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
Mar 4, 2022	2022_729615_0002	017267-21, 017672-21, 018517-21	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Westmount Long Term Care Residence
200 David Bergey Drive Kitchener ON N2E 3Y4

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

HELENE DESABRAIS (615), KIM BYBERG (729), SARAH KENNEDY (605)

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): January 18, 19, 20, 21 and 24, 2022.

The following intakes were inspected during this inspection:

**Log #017267-21/Critical Incident System (CIS) report related to falls prevention;
Log #018517-21/CIS report related to prevention of abuse, neglect and retaliation;
Log #017672-21 follow-up inspection to Order #001 from inspection #2021_729615_0029 related to sufficient staffing with a due date of November 16, 2021.**

This inspection was concurrently inspected with complaint inspection #2022_729615_0003.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Co-Director of Care (Co-DOC), the Registered Nurse - Falls Lead (RN-Falls Lead), the Registered Practical Nurse - Resident Assessment Instrument Coordinator (RPN-RAI Coordinator), five RPNs, a Physiotherapist, six Personal Support Workers (PSW), a Housekeeper and a Screener Staff.

The inspectors also observed resident rooms and common areas, observed Infection Prevention and Control practices within the home, observed residents and the care provided to them, reviewed clinical records and plans of care for identified residents, reviewed Critical Incident System (CIS) reports, reviewed the home's internal investigation reports and reviewed relevant policies and procedures of the home.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing**

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (3)	CO #001	2021_729615_0029	615

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 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 a resident was not neglected in the days after

they had a fall and suffered an injury.

“Neglect” is defined as 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. O. Reg. 79/10, s. 5.

On a specific date, a resident was using equipment to assist with their transfer when the equipment broke causing them to fall. A PSW told the inspector that despite trying to break the resident's fall, the resident sustained a skin tear and complained of pain in another area for which they received analgesic medication.

A head to toe assessment was conducted and treatment provided for the skin concern. An RPN said that they did not complete the required post fall assessment, vital signs, pain assessment and range of motion, nor did they document a physical assessment of the resident. The assessment of the resident's skin tear was not completed until the following day. Further, a skin assessment was to be completed weekly for the skin tear, but was only completed once over a period of 41 days.

The home’s “Resident Falls Prevention Program” policy, revised June 2019, stated that a fall was any unintentional change in position where the resident ends up on the floor, ground or other lower level, that included when staff or other person assisted a resident to the floor or other lower level. The registered staff were to assess the resident for any possible injury or negative outcome, and to consider range of motion assessment of extremities, colour, vital signs, level of consciousness, and emotional state. They were to complete the post fall assessment and analysis in point click care and complete applicable clinical assessments, for example pain and skin assessments.

A day after the fall, the resident complained of pain in several areas, which they rated as a level 5 out of 10 in terms of severity and analgesic was administered. Their follow up pain score was a level 4 and it was documented that the analgesic was effective. A comprehensive pain assessment was not completed. Later that day the physician was notified and suggested the pain could be from a previous incident.

Two days after the fall the resident complained of pain and mild swelling in their leg. The registered staff documented that the swelling was not new. There was no pain assessment, physical assessment or range of motion assessment completed at that time.

Three days after the fall, the resident continued to complain of pain. The registered staff made an entry in the physician communication book to assess on their next scheduled visit. Later that day, the resident's family requested an assessment as the resident had pitting edema. Despite pain and increased swelling, a comprehensive pain and mobility assessment was not completed.

A Registered Dietician (RD) assessed the resident five days after the fall, in relation to a different issue, and noted that they were not eating well. The resident stated that since their fall they did not have an appetite and continued to complain of pain in their leg. A review of their food and fluid records indicated that they had refused six meals during the last five days. The RD reported the pain and concerns about intake to the registered staff. Later that day, the physician assessed the resident and found the resident to be experiencing excruciating pain with loss of range of motion. The resident was sent to the hospital and diagnosed with a fracture.

When the resident had a fall, a post fall assessment was not completed to evaluate the presence of injury. The resident complained of pain for which they received analgesics, but despite persistent pain and swelling, and refusal of meals, the home failed to take action to complete comprehensive assessments of pain and skin, timely follow up of their analgesic administration, referrals to physiotherapy, or clear communication to the physician. The home's delay to provide the resident with the treatment, care and services for five days after the fracture, jeopardized the health and well-being of the resident.

Sources: Interview with the DOC, two PSWs, an RPN, an RN, a Physiotherapist, Record review of a resident's eMAR (electronic medication administration record), eTAR (electronic treatment administration record), post fall assessment, pain assessments, skin and wound assessment, progress notes, Policy titled Resident Safety and Risk Management, Falls Preventions, Wound Care and Pain policies. [s. 19. (1)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that when staff transferred a resident they used safe transferring and positioning devices.

A PSW transferred a resident using a device for assistance. The device broke during the transfer, and the resident fell. The resident sustained a skin tear and complained of pain in another area. They were later found to have sustained a fracture.

The resident's plan of care required extensive assistance of two staff for transferring. An RPN stated that using the identified device for transferring residents was not safe. The RN-Fall Lead, stated that home was equipped with specifically designed transfer equipment to assist residents for transfers and positioning.

The home's failure to use safe transferring and positioning devices with the resident caused actual harm to the resident.

Sources: resident's clinical records, observations of devices used for transferring residents, interviews with a Co-DOC, two PSWs, an RPN, a RN and a Physiotherapist. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect alleged abuse of a resident immediately reported to the Director.

The home submitted a Critical Incident System (CIS) report alleging abuse of a resident. The home's CIS report indicated that the allegation of abuse towards a resident was reported by a PSW to a registered staff the day before. The registered staff did not immediately report the incident to the home's management or the Director. A Co-DOC stated that the allegation of abuse should have been immediately reported to the Director.

Sources: The home's CIS report, a resident's clinical records, interviews with two PSWs, an RPN, a RN and a Co-DOC. [s. 24. (1)]

Issued on this 9th day of March, 2022

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) :	HELENE DESABRAIS (615), KIM BYBERG (729), SARAH KENNEDY (605)
Inspection No. / No de l’inspection :	2022_729615_0002
Log No. / No de registre :	017267-21, 017672-21, 018517-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 4, 2022
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Westmount Long Term Care Residence 200 David Bergey Drive, Kitchener, ON, N2E-3Y4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Dawna Courtney

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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 :

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 :

Specifically, the licensee must:

A) Ensure that weekly skin and wound assessments are conducted for any areas of skin impairment for a resident. The assessments must be documented in the resident's clinical record.

B) Ensure that post fall assessments are completed as per the home's policy titled "Resident Falls Prevention Program" policy # LTC-CA-WQ-200-07-08.

C) Ensure that a comprehensive pain assessment is completed for a resident when they are experiencing pain. A complete physical assessment including range of motion of the affected area is completed and documented in the residents' clinical record.

D) Ensure that when a resident receives additional PRN pain medication, follow up to their pain level is assessed and documented within 30-90 minutes as per the home's policy titled "Pain" policy #LTC-CA-WQ-200-05-04. If the follow up pain level is the same or greater than their initial pain level, communication with the physician for further direction is initiated.

E) Complete a facility review of specific rooms to ensure that all transfer and positioning devices are safe and secured and are specifically designed for residents' transfer. Ensure that the environmental review is documented including the location of the review, observations, corrective actions, date of the review and person completing the review. A copy of the environmental review must be kept in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was not neglected in the days after they had a fall and suffered an injury.

"Neglect" is defined as 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. O. Reg. 79/10, s. 5.

On a specific date, a resident was using equipment to assist with their transfer when the equipment broke causing them to fall. A PSW told the inspector that despite trying to break the resident's fall, the resident sustained a skin tear and complained of pain in another area for which they received analgesic medication.

A head to toe assessment was conducted and treatment provided for the skin concern. An RPN said that they did not complete the required post fall assessment, vital signs, pain assessment and range of motion, nor did they document a physical assessment of the resident. The assessment of the resident's skin tear was not completed until the following day. Further, a skin assessment was to be completed weekly for the skin tear, but was only completed once over a period of 41 days.

The home's "Resident Falls Prevention Program" policy, revised June 2019, stated that a fall was any unintentional change in position where the resident ends up on the floor, ground or other lower level, that included when staff or other person assisted a resident to the floor or other lower level. The registered staff were to assess the resident for any possible injury or negative outcome, and to consider range of motion assessment of extremities, colour, vital signs, level of consciousness, and emotional state. They were to complete the post fall assessment and analysis in point click care and complete applicable clinical assessments, for example pain and skin assessments.

A day after the fall, the resident complained of pain in several area, which they rated as a level 5 out of 10 in terms of severity and analgesic was administered. Their follow up pain score was a level 4 and it was documented that the analgesic was effective. A comprehensive pain assessment was not completed.

Later that day the physician was notified and suggested the pain could be from a previous incident.

Two days after the fall the resident complained of pain and mild swelling in their leg. The registered staff documented that the swelling was not new. There was no pain assessment, physical assessment or range of motion assessment completed at that time.

Three days after the fall, the resident continued to complain of pain. The registered staff made an entry in the physician communication book to assess on their next scheduled visit. Later that day, the resident's family requested an assessment as the resident had pitting edema. Despite pain and increased swelling, a comprehensive pain and mobility assessment was not completed.

A Registered Dietician (RD) assessed the resident five days after the fall, in relation to a different issue, and noted that they were not eating well. The resident stated that since their fall they did not have an appetite and continued to complain of pain in their leg. A review of their food and fluid records indicated that they had refused six meals during the last five days. The RD reported the pain and concerns about intake to the registered staff. Later that day, the physician assessed the resident and found the resident to be experiencing excruciating pain and range of motion difficulties to a part of their body. The resident was sent to the hospital and diagnosed with a fracture.

When the resident had a fall, a post fall assessment was not completed to evaluate the presence of injury. The resident complained of pain for which they received analgesics, but despite persistent pain and swelling, and refusal of meals, the home failed to take action to complete comprehensive assessments of pain and skin, timely follow up of their analgesic administration, referrals to physiotherapy, or clear communication to the physician. The home's delay to provide the resident with the treatment, care and services for five days after the fracture, jeopardized the health and well-being of the resident.

Sources: Interview with the DOC, two PSWs, an RPN, an RN, a Physiotherapist, Record review of a resident's eMAR (electronic medication administration record), eTAR (electronic treatment administration record), post fall assessment, pain assessments, skin and wound assessment, progress notes, Policy titled

Resident Safety and Risk Management, Falls Preventions, Wound Care and Pain policies.. [s. 19. (1)]

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

Severity: There was actual harm to the resident due to the lack of staff action in completing skin and wound, post fall and pain assessments.

Scope: The scope of this non-compliance was an isolated incident.

Compliance History: The licensee has previous compliance orders that have been complied to the same section of s.19 of O. Reg 79/10. CO #001 was issued on November 5, 2020, (inspection # 2020_800532_0023) with a compliance due date of January 15, 2021, and CO #001 on May 6, 2019, (inspection # 2019_508137_0011) with a compliance due date of August 19, 2019 in the past 36 months.
(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2022

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 4th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Helene Desabrais

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