, and they demonstrated responsive behaviours towards staff and co-residents. The resident had behavioural triggers, and their written plan of care identified some interventions under behavioural support.

The Director of Care (DOC) and the Former Social Worker (FSW) also stated that the home requested the resident's family members to limit their visits, so that the staff could observe the resident in the home's environment and identify interventions to manage the responsive behaviours.

The Attending Physician (AP) and the external Behavioural Support Ontario (BSO) team closely monitored and adjusted the resident's medications, for behavioural management.

Clinical health records showed multiple incidents of responsive behaviours by the resident, towards staff, co-residents, and visitors, on twelve different dates within a three-month period.

The staff stated that the interventions and activities that required the resident to stay in one place were not always effective, and staff were unable to monitor them at all times. With regards to care, the only strategy the staff used did not always work. The registered staff also indicated there was limitation in utilizing the available as needed medication for

the resident because they could only give it at certain times throughout the day.

Based on record reviews and staff interviews, there was not enough evidence to substantiate that the strategies and interventions to manage the resident's responsive behaviours were being re-assessed, and that there was documentation of the resident's responses to interventions. The interdisciplinary team were unable to strategize on additional interventions, due to not re-evaluating the effectiveness of the interventions that were already in place. The incidents of responsive behaviours towards staff and co-residents persisted within a three-month period.

Sources: The resident and co-residents' clinical health records; Interviews with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), FSW, Resident Support Assistant (RSA), Recreation and Leisure Aides (RLAs), BSO RPN, DOC, and the Administrator. [s. 53. (4) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was protected from abuse.

An incident occurred between two residents which resulted in a physical injury to one resident.

Sources: Residents' clinical records; Interview with the DOC. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that an incident of abuse was immediately reported to the Ministry of Long-Term Care (MLTC).

Pursuant to s. 152 (2), the licensee is vicariously liable for staff who fail to immediately report resident abuse.

A registered staff did not report an incident of resident abuse to the MLTC immediately. By not reporting the incident to the Director immediately, a follow-up to the incident was delayed.

Sources: Residents' clinical records; Interview with the DOC. [s. 24. (1) 2.]

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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, and one resident common area on every floor of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the home's records from August 19, 2021, inclusive to August 30, 2021, showed that air temperatures were not always measured nor recorded at the required specified times, in at least two resident bedrooms in different parts of the home, and one resident common area on every floor of the home.

By not measuring and documenting air temperatures of the home as required, staff may not be able to ascertain and address temperature concerns, which could put residents at risk for developing a heat-related illness.

Sources: Review of the home's air temperature records; Interviews with a Housekeeper (HK), and the DOC. [s. 21. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1.The licensee failed to ensure that a response was made to a resident's family members who made a verbal complaint, indicating that their complaint was unfounded and the reasons for the belief.

A complaint was received by the MLTC related to the home not providing a resident's family members with the outcome of their internal investigation regarding a verbal complaint.

A resident's family members made a verbal complaint to the Administrator and former Administrator of the home. One of the concerns was related to care not provided to the resident. The home's complaint records showed that the initial action taken by the home was changing the staffing assignment, and it remained in place until the full review of the complaint was completed.

The DOC, and the Administrator stated that based on their investigation, the complaint was unfounded as the staff attempted to provide the care to the resident multiple times, and were eventually successful in providing the care. However, the DOC and the Administrator could not demonstrate that this information was shared with the family.

Sources: The home's complaint records, resident's progress notes; Interviews with the DOC, Administrator, and former Administrator. [s. 101. (1) 3. ii.]

WN #6: 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 the staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

A) A review of the home's "Additional Precautions" policy, indicated that the nurse will initiate the appropriate Additional Precautions at the onset of symptoms and maintain precautions until laboratory results are available to confirm or rule out diagnosis.

Fully stocked Personal Protective Equipment (PPE) caddies were outside of two resident rooms, however, there were no additional precautions signage posted on these doors.

The registered staff indicated that the residents in these rooms were placed on isolation due to a recent contact with a COVID-19 positive individual, and both residents were tested pending lab results.

B) A resident room was on additional precautions, and an unlabelled N-95 mask was placed on the hook of their door.

The registered staff was unaware who the N-95 mask belonged to and if it was used or not, but indicated that it should not be hooked on the door, and that staff were supposed to discard masks after use.

C) A review of the home's "Personal Protective Equipment" policy, stated that the Infection Control Practitioner will ensure that there is sufficient supply of PPE available at all times.

Two resident rooms were on additional precautions, and the PPE caddies did not have the required PPE in them.

There was a potential risk for transmission of infection due to the absence of the additional precautions signage on the resident's doors, improper storage/ disposal of N-95 mask, and not having the required PPE available in the caddies outside of resident rooms that were on additional precautions.

Sources: The home's policies; Inspector #653's observations on August 31, 2021; Interviews with the registered staff, and the DOC. [s. 229. (4)]

Issued on this 10th 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) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2021_823653_0022
Log No. / No de registre :	012350-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 9, 2021
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, Walkerton, ON, N0G-2V0
LTC Home / Foyer de SLD :	Gateway Haven Long Term Care Home 671 Frank Street, P.O. Box 10, Wiarton, ON, N0H-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracee Givens

To Corporation of the County of Bruce, 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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

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

The licensee must be compliant with s. 53 (4) of the Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

1. Arrange an interdisciplinary team meeting including but not limited to the full-time Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the Recreation and Leisure Aide (RLA), primarily assigned to the resident's care, Behavioural Support Ontario (BSO) RPN, and the Director of Care (DOC):

A) To re-assess and identify the resident's behavioural triggers where possible.

B) To evaluate the effectiveness of current interventions and to develop new interventions to manage the resident's behaviours. This evaluation must be documented, and changes to the interventions will be documented in the plan of care.

2. Review the resident's updated plan of care related to responsive behaviours with their primary PSWs, RPNs, and RNs.

3. Develop and implement a system to ensure that the resident's responses to the interventions are documented, and when these interventions are not effective, new approaches are considered to manage the resident's responsive behaviours.

4. A record is required to be kept by the licensee for all actions undertaken in items #1 to #3. The record shall be made available to the inspector upon request.

Grounds / Motifs :

1. The licensee failed to ensure that for a resident who was demonstrating responsive behaviours, actions were taken to respond to their needs, including reassessments and documentation of their responses to interventions.

A resident was admitted to the home with dementia, and they demonstrated responsive behaviours towards staff and co-residents. The resident had

behavioural triggers, and their written plan of care identified some interventions under behavioural support.

The Director of Care (DOC) and the Former Social Worker (FSW) also stated that the home requested the resident's family members to limit their visits, so that the staff could observe the resident in the home's environment and identify interventions to manage the responsive behaviours.

The Attending Physician (AP) and the external Behavioural Support Ontario (BSO) team closely monitored and adjusted the resident's medications, for behavioural management.

Clinical health records showed multiple incidents of responsive behaviours by the resident, towards staff, co-residents, and visitors, on twelve different dates within a three-month period.

The staff stated that the interventions and activities that required the resident to stay in one place were not always effective, and staff were unable to monitor them at all times. With regards to care, the only strategy the staff used did not always work. The registered staff also indicated there was limitation in utilizing the available as needed medication for the resident because they could only give it at certain times throughout the day.

Based on record reviews and staff interviews, there was not enough evidence to substantiate that the strategies and interventions to manage the resident's responsive behaviours were being re-assessed, and that there was documentation of the resident's responses to interventions. The interdisciplinary team were unable to strategize on additional interventions, due to not re-evaluating the effectiveness of the interventions that were already in place. The incidents of responsive behaviours towards staff and co-residents persisted within a three-month period.

Sources: The resident and co-residents' clinical health records; Interviews with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), FSW, Resident Support Assistant (RSA), Recreation and Leisure Aides (RLAs), BSO RPN, DOC, and the Administrator.

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

Severity: There was actual risk of harm because the incidents of the resident exhibiting responsive behaviours towards staff and co-residents persisted due to the lack of re-assessment, new interventions, and documentation of the resident's responses to interventions.

Scope: The scope of this non-compliance was isolated to one of three residents reviewed during this inspection.

Compliance History: In the last 36 months, multiple Written Notifications (WNs) and Voluntary Plan of Corrections (VPCs) were issued to the home related to different sub-sections of the legislation. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 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 9th day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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