Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2019	2019_661683_0021	015666-19, 015670-19, 016304-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Villa, Dundas
56 Governor's Road DUNDAS ON L9H 5G7

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

LISA BOS (683), STACEY GUTHRIE (750)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, 31, November 1, 4, 5, 6, 7 and 8, 2019.

This inspection was completed concurrently with critical incident inspection #2019_661683_0020.

The following intakes were completed during this complaint inspection:
Log #015666-19 was related to the prevention of abuse and neglect
Log #015670-19 was related to medication administration and accommodation services
Log #016304-19 was related to responsive behaviours, medication administration, personal support services, falls prevention and management, continence care and bowel management

PLEASE NOTE:
A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 26 (3) 19 were identified in this inspection and have been issued in Inspection Report #2019_661683_0020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quality, Performance Systems and Food Services, the Director(s) of Care (DOC), the Assistant Director(s) of Care (ADOC), the Resident Care Managers (RCM), the Education, Quality and Clinical Support Lead, the Resident Assessment Instrument (RAI) Coordinator(s), the Human Resources Manager, the Physiotherapist (PT), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed internal audits, reviewed the complaints log and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this 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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents were taking an identified medication, there was monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level of the drug.

A) A complaint was submitted regarding an identified monitoring test not being completed for resident #001.

i. A review of resident #001's medication administration records (MAR) included an order for a specific medication.

The care plan for resident #001 included a focus regarding the potential complication related to the identified medication, which included an intervention to obtain and monitor lab work as ordered. The results were to be reported to the physician and followed up as indicated.

The clinical record for resident #001 was reviewed and an order was written for the resident to have a monitoring procedure completed on an identified date. The monitoring procedure was completed several days after it was ordered, then, was not completed for a period of time, despite the resident still receiving the medication.

In an interview with Registered Practical Nurse (RPN) #121, they indicated they did not have any results from the monitoring procedure for resident #001 for the identified time period.

In discussion with Assistant Director of Care (ADOC) #131, they acknowledged that the monitoring procedure was not completed for resident #001 for a period of time.

ii. A review of resident #001's MAR indicated that an identified medication was not administered for an identified time period.

A review of the clinical record for resident #001 indicated that a monitoring procedure was scheduled for an identified date. Upon review of the chart, there were no results associated with that date. The home was notified by a family member that the monitoring procedure was not completed that week. A progress note by RN #113 indicated that the resident was supposed to have the monitoring procedure completed on an identified date, and at that time, the monitoring procedure was not completed and the resident was not receiving the medication.

In an interview with ADOC #131, they acknowledged that the monitoring procedure was ordered to be completed on an identified date, and it was not completed.

The home failed to ensure that the monitoring procedure for resident #001 was completed and documented regarding the resident's response and the effectiveness of the drug appropriate to the risk level of the drug.

B) A review of resident #016's MAR included an order for a medication.

A review of the resident's written plan of care identified the potential complication related to the medication and directed staff to obtain and monitor lab work as ordered. A progress note indicated that staff reported the monitoring had not been completed since an identified date. A review of the resident's plan of care identified specific results from an identified date and no further results were located for a period of time.

In an interview with RPN #125, they confirmed that the monitoring was not completed for a medication for resident #016 for an identified time period.

C) A review of resident #015's clinical record identified a progress note written by RPN #113, which noted that a monitoring procedure had not been completed since an

identified date, and the monitoring procedure was ordered to be completed on an identified date, but was not.

A review of resident #015's chart identified a note which indicated that the monitoring test was not completed since an identified date.

In an interview with RPN #113, they acknowledged that pharmacy made them aware of the lapse in monitoring, as part of their review. RPN #113 confirmed that monitoring was not completed for a medication for resident #015 for an identified time period. [s. 134. (a)]

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, and the resident's substitute decision maker were given the opportunity to participate fully in the implementation of resident #004's plan of care.

A complaint was submitted regarding resident #004 experiencing a reaction to an identified medication. The complainant indicated that they had declined consent for resident #004 to be given the medication, but it was given to the resident on an identified date.

A review of the resident's clinical record did not identify consent for the specific medication.

In an interview with Director of Care (DOC) #101, they indicated that the resident should not have been administered the medication without consent from their Substitute Decision Maker (SDM).

The home failed to ensure that the resident and the resident's SDM were given the opportunity to participate fully in the implementation of resident #004's medication regime. [s. 6. (5)]

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 the resident and the resident's substitute decision maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving resident #001 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician, or the registered nurse in the extended class attending the resident, and the pharmacy service provider.

A complaint was submitted regarding an identified monitoring test not being completed for resident #001.

A review of resident #001's clinical record indicated there was an order to hold the medication for a period of time. A review of the resident's MAR indicated that the medication continued to be administered, and the resident received the medication on identified dates.

In an interview with RPN #121, they confirmed that they transcribed the order incorrectly

into the written orders in resident #001's chart.

In an interview with RCM #131, they acknowledged that the order incorrectly transcribed by RPN #121 and the medication being administered to the resident when it was ordered to be held, were both medication incidents. RCM #131 confirmed that both incidents were not reported as medication incidents.

The home failed to ensure that every medication incident involving resident #001 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

This finding will serve as further evidence to support Compliance Order (CO) #004 issued on November 6, 2019, during complaint inspection #2019_560632_0020 to be complied November 29, 2019. [s. 135. (1)]

2. The licensee has failed to ensure that an adverse drug reaction was documented, reviewed and analyzed for resident #004.

A complaint was submitted regarding resident #004 experiencing a reaction to a medication.

A review of resident #004's clinical record indicated that they were administered a medication on an identified date, and they experienced a reaction.

In an interview with RPN #120, they recalled the reaction the resident experienced and indicated that it occurred at the end of their shift. They indicated that they called for Registered Nurse (RN) #119 to come and assess the resident. They acknowledged that the medication was administered during their shift and explained that they did not complete an incident report as it was after their shift had ended and it would have been the responsibility of the staff that had come on.

In an interview with RN #119, they acknowledged that they did not complete a medication incident report or any report additional to the documentation located in the resident's record.

In an interview with DOC #101, they confirmed that the home failed to ensure that the adverse drug reaction, experienced by resident #004, was documented, reviewed and analyzed. [s. 135. (2)]

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 all medication incidents and adverse drug reactions are documented, reviewed and analyzed, to be implemented voluntarily.

Issued on this 11th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683), STACEY GUTHRIE (750)
Inspection No. / No de l'inspection :	2019_661683_0021
Log No. / No de registre :	015666-19, 015670-19, 016304-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 22, 2019
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Dundas 56 Governor's Road, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mieke Ewen

To St. Joseph's Health System, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 134 (a).

Specifically, the licensee must:

1. Ensure resident #001, #015, #016 and all residents who are prescribed an identified medication have an identified monitoring procedure completed at the determined frequency identified by the physician and/or the home's policy.
2. Ensure that all incidents of the identified monitoring procedure not being completed as required are documented as a medication incident.
3. Develop an auditing tool to determine if residents who are receiving the identified medication are having the identified monitoring procedure completed at the determined frequency identified by the physician and/or the home's policy. The audit should include, but is not limited to, associated orders and lab work, and is to be completed monthly. Records are to be maintained of the audits.

Grounds / Motifs :

1. The licensee has failed to ensure that when residents were taking an identified medication, there was monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level of the

drug.

A) A complaint was submitted regarding an identified monitoring test not being completed for resident #001.

i. A review of resident #001's medication administration records (MAR) included an order for a specific medication.

The care plan for resident #001 included a focus regarding the potential complication related to the identified medication, which included an intervention to obtain and monitor lab work as ordered. The results were to be reported to the physician and followed up as indicated.

The clinical record for resident #001 was reviewed and an order was written for the resident to have a monitoring procedure completed on an identified date. The monitoring procedure was completed several days after it was ordered, then, was not completed for a period of time, despite the resident still receiving the medication.

In an interview with Registered Practical Nurse (RPN) #121, they indicated they did not have any results from the monitoring procedure for resident #001 for the identified time period.

In discussion with Assistant Director of Care (ADOC) #131, they acknowledged that the monitoring procedure was not completed for resident #001 for a period of time.

ii. A review of resident #001's MAR indicated that an identified medication was not administered for an identified time period.

A review of the clinical record for resident #001 indicated that a monitoring procedure was scheduled for an identified date. Upon review of the chart, there were no results associated with that date. The home was notified by a family member that the monitoring procedure was not completed that week. A progress note by RN #113 indicated that the resident was supposed to have the monitoring procedure completed on an identified date, and at that time, the monitoring procedure was not completed and the resident was not receiving the

medication.

In an interview with ADOC #131, they acknowledged that the monitoring procedure was ordered to be completed on an identified date, and it was not completed.

The home failed to ensure that the monitoring procedure for resident #001 was completed and documented regarding the resident's response and the effectiveness of the drug appropriate to the risk level of the drug.

B) A review of resident #016's MAR included an order for a medication.

A review of the resident's written plan of care identified the potential complication related to the medication and directed staff to obtain and monitor lab work as ordered. A progress note indicated that staff reported the monitoring had not been completed since an identified date. A review of the resident's plan of care identified specific results from an identified date and no further results were located for a period of time.

In an interview with RPN #125, they confirmed that the monitoring was not completed for a medication for resident #016 for an identified time period.

C) A review of resident #015's clinical record identified a progress note written by RPN #113, which noted that a monitoring procedure had not been completed since an identified date, and the monitoring procedure was ordered to be completed on an identified date, but was not.

A review of resident #015's chart identified a note which indicated that the monitoring test was not completed since an identified date.

In an interview with RPN #113, they acknowledged that pharmacy made them aware of the lapse in monitoring, as part of their review. RPN #113 confirmed that monitoring was not completed for a medication for resident #015 for an identified time period.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was related to

three of three residents reviewed. The home had a level 3 compliance history as they had one or more non-compliances, one of which was the same subsection that included:

• Voluntary plan of correction (VPC) issued October 26, 2017 (2017_542511_0011)
(750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 22nd day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

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