Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

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
Jan 08, 2020	2019_549107_0012 (A1)	010184-19, 010185-19	Follow up

Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

Amended by MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested amendment to the compliance due date. Compliance date has been amended to January 31, 2020.

Issued on this 8 th day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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101 Creighton Road DUNDAS ON L9H 3B7

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

Amended by MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 22, 23, 26, 27, 28, 29, September 3, 4, 5, 6, 10, 11, 2019.

This Follow Up Inspection was completed concurrently with the following

inspections:

Critical Incident System Inspection 2019_549107_011 / 014961-19, 015464-19,

Complaint Inspection 2019_549107_0010 / 026278-18, 031218-18.

The following intakes were included in this Follow Up Inspection:

Log #010184-19 related to CO#002 from inspection #2019_532590_0013 / 005252-18, 006388-18, 008452-18, 008732-18, 021964-18, 033163-18 regarding LTCHA, 2007, s. 6(7), Compliance Due Date (CDD) June 21, 2019,

Log #010185-19, related to CO#001 from inspection #2019_532590_0013 / 005252 -18, 006388-18, 008452-18, 008732-18, 021964-18, 033163-18 regarding O.Reg. 79/10, s. 50(2), CDD June 21, 2019.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7), and a Written Notification and Voluntary Plan of Correction related to O.Reg. 79/10, s. 30(2), identified in concurrent inspection #2019_549107_0011 (Log # 014961-19 CIS #2641-0000012-19, and Log # 015464-19 CIS #2641-0000013-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care, Registered Nursing Staff (RN, RPN), Personal Support Workers (PSW), Wound Care Nurses, RAI-Co-ordinator, Physiotherapist (PT), Quality Manager, and the Dietary and Environmental Manager.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

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

2 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2019_532590_0013	107

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. 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 failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan related to the prevention of falls and falls management.

The following information was identified in resident #001's clinical health record, including progress notes, care plan, and assessments, and documentation provided to the Ministry of Health and Long Term Care through the Critical Incident System:

Resident #001 had a fall on a specified date that resulted in injury to the resident. The resident had a history of falls with injury.

After the fall with injury, staff completing documentation in the post fall period identified the need for a specific intervention for the resident's safety. The intervention was not implemented.

Staff continued to request the specific fall prevention intervention three more times within a one week period, as indicated in the resident's clinical health record. The specific strategy was not implemented for over two weeks and the resident had subsequent falls and injury while the strategy was not in place.

During interview with Inspector #107, the Quality Manager (#119), stated that they were responsible for implementing the specific falls prevention strategy. Quality Manager #119 confirmed they were the only staff that knew the process for implementing the strategy and during the time frame when resident #001 required the strategy, the Quality Manager was away from the home. Quality Manager #119 identified that a back up system was not in place to ensure that staff were able to implement the falls prevention strategy when the Quality Manager was away from the building. A back up system had not been implemented as of the date of this Ministry of Health and Long Term Care (MOHLTC) inspection.

Resident #001 was not provided a specific falls prevention intervention, which was identified as required in their plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to residents #002, #006, and #007, under the skin and wound care program, including assessments, reassessments, interventions and the residents' responses to interventions were documented.

A. Resident #006 required specific interventions related to skin and wound management. Interventions identified on the Treatment Assessment Record (TAR) required staff to apply the intervention and sign at specific times. The treatment records were reviewed over a two month period and the treatment was not signed as provided on 23 dates/times.

During interview with Inspector #107, Wound Care Nurse #116 stated that the computer system was set up for recording the data at specific times which were after the Wound Care Nurse's shift had finished. The Wound Care Nurse stated that the interventions were being applied, however, not documented due to the computer system set up or the resident did not require the intervention. The

Wound Care Nurse confirmed that refusals or not applicable was not recorded on the TAR at those times.

The resident stated to Inspector #107 that the interventions were not being applied, however, the Wound Care Nurse #116 stated the interventions were in place every time the resident was assessed. It was unclear if the intervention was applied as directed, however, the areas of skin impairment had not deteriorated.

The licensee did not ensure that actions taken with respect to resident #006, including reassessments, interventions, and the resident's responses to interventions, were documented.

B. According to TAR records and Physician orders, resident #007 required a specific treatment. Treatment Assessment Records (TAR) reflected the treatment was not signed as provided on three dates over a one week period.

During interview with Inspector #107, Wound Care Nurse #116 stated that the treatment was applied by floor nursing staff as the Wound Care Nurse's shift had ended at the time of the required treatment. The Wound Care Nurse confirmed the TAR was not being signed as completed. Wound Care Nurse #126 stated that in discussions with the evening nursing staff they believed the treatments were being provided as ordered and not documented. It is unclear from the documentation if the treatment was provided as ordered or refused, however, the area had not deteriorated.

According to the TAR records, resident #007 required a specific skin treatment with monitoring for areas of skin impairment. Treatment Assessment Records (TAR) were reviewed over a two month period, and documentation was incomplete on three days for the areas.

During interview with Inspector #107, resident #007 stated they received the treatment most days but when the Wound Care Nurse was away the treatment was not always provided.

During interview with Inspector #107 Wound Care Nurse #116 stated that documentation did not clearly reflect when the resident was unavailable or refused the treatment and the TAR was left incomplete at those times. It is unclear from the documentation on the TAR if the resident received the treatment on those days, however, documentation in the Wound Care Nurse's (#116) task

journal reflected that the treatments were completed but not documented on the resident's TAR.

C. TAR records indicated resident #002 required monitoring of an area of skin impairment. Treatment Assessment Records (TAR) over a one week period reflected that the monitoring record was not signed as completed on two days.

According to TAR records, resident #002 required monitoring of a different area of skin impairment. Documentation on the TAR reflected missing signatures on two days.

TAR records indicated the resident required an intervention for skin and wound management. Treatment Assessment Records were reviewed over a two month period and documentation was incomplete on four days.

The resident also required a different intervention and monitoring as indicated on the resident's TAR records. TAR documentation was incomplete on two dates.

During interview with Inspector #107, Wound Care Nurse #116 stated that the monitoring was completed as required on those dates, however was not documented. Documentation in the Wound Care Nurse's task journal reflected that the treatment/monitoring was completed, however, was not documented on the TAR.

D. Documentation on 2/3 residents reviewed related to skin and wound care management had discrepancies on the skin assessments related to the location of the altered skin integrity and it was unclear if the documentation reflected the actual reassessments and interventions provided to the resident.

i) Resident #006 had assessments on two specified dates that indicated an area of skin impairment in a specific location. On two other specified dates, the assessments identified two different locations of the same skin impairment within the same assessment. On another specified date, the assessment identified a different location than the originally identified location of the skin impairment.

During interview with Inspector #107, Wound Care Nurse #116 confirmed that it was only the original location that was affected and the assessments indicating the other location were incorrect. The area has since healed. Documented interventions and assessments were not reflective of the actual actions taken with

respect to resident #006's areas of skin impairment.

ii) Resident #007 had a skin and wound assessment indicating the resident had a new area of impairment in a specific location. Two subsequent assessments identified two different locations of the same skin impairment within the same assessment. During interview with Inspector #107, Wound Care Nurse #116 stated that the area of impairment was only on the original location and was written as the other locations in error. Documented interventions and assessments were not reflective of the actual actions taken with respect to resident #007's areas of skin impairment.

2. The licensee failed to ensure that any actions taken with respect to resident #001, under the Fall Prevention and Management Program, including assessments, reassessments, interventions, and the resident's responses to interventions, were documented.

,
The written plan of care for resident #001 provided specific directions for staff related to monitoring resident #001 when they were at increased risk of falling. During interview with Inspector #107, the Director of Care (DOC) (#101) and Physiotherapist (#125) identified specific times the resident would be at higher risk of falling.

Documentation in the resident's clinical health record indicated resident #001 had a documented un-witnessed fall on a specified date. The resident had additional subsequent falls, related to the times that the DOC and PT indicated the resident was at risk.

The DOC #101, RPN #120 and PSWs #118 and #121 confirmed that documentation for monitoring resident #001 was not completed during the times that the resident was at highest risk for falls, although RPN #120 stated during interview with Inspector #107 that they monitored the resident frequently. The DOC (#101) stated during interview with Inspector #107 that if the plan of care specifically directed staff to provide monitoring of the resident at particular times, that the specific monitoring records should have been in place.

Documentation did not reflect the frequency of monitoring on the dates of the fall incidents. [s. 30. (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 with O.Reg. 79/10, s. 30(2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 8 th day of January, 2020 (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 MICHELLE WARRENER (107) - (A1)
Inspection No. / No de l'inspection :	2019_549107_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010184-19, 010185-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 08, 2020(A1)
Licensee / Titulaire de permis :	Blackadar Continuing Care Centre Inc. 101 Creighton Road, DUNDAS, ON, L9H-3B7
LTC Home / Foyer de SLD :	Blackadar Continuing Care Centre 101 Creighton Road, DUNDAS, ON, L9H-3B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelly Desgagne

To Blackadar Continuing Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_532590_0013, CO #002;

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 :

The licensee must be compliant with LTCHA, 2007, s. 6(7).

Specifically, the licensee must:
A) Develop and implement a process to ensure that any equipment required for resident safety is available at all times as needed, and that the equipment can be implemented when required.
B) Educate all managers and direct care staff on the process that was developed and implemented related to safety equipment.
C) Keep a documented record of the training provided to managers and direct care staff.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan related to the prevention of falls and falls management.

The following information was identified in resident #001's clinical health record, including progress notes, care plan, and assessments, and documentation provided to the Ministry of Health and Long Term Care through the Critical Incident System:

Resident #001 had a fall on a specified date that resulted in injury to the resident. The resident had a history of falls with injury.

After the fall with injury, staff completing documentation in the post fall period identified the need for a specific intervention for the resident's safety. The intervention was not implemented.

Staff continued to request the specific fall prevention intervention three more times within a one week period, as indicated in the resident's clinical health record. The specific strategy was not implemented for over two weeks and the resident had subsequent falls and injury while the strategy was not in place.

During interview with Inspector #107, the Quality Manager (#119), stated that they were responsible for implementing the specific falls prevention strategy. Quality Manager #119 confirmed they were the only staff that knew the process for implementing the strategy and during the time frame when resident #001 required the strategy, the Quality Manager was away from the home. Quality Manager #119 identified that a back up system was not in place to ensure that staff were able to implement the falls prevention strategy when the Quality Manager was away from the building. A back up system had not been implemented as of the date of this Ministry of Health and Long Term Care (MOHLTC) inspection.

Resident #001 was not provided a specific falls prevention intervention, which was identified as required in their plan of care. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed for falls management. The home had a level 5 history of on-going non-compliance with this subsection of the Act that included:
Voluntary Plan of Correction (VPC) issued February 13, 2018, (2017_555506_0027), and
Compliance Order (CO) issued May 14, 2019, (2019_532590_0013)

Additionally, the LTCH has a history of nine other compliance orders in the last 36 months.

(107)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 8 th day of January, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MICHELLE WARRENER (107) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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