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

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
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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
Jul 30, 2021	2021_650565_0008 (A1)	000401-21, 001668-21	Complaint

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street Toronto ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street North York ON M6A 2E1

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

Amended by MATTHEW CHIU (565) - (A1)

Amended 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): March 26, 29-31, April 6-9, 12-15, and 19-22, 2021.

The following intakes were completed in this complaint inspection:

Log #000401-21 was related to unexpected death of a resident; and

Log #001668-21 was related to prevention of abuse and neglect, and alleged improper care of a resident.

Voluntary Plans of Correction related to LTCHA, s. 6 (10) (c) and s. 19 (1) were identified in a concurrent inspection #2021_650565_0006 and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Long-Term Care Managers (LTCMs), Director of Infection Prevention and Control (DOIPAC), Occupational Health and Safety Manager (OHSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Medical Doctors (MDs), Investigative Coroner (IC), Occupational Therapist (OT), Recreationist, Assistant to Executive Director, Residents, and Family Members.

During the course of the inspection, the inspector observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:

Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

3 WN(s)
3 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 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 :

(A1)
1. a) The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

Section 5 of O. Reg 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

A resident had been identified with impaired physical and cognitive functioning, and at risk for aspiration. They required assistance for feeding and their plan of care specified the feeding and eating guidelines.

Staff members reported they normally fed the resident slowly and specified the approximate time required to finish their meal. If the resident coughed during feeding, staff were to ensure they returned to their normal breathing and state before continuing. If staff suspected the resident might have been choking, they should report to the registered staff immediately.

During mealtime, the resident was fed by a PSW in their room in the presence of a family member. The feeding lasted approximately less than half of the time specified above by other staff members. Documentation showed the resident consumed most of their meal.

The family member stated that, at times during the feeding, the resident was not opening their mouth to eat. When the resident ate, they demonstrated certain signs and symptoms, and the PSW did not wait for the resident to return to normal, calm breathing before continuing with feeding. Shortly after the PSW finished feeding the resident, the family member observed a change in the resident’s condition. While the PSW was still in the room, the family notified the PSW.

The PSW indicated on that day, they followed the guidelines in place for feeding the resident. They reported the resident was alert and showed some signs of difficulty when swallowing. The PSW indicated they waited for the resident to return to baseline before continuing to feed them, and they did not observe any distress. The PSW stated they stopped feeding the resident because they observed them demonstrating other signs and symptoms and they reported to the

RPN.

The RPN stated the PSW reported the resident’s specified condition and asked the RPN to check on the resident. The RPN, in the presence of a RN, assessed the resident and initiated a specified therapy for the resident. The registered staff did not observe signs of choking. Subsequently, orders were received from the MD and were administered to the resident. The resident’s condition deteriorated and the resident’s substitute decision-maker (SDM) was contacted for transferring the resident to the hospital. After the paramedics arrived, the resident was found to have a significant change in their condition.

Based on the findings, choking had occurred in the presence of the PSW. The home failed to ensure that the resident was not neglected by the licensee or staff related to:
- The PSW failed to observe that the resident had the specified signs and symptoms, not returned to their normal state, before continuing to feed the resident; and
- No emergency care such as Heimlich Maneuver or airway suctioning was attempted.

Sources: Family member’s records; the resident’s clinical records; the home’s investigation notes; and interviews with the family members, the PSW, the registered staff and others.

b) The licensee has failed to ensure that a resident was protected from abuse by anyone.

Section 2 (1) of O. Reg 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

A resident wandered into another resident’s room. The resident who resided in the room hit the co-resident and caused an injury. The LTCM identified and reported this incident to the Ministry of Long Term Care as abuse of a resident.

Sources: The CIS report; the residents' progress notes; and interview with the PSW. [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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 residents are protected from abuse by anyone, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident.

A resident had been identified with impaired physical and cognitive functioning, and at risk for aspiration. The family member was involved in the development and implementation of the resident’s specified care. The family member found, on multiple occasions, that the care was not given as it was supposed to. The family member contacted the OT to follow-up.

The resident’s plan of care did not set out instructions for the specified care.

Staff reported the specified care had been implemented for the resident for at least several months. They did not recall if the care was specified in the resident’s written plan of care.

Sources: The family’s records; the resident’s clinical records; and interviews with the family member, and staff. [s. 6. (1) (a)]

2. a) The licensee has failed to ensure that a resident’s specified plan of care was reviewed and revised at least every six months.

The resident received an assessment approximately over a year ago, and it set out the recommended guidelines for specified care.

The home had included the assessment and recommended guidelines as part of the resident’s plan of care. Further review of the resident’s plan of care indicated no documented records of the guidelines had been reviewed and revised since the assessment.

Staff confirmed the recommended guidelines were part of the resident’s plan of care and they had no recollection if they were reviewed and revised at least every six months.

Sources: The resident’s clinical records; and interviews with the PSWs, RPN, and the LTCM.

b) The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan had not been effective.

A resident’s plan of care set out the fluid intake requirement at admission as per the home’s policy. Over an approximately 10-day period after admission, the resident did not meet the requirement. The resident's family and staff noted that the resident experienced a change in their condition. The family member raised their concerns to the staff.

Subsequently, the RD assessed the resident, revised their daily requirement, and the resident was meeting only a certain per cent of their needs. The RD stated it would warrant a revision of the plan of care for an intervention. The RD did not recollect if the plan of care was revised and acknowledged that this revision was not documented.

An interview with another RD indicated that if a resident was not meeting a specified per cent of their fluid need, the plan of care should be reviewed and revised.

The resident continued to consume less than their daily requirement, and was identified with health issues indicating a change in their status.

Sources: The resident's clinical records; the home's policy; and interviews with the RDs. [s. 6. (10)]

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:
- there is a written plan of care for each resident that set out the planned care for the resident; and
- the resident's plan of care is reviewed and revised at least every six months and when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint made to the licensee or a staff member concerning the care of a resident was dealt with as follows:
- A response shall be made to the person who made the complaint, indicating, i. what the licensee had done to resolve the complaint, or ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

A family member emailed the home regarding concerns about a resident's care. The family member stated they had not received a response to their complaint.

The email was brought to the LTCM’s attention on the same date, and the concerns were brought to interdisciplinary team meeting the next day. The LTCM stated the home had been working on resolving the care concerns, some had been addressed and some were ongoing. They did not recall acknowledging the receipt of the complaint or when they responded to the family member.

Sources: Home’s complaint records; the email records; interview with the family member, the LTCM and other staff. [s. 101. (1) 3.]

2. The licensee has failed to ensure that for the written complaint made to the licensee or a staff member concerning the care of a resident, a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

A review of the home’s complaint records over a seven-month period did not contain any documented record related to the above-mentioned email complaint. The LTCM stated the home used their complaint tracking tool to document record of a complaint and acknowledged they did not keep a documented record for the complaint.

Sources: The home’s complaint records; the email records; and interviews with the family member, the LTCM and other staff. [s. 101. (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
- A written complaint made to the licensee or a staff member concerning the care of a resident is dealt with as follows: A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief; and
- For written complaints made to the licensee or a staff member concerning the care of a resident, a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant, to be implemented voluntarily.

Issued on this 30th day of July, 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 MATTHEW CHIU (565) - (A1)
Inspection No. / No de l'inspection :	2021_650565_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000401-21, 001668-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 30, 2021(A1)
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, Toronto, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, North York, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Simon Akinsulie

To The Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1).
Specifically, the licensee must:
1. Provide additional training to all nursing staff on prevention of neglect related to:
i. identification of resident's signs and symptoms of choking and aspiration, including safe swallowing and feeding assistance;
ii. appropriate emergency treatments and actions to take when a resident has a potential choking or aspiration event;
2. Maintain the related training records that include, at a minimum, the following:
i. the method of the training and the training materials;
ii. list of all nursing staff members required to receive the training; and
iii. dates, names and signatures of staff members who received the training.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

Section 5 of O. Reg 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A resident had been identified with impaired physical and cognitive functioning, and

at risk for aspiration. They required assistance for feeding and their plan of care specified the feeding and eating guidelines.

Staff members reported they normally fed the resident slowly and specified the approximate time required to finish their meal. If the resident coughed during feeding, staff were to ensure they returned to their normal breathing and state before continuing. If staff suspected the resident might have been choking, they should report to the registered staff immediately.

During mealtime, the resident was fed by a PSW in their room in the presence of a family member. The feeding lasted approximately less than half of the time specified above by other staff members. Documentation showed the resident consumed most of their meal.

The family member stated that, at times during the feeding, the resident was not opening their mouth to eat. When the resident ate, they demonstrated certain signs and symptoms, and the PSW did not wait for the resident to return to normal, calm breathing before continuing with feeding. Shortly after the PSW finished feeding the resident, the family member observed a change in the resident's condition. While the PSW was still in the room, the family notified the PSW.

The PSW indicated on that day, they followed the guidelines in place for feeding the resident. They reported the resident was alert and showed some signs of difficulty when swallowing. The PSW indicated they waited for the resident to return to baseline before continuing to feed them, and they did not observe any distress. The PSW stated they stopped feeding the resident because they observed them demonstrating other signs and symptoms and they reported to the RPN.

The RPN stated the PSW reported the resident's specified condition and asked the RPN to check on the resident. The RPN, in the presence of a RN, assessed the resident and initiated a specified therapy for the resident. The registered staff did not observe signs of choking. Subsequently, orders were received from the MD and were administered to the resident. The resident's condition deteriorated and the resident's substitute decision-maker (SDM) was contacted for transferring the resident to the hospital. After the paramedics arrived, the resident was found to have a significant change in their condition.

Based on the findings, choking had occurred in the presence of the PSW. The home failed to ensure that the resident was not neglected by the licensee or staff related to:
- The PSW failed to observe that the resident had the specified signs and symptoms, not returned to their normal state, before continuing to feed the resident; and
- No emergency care such as Heimlich Maneuver or airway suctioning was attempted.

Sources: Family member's records; the resident's clinical records; the home's investigation notes; and interviews with the family members, the PSW, the registered staff and others.

An order was made by taken the following factors into account:
Severity: A resident was neglected by staff causing actual harm to the resident.
Scope: This was an isolated case as one out of the three residents reviewed was neglected by staff.
Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1). One written notification (WN); two voluntary plans of correction (VPC); and one compliance order (CO), which has been complied; were issued to the home. (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2021

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:

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

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 30th day of July, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MATTHEW CHIU (565) - (A1)

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