Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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
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 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 29, 2019	2019_800532_0010 (A1)	013902-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

Amended by NUZHAT UDDIN (532) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home is requesting for an extension until November 22, 2019.

Issued on this 29th day of October, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2019	2019_800532_0010 (A1)	013902-19	Critical Incident System

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

Amended by NUZHAT UDDIN (532) - (A1)

Amended 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): July 31, and August 1, 2, 6, 8, 2019.

During this inspection, log # 013902-19 a critical incident related to hospitalization and change of status was completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DORC), Associate Director of Resident Care (ADORC), Supervisor of Resident Care, Professional Standards Supervisors, Administrative Assistants, Registered Nurses (RN), Registered Practical Nurses, (RPN), Personal Support Workers (PSW), and residents.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Pain

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A critical incident report (CI) was submitted to the Ministry of Long-Term Care (MLTC) related to alleged improper/incompetent treatment of an identified resident.

The identified resident's clinical record documented that the resident was exhibiting signs of pain on the identified dates.

The Medication administration record (MAR) identified that the scheduled analgesic and as needed (PRN) analgesic was discontinued a month prior and it was not replaced by another analgesic. According to the MAR the resident did not receive any pain medication when the resident exhibited signs of pain.

On an identified date, the resident had a significant change in condition and was transferred to hospital where they died later that day.

The home's pain management policy stated that the interdisciplinary team would:
Conduct and document a pain assessment on admission, quarterly and as required.
Monitor for change in condition with onset of pain.
Observe for distress related behaviours or facial grimace.
Initiate a pain assessment when a scheduled pain medication did not relieve the pain or when pain remained regardless of interventions.

Record review showed that there was no pain assessment initiated during the time when the resident was experiencing pain.

A PSW stated that the resident exhibited signs of pain which became constant approximately three and half weeks before the resident passed away.

A RN acknowledged that there were two main issues with the resident; one was pain and the other was difficulty swallowing. They RN confirmed that the physician was not notified while the resident exhibited signs of pain and no pain assessment was done.

The ADOC confirmed that the physician was not notified of this concern and a pain assessment was not done when pain was not relieved by initial interventions.

The licensee has failed to ensure that when the resident pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate

assessment instrument specifically designed for this purpose.

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for an identified resident under goal for pain, stated "optimal pain relief and comfort over the next quarter" and under interventions it included as needed topical medication for relief of pain during a specific procedure and give as needed analgesic medication for relief of pain.

The Minimum Data Set (MDS), significant change in status assessment stated that the resident experienced pain daily.

The resident's Medication Administration Record (MAR) showed that as needed medication was ordered to apply topically but the oral analgesic for pain was discontinued and no other analgesic was ordered.

The MAR documented that the topical medication was not signed as given when a procedure was done on identified dates. There was no order for oral pain medication and therefore, none was given when the resident experienced pain.

A PSW stated that the resident's pain became constant the last few weeks before the resident passed away.

A RN acknowledged that the resident had pain and there were no pain medications prescribed or given to the resident to manage their pain. In addition, the RN acknowledged that the home had not notified the physician of the resident's increase in pain, nor had any referrals been made to the pain committee.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that resident #001 was not neglected by the licensee or staff.

The following is further evidence to support compliance order #001 issued on July 10, 2019, during inspection # 2019_773155_0010 to be complied July 18, 2019.

As per O. Reg 79/10 s.5 neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident report (CI) was submitted to the Ministry of Long-Term Care (MLTC) which stated that on an identified date a resident exhibited signs and symptoms of a significant change in condition. The resident was transported to hospital. The resident died in hospital later that day.

Record review identified that the resident exhibited a significant weight gain with a decrease in urine output and a decrease in food intake. The nursing staff recommended a referral to the RD. The RD requested a re-weigh, but it was not done.

A professional standard report stated that a decrease in urine output did not appear to be recognized by the staff.

Clinical records showed that the resident was diagnosed with a painful disease, and they also exhibited behaviours of unexpressed pain but there was no pain assessment done.

The resident's MAR showed that the analgiesc for pain was discontinued a month prior and no other analgesic was ordered to replace it. The resident did not receive any pain medication when they exhibited signs of pain.

Clinical review also showed that the physician was not notified of the resident's ongoing deterioration and pain issues.

The ADOC acknowledged that there was failure to provide treatment, and care from staff as required for the identified resident's health, safety and well-being. The physician was not notified when the resident's health status deteriorated, a pain assessment was not done when the resident exhibited signs and symptoms of pain. The resident's re-weigh was not completed even though the RD had requested it.

The licensee has failed to ensure that the resident was not neglected by the licensee or staff.

Issued on this 29th day of October, 2019 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NUZHAT UDDIN (532) - (A1)
Inspection No. / No de l'inspection :	2019_800532_0010 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013902-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 29, 2019(A1)
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Martina Wynia

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 52 (2).

Specifically, the licensee must:
a) ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
b) ensure that the communication alert located on Point of Care (POC) is used by the PSWs and the registered staff when verbal and non-verbal residents exhibit pain and responsive behaviours.
c) ensure that the physician-nurse communication tool that is currently in place is used by the registered staff to communicate to the physician, residents' verbal and non-verbal signs and symptoms of pain.
d) ensure training is provided to the registered staff of the home related to the home's pain policy, specifically recognizing, assessing, documenting and evaluating pain.
e) ensure that all staff sign off on the completed training and records are kept in the home.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A critical incident report (CI) was submitted to the Ministry of Long-Term Care

(MLTC) related to alleged improper/incompetent treatment of an identified resident.

The identified resident's clinical record documented that the resident was exhibiting signs of pain on the identified dates.

The Medication administration record (MAR) identified that the scheduled analgesic and as needed (PRN) analgesic was discontinued a month prior and it was not replaced by another analgesic. According to the MAR the resident did not receive any pain medication when the resident exhibited signs of pain.

On an identified date, the resident had a significant change in condition and was transferred to hospital where they died later that day.

The home's pain management policy stated that the interdisciplinary team would:
Conduct and document a pain assessment on admission, quarterly and as required.
Monitor for change in condition with onset of pain.
Observe for distress related behaviours or facial grimace.
Initiate a pain assessment when a scheduled pain medication did not relieve the pain or when pain remained regardless of interventions.

Record review showed that there was no pain assessment initiated during the time when the resident was experiencing pain.

A PSW stated that the resident exhibited signs of pain which became constant approximately three and half weeks before the resident passed away.

A RN acknowledged that there were two main issues with the resident; one was pain and the other was difficulty swallowing. They RN confirmed that the physician was not notified while the resident exhibited signs of pain and no pain assessment was done.

The ADOC confirmed that the physician was not notified of this concern and a pain assessment was not done when pain was not relieved by initial interventions.

The licensee has failed to ensure that when the resident pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The scope of this issue was a level 1 isolated. The severity of the issue was determined to be a level 3, actual harm. The home has a level 2 history previous non-compliance to a different subsection. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 2019(A1)

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 # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (7).

Specifically, the licensee must:
a) ensure that the care set out in the plan of care is provided to the residents as specified in the plan related to pain.
b) ensure that an auditing process is developed and fully implemented to ensure that the care for residents is being provided to the residents as specified in their plans of care related to pain, and the care provided is documented. This auditing process must include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The written audit must be kept available in the home.

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for an identified resident under goal for pain, stated "optimal pain relief and comfort over the next quarter" and under interventions it included as needed topical medication for relief of pain during a specific procedure and give as needed analgesic medication for relief of pain.

The Minimum Data Set (MDS), significant change in status assessment stated that the resident experienced pain daily.

The resident's Medication Administration Record (MAR) showed that as needed medication was ordered to apply topically but the oral analgesic for pain was discontinued and no other analgesic was ordered.

The MAR documented that the topical medication was not signed as given when a procedure was done on identified dates. There was no order for oral pain medication and therefore, none was given when the resident experienced pain.

A PSW stated that the resident's pain became constant the last few weeks before the resident passed away.

A RN acknowledged that the resident had pain and there were no pain medications prescribed or given to the resident to manage their pain. In addition, the RN acknowledged that the home had not notified the physician of the resident's increase in pain, nor had any referrals been made to the pain committee.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The scope of this issue was a level 1 isolated. The severity of the issue was determined to be a level 3, actual harm. The home has a level 3 history of non-compliance that included:
-VPC from inspection 2019_773155_0010 issued May 29, 2019. (532)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2019

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:

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 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)
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 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 October, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by NUZHAT UDDIN (532) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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