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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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 21, 2021	2021_638542_0006 (A1)	002328-21, 004173-21	Complaint

Licensee/Titulaire de permis

Wikwemikong Nursing Home Limited
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Wikwemikong Nursing Home
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Amended by TRACY MUCHMAKER (690) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Amendment Reason: Reference to the Community Care Access Centre (CCAC) has been corrected to Home and Community Care Support Services (HCCSS).

Issued on this 21st day of May, 2021 (A1)

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

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

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

Amended by TRACY MUCHMAKER (690) - (A1)

Amended Inspection Summary/Résumé de l'inspection

Ontario

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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 16, 17, 22, 23, 25, 29, April 14, 15, 21, May 3 and 4, 2021.

Two intakes related to complaints submitted to the Director regarding re-admission and discharge of a resident, were inspected during this off-site inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the discharge planner from Community Care Access Centre (CCAC) and the resident.

The Inspector also conducted a review of the resident's health care records from the Long-Term Care home, Manitoulin Health Centre and Kirkwood Place.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that a resident was discharged if the licensee was informed by someone permitted to do so under subsection (2) that the resident's requirements for care had changed and that, as a result, the home

could not provide a sufficiently secure environment to ensure the safety for the resident or the safety of persons who came into contact with the resident.

In accordance with O. Reg. 79/10, s. 145 (2) (b), for the purposes of subsection (1), the licensee shall be informed by, in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending to the resident.

A complaint was submitted to the Director, outlining that a resident was transferred to a hospital, on a specific day in September, 2020 and then discharged from the Long-Term Care (LTC) home the next day.

Inspector #542 reviewed the resident's progress notes from the LTC home. It was documented on a specific day in September, 2020, that the resident exhibited responsive behaviours that resulted in an injury to a staff member.

Inspector #542 was provided with additional health care documents from the hospital which included assessments, concluding that the resident had not exhibited any responsive behaviours that would prevent them from returning to the LTC home.

During a specific day in March, 2021, the resident was transferred to another institution to be observed for any responsive behaviours that would prevent them from returning to the LTC home. Inspector #542 received copies of some of the pertinent health care documents that supported the residents return to the LTC home.

Inspector #542 spoke with the Home and Community Care Support Services (HCCSS) discharge planner from the hospital where the resident was residing. The discharge planner indicated that the resident wished to return to the LTC home and the resident's family member also indicated that they wanted them to return to the LTC home. The discharge planner further indicated that the attending physician at the hospital assessed the resident not to require enhanced supports.

Inspector #542 spoke with the Administrator and the Director of Care who verified that the previous Director of Care discharged resident #001 without any consultation with the resident's physician and the interdisciplinary team.

Sources: Complaint log; review of resident #001's LTC home progress notes, care plan, census records, hospital and institutional records; interview with the complainant, the resident and the home's Administrator and DOC. [s. 145. (1)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the licensee withheld approval for admission, the licensee gave a written notice setting out, (a) the ground or grounds on which the licensee withheld the approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval; and (d) contact information for the Director.

A complaint was submitted to the Director outlining that resident #001 was denied admission to the LTC home on a specific day in February, 2021 by the licensee.

Inspector #542 spoke with the Care Coordinator who indicated that the licensee withheld approval for admission to the home and did not provide a letter to the applicant or the discharge planner.

Inspector #542 interviewed the Administrator and the DOC who both verified that a written notice was not provided to the applicant nor the appropriate placement co-ordinator.

Sources: Complaint log, interview with the complainant, the resident and the home's Administrator and DOC. [s. 44. (9)]

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 if the licensee withholds approval for admission, the licensee shall give written notice to the applicant and the appropriate placement co-ordinator, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging resident #001 under subsection 145 (1), notice of the discharge was given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct, if circumstances do not permit notice to be given before discharge, as soon as possible after the discharge.

A complaint was submitted to the Director, outlining that a resident was transferred to a hospital, on a specific day in September, 2020 and then discharged from the LTC home the next day.

Inspector #542 spoke with the discharge planner from the hospital who indicated that the licensee had not provided a notice of the discharge to the resident or the substitute decision-maker at any time.

Inspector #542 spoke with the Administrator and the Director of Care (DOC) who verified that the previous Director of Care discharged resident #001 without providing any notice to the resident or the resident’s substitute decision-maker.

Sources: Complaint log and interview with the Administrator, DOC and the placement co-ordinator. [s. 148. (1) (b)]

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 before discharging a resident under subsection 145 (1), the licensee shall, (a) ensure that alternatives to discharge have been considered and, where appropriate, tried; (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident, to be implemented voluntarily.

Issued on this 21st day of May, 2021 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TRACY MUCHMAKER (690) - (A1)
Inspection No. / No de l'inspection :	2021_638542_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002328-21, 004173-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 21, 2021(A1)
Licensee / Titulaire de permis :	Wikwemikong Nursing Home Limited 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	Wikwemikong Nursing Home 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

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 Wikwemikong Nursing Home Limited, 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. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Order / Ordre :

The licensee must comply with s. 145 (1) of the O. Reg 79/10.

Specifically, in the case of resident #001, the licensee shall:

1 (a) Return resident #001, if the resident or SDM so chooses, into the same class of accommodation, the same room, and the same bed in the room that the resident had prior to discharge;

(b) Should the resident's bed and room (at the time of discharge) not be available, return the resident into a similar class of accommodation;

(c) Should a similar class of accommodation not be available, return resident #001 into the next available bed. At the next available opportunity, resident #001 shall be moved to their original class of accommodation.

2) Collaborate with the current health service organization where resident #001 currently resides to ensure that care and services as per the resident's assessed needs are provided upon their re-admission.

3) Develop a plan to ensure that interventions are in place to respond to any responsive behaviours.

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 :

(A1)
1. 1. The licensee has failed to ensure that a resident was discharged if the licensee was informed by someone permitted to do so under subsection (2) that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety for the resident or the safety of persons who came into contact with the resident.

In accordance with O. Reg. 79/10, s. 145 (2) (b), for the purposes of subsection (1), the licensee shall be informed by, in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending to the resident.

A complaint was submitted to the Director, outlining that a resident was transferred to a hospital, on a specific day in September, 2020 and then discharged from the Long-Term Care (LTC) home the next day.

Inspector #542 reviewed the resident's progress notes from the LTC home. It was documented on a specific day in September, 2020, that the resident exhibited responsive behaviours that resulted in an injury to a staff member.

Inspector #542 was provided with additional health care documents from the hospital which included assessments, concluding that the resident had not exhibited any responsive behaviours that would prevent them from returning to the LTC home.

During a specific day in March, 2021, the resident was transferred to another institution to be observed for any responsive behaviours that would prevent them from returning to the LTC home. Inspector #542 received copies of some of the pertinent health care documents that supported the residents return to the LTC home.

Inspector #542 spoke with the Home and Community Care Support Services (HCCSS) discharge planner from the hospital where the resident was residing. The discharge planner indicated that the resident wished to return to the LTC home and the resident's family member also indicated that they wanted them to return to the LTC home. The discharge planner further indicated that the attending physician at the hospital assessed the resident not to require enhanced supports.

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

Inspector #542 spoke with the Administrator and the Director of Care who verified that the previous Director of Care discharged resident #001 without any consultation with the resident’s physician and the interdisciplinary team.

Sources: Complaint log; review of resident #001's LTC home progress notes, care plan, census records, hospital and institutional records; interview with the complainant, the resident and the home's Administrator and DOC.

An order was made taking the following into consideration:

Severity: There was actual harm to resident #001 as, they have been residing in a hospital since September 17, 2020, impacting their quality of life.

Scope: This was an isolated case.

Compliance History: The licensee was previously found to be in non compliance with different sections of the legislation in the past 36 months.

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 28, 2021

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
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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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

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

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
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 21st day of May, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by TRACY MUCHMAKER (690) - (A1)

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

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