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 West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
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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
Aug 20, 2021	2021_739694_0021	004962-21, 009897-21	Complaint

Licensee/Titulaire de permis

CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 Cambridge ON N3H 5L8

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

Errinrung Long Term Care Home
67 Bruce Street P.O. Box 69 Thornbury ON N0H 2P0

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

AMANDA COULTER (694)

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): July 21, 22, 23, 26 and 27, 2021.

The following intakes were inspected during this complaint inspection;
Log #009897-21, regarding care concerns, and Log #004962-21, regarding falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aid, family members and residents.

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, policies and procedures, internal investigation and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A resident required assistance from two staff for safe transferring, as outlined in their plan of care. On a specific date, a staff member independently transferred the resident. During the transfer, an incident occurred and the resident was observed to be in significant pain after the incident. The resident was transferred to hospital and diagnosed with a medical injury. The resident passed away approximately one month later for reasons related to their injuries.

A staff member did not use safe techniques while transferring a resident, which resulted in actual harm to the resident.

Sources: CIS report, the home's Internal Investigation, resident's care plan, DOC interview. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee shall ensure that the care provided to a resident was documented.

Staff observed a resident had increased pain. The home's internal investigation identified that the resident had sustained an injury after an improper transfer. Staff had not completed documentation of the care provided to the resident on the date of the incident.

As a result of staff not documenting the care they provided, including the transfer and incident involving the resident, the home was unaware of the incident, which may have delayed the resident's assessment and treatment of their injuries.

Sources: Resident's POC documentation, DOC interview, home's investigation notes. [s. 6. (9) 1.]

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 care provided to residents is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents and locked when not supervised by staff.

A small door was seen on the wall of the south unit which was unsupervised. On Tuesday July 27, 2021, the inspectors noted that the lock, when engaged could be opened without a key or code. The opening was 14.5 inches by 20 inches and was approximately three feet off the ground. A PSW said the opening was a laundry chute that lead to a large bin that collected dirty linen bags.

There was potential risk of harm to residents if they were to enter the unlocked door and fall down the laundry chute.

Sources: Observations, interview with PSW and ED. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and are locked when not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements were kept.

As of May 15, 2021, Ontario Regulation 79/10 included additional amendments related to cooling requirements and air temperatures in the LTC home.

The home was required to at a minimum measure and document in writing the air temperatures in the following areas of the home: two resident bedrooms in different parts of the home, and one resident common area on every floor of the home. These temperatures were required to be documented at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night.

Air/humidity monitoring records, for the North wing and South wing, were provided to the inspectors. A nursing staff member was responsible to measure and document the air temperature of one resident room and one common area on the day shift, evening shift and night shift. Of the 126 required temperature entries, 16 of the entries were blank

Failure to measure and document temperatures as required, could result in the home being unaware of increasing temperatures in the home, which could place residents at risk for heat related illnesses.

Sources: Air/humidity and water monitoring record for July 2021, inspector tested air temperatures, interviews with ED and DOC. [s. 21. (3)] [s. 21. (3)]

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 air temperature is measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements are kept, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure maintenance services were available in the home seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems were maintained in good repair.

A complaint was reported to the Ministry of Long-Term Care (MLTC) regarding the state of poor repair and appearance of the home. The ED said the home had not had a maintenance manager or any maintenance staff since the end of June, 2021. The home used an electronic Maintenance Care system, where staff alerted the maintenance staff about items that required repair; however, this system was no longer being monitored, and requests were not being actioned.

During the course of the inspection, the following was observed:

On July 22, and 23, 2021, a resident bathroom had a paper towel dispenser that had come off the wall and was sitting on the floor. As a result, the paper towel was not accessible to residents. The inspectors informed the ED and DOC on Friday July 23, 2021, who were not aware the dispenser needed repair.

Flooring in the home, specifically the hallway from the north to south unit was cracked and had holes in the tiles.There were scratch marks from equipment on the walls, railings in common areas, resident washrooms and rooms. Some of the areas were covered with a poly fill or patching material. Baseboards in a resident room had separated and was peeling off the wall and had a one foot section missing.

The ceiling tiles in the south unit area were not secure. A number of tiles had been painted white after it appeared they had been wet, which caused the material to swell and lose their shape. A number of ceiling tiles were stained with yellow dried marks. Some ceiling tiles were missing, exposing pipes.

A staff member said repairs within the home were not being completed at this time. If staff could fix the issue, they would, or a contract service may be called in to repair if it was urgent. Staff also said there were no maintenance staff in the home for the past four weeks and items that required repair were to be reported to the person in charge.

As a result of maintenance services not being available in the home seven days per week, there were areas of the home that were not in a state of good repair; which may place residents at risk for health and safety concerns.

Sources: observations, interviews with staff. 90. (1) (a)]

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 maintenance services are available in the home seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair, to be implemented voluntarily.

WN #6: 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).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program was in

accordance with evidence-based practices related to the use of portable fans.

Public Health Ontario (PHO) "At a Glance: The use of portable fans and portable air conditioning units during COVID-19 in Long-Term Care and Retirement homes", document provided the following best practice guidance:

Portable fans can disperse dust particles and micro-organisms and change the airflow pattern. Also, portable fans can spread infectious droplets beyond two metres and contribute to COVID-19 transmission. Portable fans and air conditioning units should be turned off during aseptic or sterile procedures. When using a portable fan or air conditioning unit keep the fan setting to low in order to minimize turbulence and reduce particle spread.

Inspectors observed a portable fan placed on the nursing desk of the north unit throughout the inspection. The fan was set to the middle of three settings and was on at all times. Also, a stand-up osculating fan was observed in the lounge area of the north unit, set on the highest setting at all times during the inspection.

The DOC said they were aware the fans were used in those areas as they were warmer areas of the home. The fans remained on medium and high settings on July 27, 2021, after speaking with the DOC.

Sources: Observations, interview with the DOC, and Public Health Ontario (PHO) "At a Glance: The use of portable fans and portable air conditioning units during covid-19 in Long-Term Care and Retirement homes, document. [s. 229. (4)]

2. The licensee failed to ensure that the hand-hygiene program was in accordance with evidence-based practices related to resident hand hygiene.

Just Clean Your Hands (JCYH) Long-Term Care Homes Implementation Guide, provided the following best practice guidance:

“When to Clean”: To reduce the spread of organisms, residents, staff, volunteers and family members were to clean or assist residents with cleaning their hands before or after an activity, meal or snack.

Inspectors observed the lunch meal a number of times during the inspection in both the North and South dining rooms. Snack service was also observed on three occasions.

Resident hand hygiene was not observed before or after their meal/snack. Staff said they were unsure when a resident was to be provided assistance with hand hygiene and said they only assisted residents with hand hygiene during morning care.

Inspectors informed the licensee's Regional Infection Prevention and Control nurse and DOC, that staff had not been observed assisting residents with hand hygiene. According to the DOC and the Regional Infection Prevention and Control nurse, staff should have been assisting residents with hand hygiene before and after meal/snack service. Staff were again observed not assisting or reminding residents with hand hygiene before or after meals, the day after inspectors had spoken with the DOC and the Regional Infection Prevention and Control Nurse.

Not ensuring staff reminded, encouraged or assisted residents with hand hygiene prior to or following meals and snacks, increased the risk of infectious disease transmission to staff and residents.

Sources: Observations, interview with DOC and RN, and Just Clean Your Hands (JCYH) Long-Term Care Homes Implementation Guide, document. [s. 229. (9)]

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 hand-hygiene program is in accordance with evidence-based practices related to resident hand hygiene, to be implemented voluntarily.

Issued on this 8th day of September, 2021

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) :	AMANDA COULTER (694)
Inspection No. / No de l’inspection :	2021_739694_0021
Log No. / No de registre :	004962-21, 009897-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 20, 2021
Licensee / Titulaire de permis :	CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Errinrung Long Term Care Home 67 Bruce Street, P.O. Box 69, Thornbury, ON, N0H-2P0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Leanne Haynes

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

To CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), 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

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of O. Reg. 79/10.

Specifically, the licensee must ensure:

a) The staff involved receives re-training on the home's policy for safe lifts and transfers.

b) That audits are conducted for three months to ensure that staff use safe transferring techniques when assisting residents with transfers.

c) The audits should include the date and time, the name of the staff observed, the name of the resident being transferred, the transferring technique or device used, and whether the transfer was safe. The audits should be documented and a copy of them should be kept at the home.

Grounds / Motifs :

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

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A resident required assistance from two staff for safe transferring, as outlined in their plan of care. On a specific date, a staff member independently transferred the resident. During the transfer, an incident occurred and the resident was observed to be in significant pain after the incident. The resident was transferred to hospital and diagnosed with a medical injury. The resident passed away approximately one month later for reasons related to their injuries.

A staff member did not use safe techniques while transferring a resident, which resulted in actual harm to the resident.

Sources: CIS report, the home's Internal Investigation, resident’s care plan, DOC interview. [s. 36.]
An order was made by taking the following factors into account:

Severity: Staff failing to use safe transferring techniques resulted in actual harm to a resident.

Scope: The scope of this non-compliance was isolated.

Compliance history: Previous non compliance issued to this subsection, a voluntary plan of corrective action (VPC) was issued during inspection #2020_836766_0002. (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 09, 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 20th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

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