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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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
May 29, 2018	2018_742527_0007	008931-17, 021666-17, 024789-17, 001362-18, 003105-18, 004727-18, 007003-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

KATHLEEN MILLAR (527), AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 18, 19, 20, 23, 24, 26, 27, 30, May 1, 2, and 3, 2018.

The following Critical Incident Inspections were conducted:

Log #008931-17, CIS #2887-0000017, related to a fall;
Log #021666-17, CIS #2887-000028-17, related to a fall;
Log #024789-17, CIS #2887-000034-17, related to missing narcotics;
Log #001362-18, CIS #2887-000006-18, related to an alleged abuse;
Log #004727-18, CIS #2887-000009-18, related to an alleged abuse; and
Log #007003-18, CIS #2887-0000013-18, related to an alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Director of Care, the Scheduling Coordinator, the RAI Coordinator, the Environmental Director, the Food Service Director, the Physiotherapist (PT), the Physiotherapy Assistants (PTA), the registered nurses (RNs), the registered practical nurses (RPNs) and the Personal Support Workers (PSWs).

During the course of the inspection, the LTCH Inspector(s) toured the home, reviewed clinical records, interviewed staff, residents and families, reviewed policies and procedures, reviewed training records and observed the provision of resident care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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	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 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 protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Resident #002 received care from PSW #116 in March 2018. PSW #116 had a PSW student assist with the resident's care. The resident became agitated and hit PSW #116 on the hand. PSW #116 reacted by injuring the resident, as witnessed by the PSW student. The resident required additional care as a result of their injuries.

The clinical record and investigative notes were reviewed, which confirmed the abuse of resident #002 and the injuries sustained by the resident, as well as the ongoing assessments and monitoring required.

The resident was observed on specific dates in April and May 2018. The resident's skin was observed and was abnormal.

The PSW student stated that PSW #116 was being too rough when assisting the resident. The resident then became agitated and irritated and hit the PSW lightly, not hard, then the PSW injured the resident, while at the same time verbally threatening the resident. The PSW was also calling the resident derogatory names. The PSW student said that they offered PSW #116 to complete the resident's care and then PSW #116 left the room. The PSW student then completed the resident's care and wheeled the resident to the dining room. It was at this time the PSW student said that they reported the abuse they witnessed of resident #002 to their Clinical Instructor.

The Administrator was interviewed and acknowledged that the resident's Substitute Decision Maker (SDM) was notified of the incident and the police were also notified of the abuse of resident #002 in March 2018, they became aware of the incident. The Administrator provided a picture that they had taken in April 2018 of the resident's injury, which was approximately 20 days after the incident and reflected the injury to the resident.

The licensee failed to protect resident #002 from physical abuse by PSW #116.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #007003-18, CIS #2887-000013-18.

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 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 license failed to ensure that, 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, (b) is complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including a skin and wound care program were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

Resident #002 sustained an injury as a result of physical abuse by PSW #116 in March 2018.

The resident's clinical record and investigative notes were reviewed, which identified that once the home became aware of the incident, one of the actions taken was that the resident was to receive skin assessments on every shift for 72 hours, starting on a specific date in March 2018.

The licensee's policy titled "Preventative Skin Care and Skin & Wound Care Management Protocol" were reviewed; however they did not direct registered staff to conduct skin assessments every shift for 72 hours as a result of altered skin integrity. RPN #113 was interviewed and said that they completed the first skin assessment on their shift in March 2018, for the resident after it was alleged that the resident was physically abused by a staff member. The RPN said that they were trained on their protocol to complete skin assessments on every shift for 72 hours, which totalled nine assessments over three days. The RPN told the inspector that based on the resident's assessment that they completed, the resident had abnormalities.

The Director of Care (DOC) was interviewed and acknowledged that one of their actions as a result of the physical abuse of resident #002, was for registered staff to conduct skin assessments every shift for 72 hours. The DOC said that it was their protocol to do this in their home and during training of staff related to when a resident obtained a bruise, skin tear and/or pressure ulcer, their registered staff were trained to follow this protocol. The DOC provided documentation to reflect that the last training session related to this protocol was in June 2017. The skin assessments were reviewed with the DOC in the resident's clinical record and there were only seven out of nine skin assessments completed by registered staff. The DOC acknowledged that the registered staff did not follow their skin assessment protocol.

The licensee failed to ensure that their protocol for skin assessments when a resident had a new bruise, skin tear and/or pressure ulcer was complied with for resident #002.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #007003-18 and CIS #2887-000013-18.

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 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Resident #002 was receiving personal care from PSW #116 in March 2018. The resident was exhibiting responsive behaviours during care and based on the licensee's investigative notes and an interview with the witness, the PSW physically abused and threatened the resident. Resident #002 was injured as a result of this incident.

The licensee's policy titled "Prevention of Abuse & Neglect of a Resident", number VII-G-10.00, and last revised in January 2015, directed all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families to report immediately any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long Term Care (MOHLTC) and the Executive

Director/Administrator or designate in charge of the home. The policy also said that all those who voice their concerns will be protected under the organization's Whistle Blower policy, which provided anonymity to the person who reports abuse or neglect and protects that person from any potential retaliation.

The Personal Support Worker (PSW) student who witnessed the abuse in March 2018, had reported the abuse to their Clinical Instructor after completing the resident's care for PSW #116. The student said that they were trained to report abuse immediately to their Clinical Instructor by their College and when they were orientated to the home the Administrator told them they can report to them or their Instructor, as long as their was immediate reporting because of their responsibilities under the legislation and their Prevention of Abuse & Neglect policy and procedures.

The Clinical Instructor was interviewed and acknowledged that the PSW student had reported the abuse of resident #002 by PSW #116 after they completed the resident's personal care. The instructor said that they did not report to the Administrator or anyone else in the home until several days later, because they didn't want the PSW students to experience any retaliation in their last week of clinical practice in the home.

The Administrator was interviewed and acknowledged the training provided to the students and clinical instructor during their orientation related to mandatory and immediate reporting of any alleged, suspected or witnessed abuse of any resident in the home to them or designate. The Administrator confirmed that they were not aware of the abuse of resident #002 until four days after the incident and at which time they reported immediately to the Director.

The licensee failed to comply with their written policy to promote zero tolerance of abuse for resident #002.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #007003-18, CIS #2887-000013-18.

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 without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: 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 each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible.

Resident #002 was assessed as being verbally and physically abusive to staff related to their disease. In March 2018, the resident was exhibiting responsive behaviours while PSW #116 was providing personal care.

The clinical record was reviewed, which indicated that the trigger for the resident's behaviours was personal care. Interventions were developed and documented on the plan of care. The written plan of care directed staff to use a specific approach when providing care.

PSW #100 was interviewed and acknowledged that when the resident had physical or verbal behaviours, they were to use a specific approach when providing care to the resident'. When the PSW student was interviewed, they witnessed the care provided to resident #002 on a specific date in March 2018 and confirmed that PSW #116 did not implement the behavioural strategy when the resident was exhibiting responsive behaviours and continued to try and provide care to the resident when they were resisting.

The licensee failed to ensure that, for resident #002 who was demonstrating responsive behaviours, PSW #116 did not implement the strategies to respond to these behaviours.

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, for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 26th day of June, 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) :	KATHLEEN MILLAR (527), AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2018_742527_0007
Log No. / No de registre :	008931-17, 021666-17, 024789-17, 001362-18, 003105-18, 004727-18, 007003-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 29, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Hawthorn Woods Care Community 9257 Goreway Drive, BRAMPTON, ON, L6P-0N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Adam Kertesz

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:

1. Ensure that all residents, including but not limited to resident #002, are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Resident #002 received care from PSW #116 in March 2018. PSW #116 had a PSW student assist with the resident's care. The resident became agitated and hit PSW #116 on the hand. PSW #116 reacted by injuring the resident, as witnessed by the PSW student. The resident required additional care as a result of their injuries.

The clinical record and investigative notes were reviewed, which confirmed the abuse of resident #002 and the injuries sustained by the resident, as well as the ongoing assessments and monitoring required.

The resident was observed on specific dates in April and May 2018. The resident's skin was observed and was abnormal.

The PSW student stated that PSW #116 was being too rough when assisting the resident. The resident then became agitated and irritated and hit the PSW lightly, not hard, then the PSW injured the resident, while at the same time

verbally threatening the resident. The PSW was also calling the resident derogatory names. The PSW student said that they offered PSW #116 to complete the resident's care and then PSW #116 left the room. The PSW student then completed the resident's care and wheeled the resident to the dining room. It was at this time the PSW student said that they reported the abuse they witnessed of resident #002 to their Clinical Instructor.

The Administrator was interviewed and acknowledged that the resident's Substitute Decision Maker (SDM) was notified of the incident and the police were also notified of the abuse of resident #002 in March 2018, they became aware of the incident. The Administrator provided a picture that they had taken in April 2018 of the resident's injury, which was approximately 20 days after the incident and reflected the injury to the resident.

The licensee failed to protect resident #002 from physical abuse by PSW #116.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #007003-18, CIS #2887-000013-18.

2. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #002 experienced, the scope of one isolated incident, and the Licensee's history of noncompliance, which included: CO served on February 7, 2017, Inspection #2017_449619_0003; and a VPC issued on May 24, 2016, Inspection #2016_431527_0010

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 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 29th day of May, 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 : Kathleen Millar

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