

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

**Rapport d'inspection en vertu
de la Loi de 2007 sur les
foyers de soins de longue
durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 20, 2022	2022_876606_0011 (A1)	001511-22, 001529-22, 001798-22, 001805-22	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Sandalwood Park
425 Great Lakes Drive Brampton ON L6R 2W8

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

Amended by JANET GROUX (606) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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durée**

The Compliance Due Date (CDD) for CO #001 had been changed to June 17, 2022, as per the home's request.

Issued on this 20th day of May, 2022 (A1)

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

Original report signed by the inspector.

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

Amended by JANET GROUX (606) - (A1)

Amended Inspection Summary/Résumé de l'inspection

**Inspection Report under
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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 28-31 and April 1-3, 2022.

The following intakes were completed in this complaint inspection:

Log #001511-22, log #001529-22, log #001798-22, and log #001805-22 regarding the home's skin and wound program.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DNC), Neighbourhood Coordinator (NC), Dietitian, Enterostomal Therapy (ET) Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Staff, Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the inspector observed resident and staff interactions, Infection prevention and control (IPAC) program, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Skin and Wound Care

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

**1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 50. Skin and wound care

Specifically failed to comply with the following:

- s. 50. (2) Every licensee of a long-term care home shall ensure that,**
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
 - (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
 - (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
 - (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
 - (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that a resident received immediate treatment and interventions for the infection to their wound.

The home's policy said registered staff were to send a referral to the Skin and Wound lead when a wound was worsening.

The resident was identified with a wound which became infected. A week prior to the date, a registered staff who assessed the resident identified a change in the appearance of the resident's wound. The registered staff said they did not send a referral to the Skin and Wound Care Lead to let them know that there was a change in the condition of the resident's wound.

The Skin and Wound Lead said when changes to a resident's wound were identified, registered staff were to initiate a referral to them to follow up with the physician and involve the ET Nurse.

The ET Nurse said the resident should have been referred to them earlier.

Failure to initiate a referral to the Skin and Wound Lead regarding changes to the resident's wound delayed changes to treatment based on assessments by the physician and ET Nurse, and resulted in actual harm to the resident.

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durée**

Sources: a resident's progress notes, weekly Skin and Wound Evaluations, the home's wound care Skin application, Treatment Administration Records, the home's policy, interviews staff and ET Nurse. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that two residents' wound were assessed weekly.

Two residents developed wounds The residents' weekly skin and wound evaluations on identified dates were incomplete and did not include the information required in the assessment including whether the wound showed signs of infection.

The home's policy directed staff to complete a wound assessment weekly and to observe for clinical signs and symptoms of infection, including redness, swelling, increased pain, increased temperature, odour, malaise, purulent exudate, and fever.

Two registered staff and the Skin and Wound Lead said registered staff were to observe for signs and symptoms of infection when completing a weekly skin and wound assessment.

Failure to complete weekly assessments to include assessing for signs and symptoms of infection may have delayed treatment and contributed to one of the resident's changes in condition; and failure to complete the other resident's weekly assessments may have delayed appropriate follow up for the resident's skin care.

Sources: the residents' progress notes, weekly Skin and Wound Evaluations, a home's and staff interviews. [s. 50. (2) (b) (iv)]

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 / Le/les ordre(s) suivant(s) ont été
modifiés: CO# 001**

Issued on this 20th day of May, 2022 (A1)

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

Original report signed by the inspector.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch
Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** Amended by JANET GROUX (606) - (A1)

**Inspection No. /
No de l'inspection :** 2022_876606_0011 (A1)

**Appeal/Dir# /
Appel/Dir#:**

**Log No. /
No de registre :** 001511-22, 001529-22, 001798-22, 001805-22 (A1)

**Type of Inspection /
Genre d'inspection :** Complaint

**Report Date(s) /
Date(s) du Rapport :** May 20, 2022(A1)

**Licensee /
Titulaire de permis :** Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, Kitchener, ON,
N2E-4H5

**LTC Home /
Foyer de SLD :** The Village of Sandalwood Park
425 Great Lakes Drive, Brampton, ON, L6R-2W8

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** Zoie Mohammed

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 Schlegel Villages Inc., 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 # /

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. 50. (2) Every licensee of a long-term care home shall ensure that,

- (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
 - (i) within 24 hours of the resident's admission,
 - (ii) upon any return of the resident from hospital, and
 - (iii) upon any return of the resident from an absence of greater than 24 hours;
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
 - (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
 - (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
 - (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
 - (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
- (c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
- (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

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 comply with O.Reg. 79/10, s. 50(2).

Specifically the licensee must:

- a) Ensure that all registered nursing staff receive refresher training on how to complete the home's weekly Skin and Wound Evaluation assessment; including review of the home's policies and procedures related to skin and wound assessments specifically on when to refer to the skin care lead; and what to do if there are signs and symptoms of a wound infection. A record of the date and who attended the training must be kept in the home.
- b) Develop and implement a weekly auditing system to ensure that weekly wound care assessments are completed (in their entirety) for areas of altered skin integrity, including pressure ulcers. A record of the audit tool including the date, what was reviewed, auditor, and actions taken if any, must be documented and maintained at the home.

Grounds / Motifs :

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

1. The licensee failed to ensure that a resident received immediate treatment and interventions for the infection to their wound.

The home's policy said registered staff were to send a referral to the Skin and Wound lead when a wound was worsening.

The resident was identified with a wound which became infected. A week prior to the date, a registered staff who assessed the resident identified a change in the appearance of the resident's wound. The registered staff said they did not send a referral to the Skin and Wound Care Lead to let them know that there was a change in the condition of the resident's wound.

The Skin and Wound Lead said when changes to a resident's wound were identified, registered staff were to initiate a referral to them to follow up with the physician and involve the ET Nurse.

The ET Nurse said the resident should have been referred to them earlier.

Failure to initiate a referral to the Skin and Wound Lead regarding changes to the resident's wound delayed changes to treatment based on assessments by the physician and ET Nurse, and resulted in actual harm to the resident.

Sources: a resident's progress notes, weekly Skin and Wound Evaluations, the home's wound care Skin application, Treatment Administration Records, the home's policy, interviews staff and ET Nurse. [s. 50. (2) (b) (ii)]

(606)

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

2. The licensee has failed to ensure that two residents' wound were assessed weekly.

Two residents developed wounds The residents' weekly skin and wound evaluations on identified dates were incomplete and did not include the information required in the assessment including whether the wound showed signs of infection.

The home's policy directed staff to complete a wound assessment weekly and to observe for clinical signs and symptoms of infection, including redness, swelling, increased pain, increased temperature, odour, malaise, purulent exudate, and fever.

Two registered staff and the Skin and Wound Lead said registered staff were to observe for signs and symptoms of infection when completing a weekly skin and wound assessment.

Failure to complete weekly assessments to include assessing for signs and symptoms of infection may have delayed treatment and contributed to one of the resident's changes in condition; and failure to complete the other resident's weekly assessments may have delayed appropriate follow up for the resident's skin care.

Sources: the residents' progress notes, weekly Skin and Wound Evaluations, a home's and staff interviews. [s. 50. (2) (b) (iv)]

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

Severity: Failure to complete a resident's weekly skin and wound assessments resulted in a delay in the resident receiving treatment for their wound.

Scope: The scope of this non-compliance was a pattern because weekly skin assessments were not completed for two of the three residents reviewed during this inspection.

Compliance History: A compliance order (CO) is being issued for the licensee failing to comply with s. 52(2) of O. Reg 79/10. This subsection was issued as a written notification (WN) on August 10, 2020, during inspection #2020_826606_0014. (606)

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 :**

Jun 17, 2022(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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term
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2007, c. 8

Ordre(s) de l'inspecteur

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2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
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 20th day of May, 2022 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

Amended by JANET GROUX (606) - (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

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

Central West Service Area Office