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 prévue le Loi de 2007 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2018;	2018_539120_0015 (A1)	004301-18, 004616-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

Amended by BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

As requested by the licensee, the compliance due date was amended from June 18, 2018 to July 6, 2018.
The resident number was corrected from #100 to #101 on the Licensee Order report.

Issued on this 18 day of June 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Amended by BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 20, 21, 22, 23, May 3, 2018

A complaint was received in March 2018, related to the licensee's investigation into an alleged altercation between a staff member and a resident.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, resident #101, registered staff, personal support workers, housekeepers and the resident's physician.

During the course of the inspection, the inspector reviewed the licensee's prevention of abuse policies and procedures, investigative documentation (emails, interview notes, letters), the resident's clinical records and staff work schedules.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

3 WN(s)
0 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	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. 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 residents from abuse by anyone, specifically physical abuse.

In February 2018, the licensee submitted a Mandatory Report as required under s.24(1) of the LTCHA, identifying that resident #101 had sustained an injury from an alleged altercation between themselves and an alleged staff member.

According to Resident #101, who was interviewed several times during the inspection in March 2018, the alleged employee was a personal support worker (PSW) known to the resident and the PSW had occasionally assisted the resident with their care. Although the resident could not remember the exact date of the altercation, they recalled that it occurred several days to a week prior to the date the injury was first identified by a staff member. The resident stated that there were no witnesses at the time of the altercation but that they reported the incident to a staff member. The resident provided a detailed physical description of the alleged PSW. The resident stated that after the altercation, they did not see the same PSW working in their home area again.

The Administrator, who began an investigation into the altercation three days after the injury was first observed by staff, concluded on their "Complaint Investigation" form, that "no suspect" was identified and the "exact cause of the resident's injury was undetermined" and the case was closed.

During the inspection, based on the details provided by resident #101, one PSW matched the physical description and the time frame worked in the resident's home area. The alleged PSW #010 was interviewed on the last date of inspection and confirmed that they knew resident #101, had provided care to the resident in the recent past and that they worked on the resident's home area one week prior, and not thereafter. The alleged PSW denied the allegation of having any altercations with the resident.

Interviews were held with staff members #005, #008, #018 and #019 during the inspection, all who knew resident #101. Staff members #018 and #019 both stated that the resident had a good memory in general. Based on the resident's clinical records, the resident was capable of making their own daily decisions and was independent for all activities of daily living.

The resident's family member was interviewed in March 2018, who provided information that they had visited the resident two days after the injury was identified. At that time, the resident's family member acquired additional details from the resident about the altercation and the alleged PSW's physical attributes. The additional details were emailed to the home's Director of Care and

Administrator the following day.

The resident's physician, who was interviewed in May 2018, reported that the type of injury the resident sustained took no more than one week to form. PSW #007, who was interviewed in March 2018, said they spoke with resident #101 one day before the injury was identified, and at that time the resident showed the PSW their injury and said that it hurt. The PSW stated that the resident's injury was not obvious at the time. By the following day, the injury had progressed and the details documented by RPN #004 in the resident's clinical record.

Based on the resident's account of the incident, along with other facts gathered during the interviews and the clinical records, the evidence supports that the resident was injured by a PSW in the home and that the licensee failed to protect the resident from physical abuse. [s. 19. (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:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that appropriate action was taken in response to an allegation of abuse of a resident by anyone.

In February 2018, the licensee submitted a Mandatory Report as required under s.24(1) of the LTCHA, identifying that resident #101 had sustained an injury from an alleged altercation between themselves and an alleged staff member.

According to Resident #101, who was interviewed several times during the inspection in March 2018, the alleged employee was a personal support worker (PSW) known to the resident for over three years and the PSW had occasionally assisted the resident with their care. Although the resident could not remember the exact date of the altercation, they recalled that it occurred several days to a week prior to the date the injury was identified by a staff member. The resident stated that there were no witnesses at the time of the altercation but that they reported the incident to a staff member. The resident provided a detailed physical description of the alleged PSW. The resident stated that after the altercation, they did not see the same PSW working in their home area again.

The alleged PSW #010 was interviewed in May 2018, and confirmed that they knew resident #101, had provided care to the resident in the recent past and that they worked on the resident's home area one week prior and not thereafter. The

alleged PSW denied the allegation of having any altercations with the resident.

The Administrator, reported to the inspector in March 2018, that their internal investigation was conducted by a nurse consultant from their corporate office and herself. Their Director of Care was not in the home to assist during the investigation. The nurse consultant and Food Services Supervisor confirmed for the inspector in March 2018, that they had conducted interviews of employees who worked on the resident's home area on two specified dates in February 2018.

The administrator concluded on their "Complaint Investigation" form, that "no suspect" was identified and the "exact cause of the the resident's injury was undetermined" and the case was closed.

During the inspection, it was determined that, although the resident was not given the opportunity to see the alleged PSW after the incident, the resident's statement of account, along with other facts gathered support that the resident was injured by a PSW in the home. The interview notes, documentation, emails and resident clinical records that were collected by the administrator and nurse consultant revealed minimal investigative efforts to narrow down and identify the alleged PSW.

The nurse consultant limited their documented interviews to employees who worked only on the day the injury was identified, although they reported that others who worked the day before, where also interviewed, but no written statements were taken.

Interview with the resident in March 2018, included a detailed account of the incident, a description of the person, what they wore, place and the time of day it occurred. The resident was also able to provide information that the PSW who allegedly physically abused the resident, had worked in their home area before, but not again after the incident. According to PSWs #006, #018 and #019, the resident had a fairly good memory and was independent with activities of daily living. The nurse consultant stated that they spoke to the resident, however they did not document what details, if any, were provided to them by the resident regarding the incident.

The resident's physician, who was interviewed in May 2018, reported that the type of injury the resident sustained took no more than one week to form. PSW #007, who was interviewed in March 2018, said they spoke with resident #101 one day

before the injury was identified, and at that time the resident showed the PSW their injury and said that it hurt. The PSW stated that the resident's injury was not obvious at the time. By the following day, the injury had progressed and the details documented by RPN #004 in the resident's clinical record.

In May 2018, PSW #018, when interviewed, reported that based on their suspicions, after they spoke with resident #101, they went to see the Director of Care, in March 2018. The PSW felt that no action was being taken to deal or manage what happened to resident #101 in February 2018, as they continued to see the alleged PSW working.

The actions taken in response to an allegation of abuse of a resident by anyone were minimal in this case, as the licensee did not take into account all relevant factors that were available to them. The Administrator and nurse consultant did not expand their evidence gathering process to include additional staff members, did not develop adequate questionnaires and ensure that staff and witness statements were properly documented and reviewed by the interviewee and did not include the progression of the injury as a clue to the date the injury was acquired. [s. 23. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 that a resident was improperly treated or abused by another person that resulted in harm to the resident, immediately reported the information upon which it was based to the Director.

In February 2018, according to PSW #006 and according to progress notes, PSW #006 discovered that resident #101 had an injury. The PSW reported the incident to RPN #004. RPN #004 reported the injury to RN #003 and the RN directed RPN #004 to make a note in the resident's clinical record of the details provided to them by the resident and the need to contact the resident's family. No person reported the suspected or alleged story of improper treatment or physical abuse to management staff and no further actions were taken by the registered staff. According to the Administrator, who was interviewed in March 2018, registered staff who worked on the days following the resident's claim of being hurt by someone, and had become aware of the incident via the resident's progress notes, also failed to report the information to the Administrator, who was on call that weekend.

Once the resident's family member visited with the resident and obtained all of the necessary details from the resident two days after the injury was first identified, the management staff were notified the following day. The details that were provided by the resident and acquired by the family member were very specific, including a description of an employee and a complete account of the details of the altercation between the resident and the employee were provided. The Administrator subsequently reported the incident to the Director of the MOHLTC in February 2018. [s. 24. (1)]

Issued on this 18 day of June 2018 (A1)

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2018_539120_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 004301-18, 004616-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 18, 2018;(A1)

Licensee / Titulaire de permis :
Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9

LTC Home / Foyer de SLD :
Extendicare Halton Hills
9 Lindsay Court, Georgetown, ON, L7G-6G9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Emily Bosma

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee must be compliant with s.19(1) of the LTCHA.

The licensee shall prepare, submit and implement a plan that summarizes how resident #101, or any other resident will be protected from harm or abuse by any employee or volunteer of the home. The plan must include, but is not limited to identifying what actions need to be taken by the licensee to ensure that employees are following the licensee's prevention of abuse and neglect policies and procedures, specifically with respect to reporting suspicions or allegations of abuse and subsequently taking appropriate actions to investigate allegations of abuse.

Please submit the written plan for achieving compliance to Bernadette Susnik, LTC Homes Inspector, MOHLTC, by email to Bernadette.susnik@ontario.ca by July 6, 2018.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone, specifically physical abuse.

In February 2018, the licensee submitted a Mandatory Report as required under s.24(1) of the LTCHA, identifying that resident #101 had sustained an injury from an

alleged altercation between themselves and an alleged staff member.

According to Resident #101, who was interviewed several times during the inspection in March 2018, the alleged employee was a personal support worker (PSW) known to the resident and the PSW had occasionally assisted the resident with their care. Although the resident could not remember the exact date of the altercation, they recalled that it occurred several days to a week prior to the date the injury was first identified by a staff member. The resident stated that there were no witnesses at the time of the altercation but that they reported the incident to a staff member. The resident provided a detailed physical description of the alleged PSW. The resident stated that after the altercation, they did not see the same PSW working in their home area again.

The Administrator, who began an investigation into the altercation three days after the injury was first observed by staff, concluded on their "Complaint Investigation" form, that "no suspect" was identified and the "exact cause of the resident's injury was undetermined" and the case was closed.

During the inspection, based on the details provided by resident #101, one PSW matched the physical description and the time frame worked in the resident's home area. The alleged PSW #010 was interviewed on the last date of inspection and confirmed that they knew resident #101, had provided care to the resident in the recent past and that they worked on the resident's home area one week prior, and not thereafter. The alleged PSW denied the allegation of having any altercations with the resident.

Interviews were held with staff members #005, #008, #018 and #019 during the inspection, all who knew resident #101. Staff members #018 and #019 both stated that the resident had a good memory in general. Based on the resident's clinical records, the resident was capable of making their own daily decisions and was independent for all activities of daily living.

The resident's family member was interviewed in March 2018, who provided information that they had visited the resident two days after the injury was identified. At that time, the resident's family member acquired additional details from the resident about the altercation and the alleged PSW's physical attributes. The additional details were emailed to the home's Director of Care and Administrator the following day.

The resident's physician, who was interviewed in May 2018, reported that the type of injury the resident sustained took no more than one week to form. PSW #007, who was interviewed in March 2018, said they spoke with resident #101 one day before the injury was identified, and at that time the resident showed the PSW their injury and said that it hurt. The PSW stated that the resident's injury was not obvious at the time. By the following day, the injury had progressed and the details documented by RPN #004 in the resident's clinical record.

Based on the resident's account of the incident, along with other facts gathered during the interviews and the clinical records, the evidence supports that the resident was injured by a PSW in the home and that the licensee failed to protect the resident from physical abuse

This Compliance Order (CO) is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope (pervasiveness), severity (of the harm or risk of harm) and history of non-compliance. In relation to s. 19(1) of the Long Term Care Homes Act, the scope of the non-compliance was isolated, as one resident was harmed, the severity of the non-compliance was actual harm and the history of non-compliance was a level 3 as 1 or more related non-compliance was issued in the last 36 months. Previously issued non-compliance included;

• A Voluntary Plan of Compliance made under s.19(1) which was issued on December 5, 2016 (2016-215123-0012)
• A Voluntary Plan of Compliance made under s.20(1) which was issued on November 16, 2017 (2017-482640-0013) (120)

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

Jul 06, 2018(A1)

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 18 day of June 2018 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by BERNADETTE SUSNIK - (A1)

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

Service Area Office / Bureau régional de services : Central West