Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 4, 2017	2017_644507_0015	024701-17	Critical Incident System

Licensee/Titulaire de permis

VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC.
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

VILLA COLOMBO SENIORS CENTRE
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

STELLA NG (507)

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): October 27 and 30, November 27 and 28, 2017.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care - administrative (DOC-A), nurse designate (ND), registered practical nurse (RPN), personal support workers (PSW), and resident assessment instrument (RAI) coordinator.

During the course of the inspection, the inspector conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staff education records, employee file, staff schedules and relevant polices and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect resident #001 from neglect by staff.

Review of the spilled action centre (SAC) report on an identified date, revealed the home called to report an incident of incompetent care provided to resident #001 which had occurred on the same day. The SAC report further revealed that during care, resident #001 sustained injury and was sent to the hospital for assessment.

Review of an identified critical incident system report (CIS) submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on an identified date, and the home's investigation notes revealed that on the identified date, staff #100 reported to staff #102 that during care, resident #001 sustained injury and was sent to the hospital for further assessment.

Review of resident #001's resident assessment instrument – minimum data set (RAI-MDS) assessment completed two months prior revealed that resident #001 was totally dependent and required more than one person assistance for care.

Review of resident #001's written plan of care completed two months prior, revealed that resident #001 required assistance with care. The same written plan of care further revealed one of the interventions for resident #001's care was to provide more than one person total physical assist.

During the course of the inspection, the inspector attempted to reach staff #100 for an interview, without success.

In an interview, staff #102 stated that on the identified date, he/she was called by staff #100 in regards to resident #001's injury. Staff #102 told the inspector that staff #100 reported to him/her that staff #100 provided care to resident #001 and caused resident #001 to sustain an injury. Staff #102 contacted the family, physician and staff #103 and informed them of the injury and arranged sending resident #001 to the hospital for further assessment.

Review of the home's investigation notes and interviews with the staff #105 and #106 revealed the following:
- During an interview on the above mentioned identified date, staff #100 told the home that he/she provided care to resident #001 and caused resident #001 to sustain an injury.
- During an interview on the next day, staff #100 told staff #105 and #106 that he/she provided care to resident #001 without the assistance of another staff member, and caused resident #001 to fall and sustain an injury. Staff #100 further stated he/she transferred resident #001 to bed unassisted after resident #001 has fallen.

In an interview, staff #105 stated when a resident has fallen, the home's protocol is not to move the resident until the resident is assessed by a registered staff and the registered staff determined it is safe to move the resident. Staff #105 acknowledged resident #001 sustained injury during care provided by staff #100 on the above mentioned identified date. Staff #105 further stated staff #100 should not provide care to resident #001 without the assistance of another staff member when resident #001's written plan of care indicated the resident required more than one person assistance for care. In addition, when resident #001 fell, staff #100 should have reported to the registered staff on the unit immediately so that assessment and/or treatment could be provided to resident #001; instead of continuing the care and moving the resident which may have caused more harm to the resident.

The severity of this noncompliance is actual harm. The scope is isolated to resident #001. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report #2017_656596_0004 on March 16, 2017 for s. 19 (1). As a result of actual harm and ongoing of noncompliance, a compliance order is warranted. [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 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.

Review of the spilled action centre (SAC) report on an identified date, revealed the home called to report an incident of incompetent care provided to resident #001 which had occurred on the same day. The SAC report further revealed that during care, resident #001 sustained injury and was sent to the hospital for assessment.

Review of an identified critical incident system report (CIS) submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on an identified date, and the home's investigation notes revealed that on the identified date, staff #100 reported to staff #102 that during care, resident #001 sustained injury and was sent to the hospital for further assessment.

Review of resident #001's resident assessment instrument – minimum data set (RAI-MDS) assessment completed two months prior revealed that resident #001 was totally dependent and required more than one person assistance for care.

Review of resident #001's written plan of care completed two months prior, revealed that resident #001 required assistance with care. The same written plan of care further revealed one of the interventions for resident #001's care was to provide more than one person total physical assist.

Review of the documentation survey reports for resident #001 in regards to the above mentioned care for a period of three months, revealed staff #100 documented resident #001 was totally dependent and was assisted by one person for the care on 46 shifts.

During the course of the inspection, the inspector attempted to reach staff #100 for an interview, without success.

In an interview, staff #102 stated that on the identified date, he/she was called by staff #100 in regards to resident #001's injury. Staff #102 told the inspector that staff #100 reported to him/her that staff #100 provided care to resident #001 and caused resident #001 to sustain an injury. Staff #102 contacted the family, physician and staff #103 and informed them of the injury and arranged sending resident #001 to the hospital for further assessment.

Review of the home's investigation notes and interviews with the staff #105 and #106 revealed the following:
- During an interview on the above mentioned identified date, staff #100 told the home

that he/she provided care to resident #001 and caused resident #001 to sustain an injury. - During an interview on the next day, staff #100 told staff #105 and #106 that he/she provided care to resident #001 without the assistance of another staff member, and caused resident #001 to fall and sustain an injury. Staff #100 further stated he/she transferred resident #001 to bed unassisted after resident #001 has fallen. Staff #100 also told staff #105 and #106 that he/she was aware of resident #001 required more than one person assistance for care; however, he/she provided the care to resident #001 without the assistance of another staff member.

In an interview, staff #105 acknowledged resident #001 sustained injury during care provided by staff #100 on the above mentioned identified date. Staff #105 stated he/she was not aware of resident #001 was assisted with care by one staff member as documented by staff #100 on the above mentioned days. Staff #105 further stated that staff #100 should not provide the care to resident #001 without the assistance of another staff member when resident #001's written plan of care indicated the resident required more than one person assistance for care.

The severity of this noncompliance is actual harm. The scope is isolated to resident #001. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report #2017_420643_0019 on October 13, 2017, #2017_656596_0005 on March 16, 2017, and #2016_397607_0025 on November 21, 2016 for s. 6 (7). As a result of actual harm and ongoing of noncompliance, a compliance order is warranted. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 4th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2017_644507_0015
Log No. / No de registre :	024701-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 4, 2017
Licensee / Titulaire de permis :	VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC. 10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	VILLA COLOMBO SENIORS CENTRE 10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sabrina Filintisis

To VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

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 :

Upon receipt of this Compliance Order the licensee shall prepare, submit and implement a plan to ensure that all residents are protected from neglect by staff. The plan shall include, but is not limited to the following:

1. Develop and implement a written quality improvement process to audit, monitor and analyze the level of compliance by all staff to the requirements set out in the Home's zero tolerance policy and the protocol on dealing with resident's falls.
2. Maintain a written record of the quality improvement process that identifies when the Home policy was not complied with and the steps taken by the licensee when non-compliance with the home's policy.

The plan must be submitted to inspector Stella Ng via email at stella.ng@ontario.ca by December 18, 2017.

Grounds / Motifs :

1. The licensee has failed to protect resident #001 from neglect by staff.

Review of the spilled action centre (SAC) report on an identified date, revealed the home called to report an incident of incompetent care provided to resident #001 which had occurred on the same day. The SAC report further revealed that during care, resident #001 sustained injury and was sent to the hospital for assessment.

Review of an identified critical incident system report (CIS) submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on an identified date, and the home's investigation notes revealed that on the identified date,

staff #100 reported to staff #102 that during care, resident #001 sustained injury and was sent to the hospital for further assessment.

Review of resident #001's resident assessment instrument – minimum data set (RAI-MDS) assessment completed two months prior revealed that resident #001 was totally dependent and required more than one person assistance for care.

Review of resident #001's written plan of care completed two months prior, revealed that resident #001 required assistance with care. The same written plan of care further revealed one of the interventions for resident #001's care was to provide more than one person total physical assist.

During the course of the inspection, the inspector attempted to reach staff #100 for an interview, without success.

In an interview, staff #102 stated that on the identified date, he/she was called by staff #100 in regards to resident #001's injury. Staff #102 told the inspector that staff #100 reported to him/her that staff #100 provided care to resident #001 and caused resident #001 to sustain an injury. Staff #102 contacted the family, physician and staff #103 and informed them of the injury and arranged sending resident #001 to the hospital for further assessment.

Review of the home's investigation notes and interviews with the staff #105 and #106 revealed the following:
- During an interview on the above mentioned identified date, staff #100 told the home that he/she provided care to resident #001 and caused resident #001 to sustain an injury.
- During an interview on the next day, staff #100 told staff #105 and #106 that he/she provided care to resident #001 without the assistance of another staff member, and caused resident #001 to fall and sustain an injury. Staff #100 further stated he/she transferred resident #001 to bed unassisted after resident #001 has fallen.

In an interview, staff #105 stated when a resident has fallen, the home's protocol is not to move the resident until the resident is assessed by a registered staff and the registered staff determined it is safe to move the resident. Staff #105 acknowledged resident #001 sustained injury during care provided by staff #100 on the above mentioned identified date. Staff #105 further stated staff #100

should not provide care to resident #001 without the assistance of another staff member when resident #001's written plan of care indicated the resident required more than one person assistance for care. In addition, when resident #001 fell, staff #100 should have reported to the registered staff on the unit immediately so that assessment and/or treatment could be provided to resident #001; instead of continuing the care and moving the resident which may have caused more harm to the resident.

The severity of this noncompliance is actual harm. The scope is isolated to resident #001. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report #2017_656596_0004 on March 16, 2017 for s. 19 (1). As a result of actual harm and ongoing of noncompliance, a compliance order is warranted. [s. 19. (1)]

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

Order # / Ordre no : 002

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

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 :

Upon receipt of this Compliance Order the licensee shall prepare and submit a plan to ensure that the care set out in the plan of care is provided to all residents as specified in the plan.

The plan will include, but is not limited to the following:
1. Conduct meetings with all direct care staff to review the importance of providing care to the residents as specified in the plan of care, and maintain a record of attendance, and the date the meeting(s) occurred.
2. Develop and implement a monitoring process that ensures residents are repositioned safely as outlined in the plan of care.
3. Develop and implement a written quality improvement process to audit, monitor and analyze the level of compliance by direct care staff to ensure resident care is provided as specified in each resident's plan of care.
4. Include in the compliance plan a system that outlines how the licensee will monitor staff adherence to ensure residents are provided the required care as set out in each resident's plan of care.

The plan must be submitted to inspector Stella Ng via email at stella.ng@ontario.ca by December 18, 2017.

Grounds / Motifs :

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.

Review of the spilled action centre (SAC) report on an identified date, revealed the home called to report an incident of incompetent care provided to resident #001 which had occurred on the same day. The SAC report further revealed that

during care, resident #001 sustained injury and was sent to the hospital for assessment.

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Review of the documentation survey reports for resident #001 in regards to the above mentioned care for a period of three months, revealed staff #100 documented resident #001 was totally dependent and was assisted by one person for the care on 46 shifts.

During the course of the inspection, the inspector attempted to reach staff #100 for an interview, without success.

In an interview, staff #102 stated that on the identified date, he/she was called by staff #100 in regards to resident #001's injury. Staff #102 told the inspector that staff #100 reported to him/her that staff #100 provided care to resident #001 and caused resident #001 to sustain an injury. Staff #102 contacted the family, physician and staff #103 and informed them of the injury and arranged sending resident #001 to the hospital for further assessment.

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he/she provided care to resident #001 without the assistance of another staff member, and caused resident #001 to fall and sustain an injury. Staff #100 further stated he/she transferred resident #001 to bed unassisted after resident #001 has fallen. Staff #100 also told staff #105 and #106 that he/she was aware of resident #001 required more than one person assistance for care; however, he/she provided the care to resident #001 without the assistance of another staff member.

In an interview, staff #105 acknowledged resident #001 sustained injury during care provided by staff #100 on the above mentioned identified date. Staff #105 stated he/she was not aware of resident #001 was assisted with care by one staff member as documented by staff #100 on the above mentioned days. Staff #105 further stated that staff #100 should not provide the care to resident #001 without the assistance of another staff member when resident #001's written plan of care indicated the resident required more than one person assistance for care.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : STELLA NG

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