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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie 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 28, 2022	2022_918426_0001	010699-21, 014325-21, 000416-22, 000764-22	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Bloomington Cove Care Community
13621 Ninth Line Stouffville ON L4A 3C8

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

FRANK GONG (694426), ERIC TANG (529)

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): January 13, 14, 18, 19, and 20, 2022

The following intakes were completed during this Inspection:
000416-22 related to a complaint regarding the home's recreational program, nutrition and hydration program, continence care, and plan of care
000764-22 related to a complaint regarding staffing and the home's Infection Prevention and Control program, critical incident reporting, and availability of supplies
010699-21 related to a complaint regarding staffing and plan of care
014325-21 related to a complaint regarding continence care, nutrition and hydration, the home's recreational program, Infection Prevention and Control program, and plan of care

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Environmental Services Manager, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Recreational Therapist, Recreational Therapist Assistant, Personal Support Workers (PSW), Housekeepers, and residents.

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions, reviewed clinical health records, staff schedules, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities

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

4 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Public Health declared the home to be in COVID-19 outbreak, and multiple staff and residents tested positive for the virus. As per directions from the local public health unit, all residents in the home were placed on additional droplet and contact precautions, and staff were required to wear N95 masks when in direct contact with the residents.

Observations were conducted during the inspection and the following concerns were identified:

Additional droplet and contact precaution signs were missing from some resident rooms, and incorrect precaution signs were posted on some resident rooms. DOC acknowledged that correct droplet and contact precaution signs should have been placed on resident rooms that required such.

Staff and caregivers were observed feeding residents on additional droplet and contact precautions in their room without eye protection.

Staff assisted a resident that required additional droplet and contact precautions without eye protection. DOC verified that full Personal Protective Equipment (PPE), including eye protection, should have been worn to provide care to residents that require additional droplet and contact precautions.

Multiple staff members were observed exiting resident rooms that required additional droplet and contact precautions without disinfecting their eye protection. DOC verified that eye protection should have been disinfected upon leaving a room with additional droplet and contact precautions.

Observations made on an outbreak home area noted that food was delivered to resident rooms by staff; however, hand hygiene was not provided for the residents. Staff indicated that they were not aware that hand hygiene was required to be provided to residents prior to meals, only after. DOC verified that hand hygiene should have been performed for residents prior to and after meals.

Staff indicated that due to time constraints, on a non-outbreak home area, high touch surface areas in resident rooms may be disinfected at a frequency of fewer than once per day. Another staff indicated that on an outbreak home area, high touch surface areas were only disinfected at a frequency of once per day for a specified period. DOC verified that high touch surface areas should have been disinfected at a minimum of once per day in non-outbreak home areas and twice per day in outbreak home areas.

Multiple observations made on a home area noted that there were no housekeeping staff present. Discussions with multiple staff indicated that no housekeepers were available for the specified home area. Staff were not made aware of any backup staffing plans regarding the disinfection of high touch surface areas when no housekeepers are available. It was noted that garbage cans were overflowing with discarded PPE in multiple resident rooms. When discussed with DOC and Environmental Services Manager, it was indicated that PSWs were to disinfect high touch surface areas should housekeepers not be available; however, staff indicated that they were not aware of this, nor was it indicated in the home's staffing plan.

Failure to ensure that staff participated in the implementation of the infection prevention and control program may lead to further transmission of disease.

Sources: Critical Incident Report, observations, Bloomington Cove Care Community Staffing Plan Requirements, Cleaning During Outbreak Conditions Policy, interview with DOC, Environmental Services Manager, and other staff.

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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 expressed pain, they were assessed using a clinically appropriate assessment instrument.

The home required that a resident be assessed for pain through a pain study tool when a scheduled medication regimen does not relieve pain.

Resident #001 expressed pain and exhibited specified behaviours on specified dates. PRN pain medication was administered on specified dates; however, clinically appropriate pain assessments were not completed during that period. The resident was transferred to the hospital, and a specified injury was identified.

Registered staff #117 and #115 verified that when resident #001 expressed pain, clinically appropriate pain assessments should have been completed but were missed.

Failure to ensure that when a resident expressed pain, they were assessed by a clinically appropriate pain assessment instrument may result in unnecessary pain, delay in receiving treatment, and further injury.

Sources: Resident #001's assessments, medication administration records, care plan, Minimum Data Set assessments, and progress notes, Pain & Symptom Management Policy (#VII-G-30.30, revised April 2019), interview with registered staff #117, #115, and DOC.

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, of an outbreak of a disease of public health significance, as defined in the Health Protection and Promotion Act.

Public Health declared the home to be in COVID-19 outbreak on a specified date; however, the Director was not informed until specified date, when a critical incident report was submitted.

DOC verified that the Director should have been immediately informed through the afterhours line but was not done.

Sources: Critical Incident Report and interview with DOC

2. The licensee has failed to ensure that the Director was informed of resident #001 and #007's incidents with injury, that resulted in transfer to hospital and significant changes in health condition.

Resident #001 was transferred to hospital on a specified date and returned with a specified injury diagnosis. MDS assessments completed indicated significant change in status. A critical incident report was not submitted to the Director.

Resident #007 had a specified incident; a specified injury was noted on a specified date and they were subsequently sent to the hospital. Resident #007 returned from hospital with a specified injury diagnosis. A critical incident report was not submitted to the Director.

After presentation of evidence and discussion with DOC, it was acknowledged that critical incident reports should have been submitted to the Director but was not done.

Sources: Resident #001 and #007's progress notes, resident #001's Minimum Data Set assessments, interview with DOC.

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 Director is informed, of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition; and immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions were applied by the registered staff for resident #005 as per their plan of care.

Resident #005's plan of care identified specified interventions to be applied by registered staff at specified times.

An observation made with RPN #103 noted that specified interventions were not applied. RPN #103 indicated adverse effects should specified intervention not be applied for resident #005.

An interview with the DOC confirmed that nursing staff were expected to follow resident #005's plan of care and failure to do such may adversely affect resident #005's quality of life.

Sources: Resident #005's plan of care, observations, and interviews with RPN #103 and DOC.

Issued on this 28th day of January, 2022

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANK GONG (694426), ERIC TANG (529)
Inspection No. / No de l'inspection :	2022_918426_0001
Log No. / No de registre :	010699-21, 014325-21, 000416-22, 000764-22
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 28, 2022
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Bloomington Cove Care Community 13621 Ninth Line, Stouffville, ON, L4A-3C8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Iwaszczenko

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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of Ontario Regulations 79/10.

Specifically, the licensee must:
1. Ensure daily audits are completed for all home areas and records maintained related to appropriate PPE adherence and disinfection.
2. Ensure hand hygiene is provided to residents prior to and after meals and snacks.
3. Complete audits and maintain records to ensure all high touch surface areas are disinfected at a minimum frequency of once per day in non-outbreak home areas and twice daily in outbreak home areas.
4. Provide on the spot education to correct improper practices identified related to the home's IPAC program and maintain records of such.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Public Health declared the home to be in COVID-19 outbreak, and multiple staff and residents tested positive for the virus. As per directions from the local public health unit, all residents in the home were placed on additional droplet and contact precautions, and staff were required to wear N95 masks when in direct contact with the residents.

Observations were conducted during the inspection and the following concerns were identified:

Additional droplet and contact precaution signs were missing from some resident rooms, and incorrect precaution signs were posted on some resident rooms.

DOC acknowledged that correct droplet and contact precaution signs should have been placed on resident rooms that required such.

Staff and caregivers were observed feeding residents on additional droplet and contact precautions in their room without eye protection.

Staff assisted a resident that required additional droplet and contact precautions without eye protection. DOC verified that full Personal Protective Equipment (PPE), including eye protection, should have been worn to provide care to residents that require additional droplet and contact precautions.

Multiple staff members were observed exiting resident rooms that required additional droplet and contact precautions without disinfecting their eye protection. DOC verified that eye protection should have been disinfected upon leaving a room with additional droplet and contact precautions.

Observations made on an outbreak home area noted that food was delivered to resident rooms by staff; however, hand hygiene was not provided for the residents. Staff indicated that they were not aware that hand hygiene was required to be provided to residents prior to meals, only after. DOC verified that hand hygiene should have been performed for residents prior to and after meals.

Staff indicated that due to time constraints, on a non-outbreak home area, high touch surface areas in resident rooms may be disinfected at a frequency of fewer than once per day. Another staff indicated that on an outbreak home area, high touch surface areas were only disinfected at a frequency of once per day for a specified period. DOC verified that high touch surface areas should have been disinfected at a minimum of once per day in non-outbreak home areas and twice per day in outbreak home areas.

Multiple observations made on a home area noted that there were no housekeeping staff present. Discussions with multiple staff indicated that no housekeepers were available for the specified home area. Staff were not made aware of any backup staffing plans regarding the disinfection of high touch surface areas when no housekeepers are available. It was noted that garbage cans were overflowing with discarded PPE in multiple resident rooms. When discussed with DOC and Environmental Services Manager, it was indicated that

PSWs were to disinfect high touch surface areas should housekeepers not be available; however, staff indicated that they were not aware of this, nor was it indicated in the home's staffing plan.

Failure to ensure that staff participated in the implementation of the infection prevention and control program may lead to further transmission of disease.

Sources: Critical Incident Report, observations, Bloomington Cove Care Community Staffing Plan Requirements, Cleaning During Outbreak Conditions Policy, interview with DOC, Environmental Services Manager, and other staff.

An order was made by taking the following factors into account:

Severity: The home was declared to be on outbreak and remained in such throughout the course of the inspection. Failure to adhere to appropriate IPAC practices may increase the risk of disease transmission; thus, the severity was an actual risk of harm.

Scope: This issue was widespread since numerous staff members from different home areas were identified with incorrect IPAC practices related to adherence of PPE and disinfection of such. High touch surface areas were disinfected at a lower frequency than minimally required for two home areas.

Compliance History: In the past 36 months, the licensee was found to be non compliant with s. 229 (9) of Ontario Regulation 79/10, and one VPC was issued under section 229. (694426)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 03, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 28th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Frank Gong

Service Area Office /
Bureau régional de services : Central East Service Area Office