Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 22, 2017	2017_509617_0015	032820-16, 033264-16, 034375-16, 034650-16, 034885-16, 003237-17, 007048-17, 007968-17, 010091-17, 010095-17, 011070-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 4-7, 2017

This Critical Incident System Inspection was conducted as a result of the following 11 critical incident (CI) reports, the home submitted, in which

-six were related to resident falls:
CI #2590-000046-17/ log #010095-17,
CI #2590-000073-16/ log #034885-16,
CI #2590-000030-17/ log #007048-17,
CI #2590-000036-17/ log #007968-17,
CI #2590-000049-17/ log #011070-17,
CI #2590-000045-17/ log #010091-17,

-two were related to resident to resident abuse:
CI #2590-000066-16/ log #033264-16,
CI #2590-000071-16/ log #034650-16,

-two were related to staff to resident abuse:
CI #2590-000008-17/ log #003237-17,
CI #2590-000062-16/ log #032820-16, and

-one was related to missing medication:
CI #2590-000069-16/ log #034375- 16.

A Follow Up inspection #2017_463616_0010, and a Complaint inspection #2017_463616_0009, were conducted concurrently with this Critical Incident System inspection.

The inspector also conducted a tour of the resident care areas, reviewed residents health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personal records, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behavioural Support Ontario PSWs (BSO-PSWs), Kinesiologist, family members and residents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the written plan of care for resident #018's was reviewed and revised when care set out in the plan had not been effective regarding their risk of injury from falling.

Critical Incident (CI) report # 2590-000049-17 was submitted by the home to the Director regarding an incident that caused injury to resident #018 for which the resident was taken to hospital resulting in a significant change to their health status. The CI report indicated that after a meal resident #018 had attempted to stand up from their wheelchair at the table in the dining room, and fell resulting in injury. Resident #018 was sent to the hospital for assessment and treatment. Later on, resident #018's condition had deteriorated and they passed away.

A review of resident #018's medical certificate of death directly related the cause of death to the complications of the injury, as a result of the accidental fall at the home.

A review of resident #018's Resident Assessment Instrument Minimal Data Set (RAI MDS) relevant at the time of the fall, indicated that the resident required staff assistance to transfer safely and a specific mobility aid.

A review of resident #018's care plan specific to falls, and in use on the day of the fall, indicated that they were at risk for falling and interventions were in place to mitigate injury from falling.

Since the last revision date for resident #018's care plan, the resident had fallen on four occasions, (based on a review of the resident's health care record) and their care plan was not revised to mitigate their risk of falling specifically related to issues with their transferring.

In an interview with the Inspector, PSW #117 and PSW #108 both reported that resident #018 required the assistance of staff to transfer. Both PSW #117 and PSW #108 explained to the Inspector that resident #018 continued to have issues with transferring themselves unsafely.

A review of resident #018's post fall assessment completed on the date of the CI, by RN #102, indicated that a recommendation for the use of a specific monitoring device could have prevented their fall.

Both PSW #117 and PSW #108 reported to the Inspector respectively that resident #018 needed to have a specific monitoring device to alert the staff when self-transferring and reduce their risk for falling. PSW #117 and PSW #108 confirmed to the Inspector that resident #018 did not have these preventative measures in place prior to their fall.

In an interview with the Inspector, ADOC #110 confirmed that resident #018's fall risk was assessed as a high risk as the resident was known to self-transfer, did not call for help and may have benefited from the use of a specific monitoring device to prevent injury. ADOC #110 confirmed that resident #018's post fall assessment did indicate the recommendation of the specific monitoring device and that the resident's plan of care was not revised. [s. 6. (10) (c)]

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a) and every action taken under clause (1) (b).

Critical Incident System (CIS) report #2590-000062-16 was submitted to the Director which identified an allegation of physical abuse from PSW #112 to resident #023. A review of the CIS report by the Inspector indicated that on a specific date, resident #023 reported to RN #113 that PSW #112 provided rough care and no longer wanted PSW #112 to provide them with care. The alleged physical abuse incident did not result in injury to the resident #023.

Inspector #617 reviewed the home's investigation notes into the allegation of resident #023 being physically abused by PSW #112 which did not conclude whether physical abuse did or did not occur.

During an interview with the Inspector, the Administrator confirmed that the home did conclude their investigation which determined that physical abuse of resident #023 was not founded. The Administrator reported to the Inspector that PSW #112 was scheduled to work at the home under the "Plan A Health Care Staffing" agency when this incident occurred. By the request of the home, the agency no longer offered shifts to PSW #112 to work at the home due to performance issues recognized by the home.

A review of the Long Term Care (LTC) Homes report system by the Inspector identified that the original CIS report was not amended. A further review of this CIS report did not include the conclusion of the home's investigation or the actions taken in no longer staffing PSW #112 at the home.

A review of the home’s policy titled, “Mandatory and Critical Incident Reports (ON)-#RC-11-01-06”, revised on April 2016, indicated that the DOC was responsible to amend the CIS report for abuse of a resident by anyone that resulted in harm or risk of harm to the resident, as appropriate, with new or additional information as it became available and submit to the MOH LTC within the established time frames.

During an interview with the Inspector, the Administrator confirmed that the CIS report had not been amended to indicate the results of the home's investigation and the actions taken to protect resident #023. [s. 23. (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 report to the Director includes the results of every investigation undertaken under clause (1) (a) and every action taken under clause (1) (b), to be implemented voluntarily.

WN #3: 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 techniques when assisting resident #016 in the tub chair lift.

Critical Incident System (CIS) report #2590-000036-17 was submitted by the home to the Director regarding an incident that caused an injury to resident #016 for which the resident was taken to hospital and resulted in significant change in the resident’s health status. The CI report indicated that on a specific date, RN #115 found that resident #016 had fallen onto the floor in the tub room while sitting in the tub chair lift. The CI report identified that PSW #116 was assisting resident #016 out of the tub using the tub chair lift when the resident fell. As a result of the incident resident #016 complained of pain and numbness. Resident #016 was sent to hospital for assessment.

On a specific date, the Inspector interviewed resident #016 who explained to the Inspector that PSW #116 operated the tub chair lift and assisted the resident out of the tub with the tub chair lift when the resident fell to the ground. Resident #016 confirmed to the Inspector that when they were in the tub chair lift, PSW #116 was alone in the tub room with the resident. Resident #016 reported to the Inspector that since the incident they continued to have pain.

A review of resident #016’s Resident Assessment Instrument Minimum Data Set (RAI MDS), indicated that they required two staff to assist them. A review of resident #016’s

care plan dated at the time of the CI indicated that the resident required a specific level of assistance by two staff to transfer in and out of the tub in which one staff acted as a guide and the other operated the tub lift chair.

A review of the home’s policy titled, “Mechanical Lifts-#01-02”, last revised May 2009, indicated that two trained staff were required at all times when performing a mechanical lift.

On a specific date, the Inspector interviewed PSW #108, PSW #109 and PSW #110 who all reported that when assisting a resident in and out of the tub using the tub chair lift, two staff were required to operate the lift safely. All three PSWs confirmed to the Inspector that two staff must be present at all times when the resident is lifted to prevent an accident.

A review of the home’s investigation notes indicated that PSW #107 and PSW #116 were assisting resident #016 out of the tub using the Alenti tub chair lift at the time of the incident. PSW #107 left the tub room before PSW #116 had finished operating the lift with resident #016 seated in it. PSW #116 was alone with resident #016 when the resident had fallen.

In an interview with both PSW #116 and PSW #107, they confirmed to the Inspector that they did not follow the policy when operating the tub lift chair with resident #016 in it. PSW #107 further explained to the Inspector that they were operating the tub chair and not solely focused on the operation of the chair.

In an interview with the ADOC they reported to the Inspector that it was an expectation of the home that two staff were required to be in attendance at all times when performing a mechanical lift. Both PSW #116 and #107 did not follow the policy when transferring resident #016 using thei tube chair which resulted in the resident fall. [s. 36.]

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 staff use safe transferring techniques when assisting resident #016 in the Alenti tub chair lift, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, including policies of the licensee, that are relevant to the person's responsibilities.

The home submitted Critical Incident System (CIS) report #2590-000069-16 to the Director on a specific date in December 2016, related to a missing/unaccounted controlled substance. The report identified that a 0.5 milligram Dilaudid tablet was unaccounted for.

Inspector #616 reviewed the amended CIS report and the home's investigation record where they had determined that the controlled substance was in fact accounted for.

In an interview with ADOC #110, they indicated to the Inspector that the home's policy titled, "Drug Destruction and Disposal-#5-4", dated January 2017, had been reviewed with the registered staff who were involved in the administration or destruction of medications by November 30, 2016.

Inspector #616 reviewed the home's re-training record related to drug destruction and disposal and found that RPN #103 was not listed.

The ADOC confirmed to the Inspector that RPN #103 had not received the re-training on the home's policy for drug destruction and disposal. [s. 76. (4)]

Issued on this 12th day of October, 2017

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_509617_0015
Log No. / No de registre :	032820-16, 033264-16, 034375-16, 034650-16, 034885-16, 003237-17, 007048-17, 007968-17, 010091-17, 010095-17, 011070-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 22, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE FALCONBRIDGE 281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laura Halloran

---

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all residents assessed for the risk of falling and have fallen, their plan of care is reviewed and revised when care set out in the plan has not been effective in mitigating subsequent falls that resulted in injury.

This plan shall be submitted in writing, to:

Sheila Clark - Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at

SudburySAO.moh@ontario.ca.

Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133.

This plan must be received by October 6, 2017, and fully implemented by November 10, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care for resident #018's was reviewed and revised when care set out in the plan had not been

effective regarding their risk of injury from falling.

Critical Incident (CI) report # 2590-000049-17 was submitted by the home to the Director regarding an incident that caused injury to resident #018 for which the resident was taken to hospital resulting in a significant change to their health status. The CI report indicated that after a meal resident #018 had attempted to stand up from their wheelchair at the table in the dining room, and fell resulting in injury. Resident #018 was sent to the hospital for assessment and treatment. Later on, resident #018's condition deteriorated and they passed away.

A review of resident #018's medical certificate of death directly related the cause of death to the complications of the injury, as a result of the accidental fall at the home.

A review of resident #018's Resident Assessment Instrument Minimal Data Set (RAI MDS) relevant at the time of the fall, indicated that the resident required staff assistance to transfer safely and a specific mobility aid.

A review of resident #018's care plan specific to falls, and in use on the day of the fall, indicated that they were at risk for falling and interventions were in place to mitigate injury from falling.

Since the last revision date for resident #018's care plan, the resident had fallen on four occasions, (based on a review of the resident's health care record) and their care plan was not revised to mitigate their risk of falling specifically related to issues with their transferring.

In an interview with the Inspector, PSW #117 and PSW #108 both reported that resident #018 required the assistance of staff to transfer. Both PSW #117 and PSW #108 explained to the Inspector that resident #018 continued to have issues with transferring themselves unsafely.

A review of resident #018's post fall assessment completed on the date of the CI, by RN #102, indicated that a recommendation for the use of a specific monitoring device could have prevented their fall.

Both PSW #117 and PSW #108 reported to the Inspector respectively that resident #018 needed to have a specific monitoring device to alert the staff when self-transferring and reduce their risk for falling. PSW #117 and PSW #108

confirmed that resident #018 did not have these preventative measures in place prior to their fall.

In an interview with the Inspector, ADOC #110 confirmed that resident #018's fall risk was assessed as a high risk as the resident was known to self-transfer, did not call for help and may have benefited from the use of a specific monitoring device to prevent injury. ADOC #110 confirmed that resident #018's post fall assessment did indicate the recommendation of the specific monitoring device and that the resident's plan of care was not revised.

The decision to issue a Compliance Order (CO) was determined by actual harm to resident #018 directly related to their fall as their care plan did not have strategies in place to prevent them from self-transferring. Although the scope was isolated in this inspection, the home has continued non-compliance in a similar area of this section of the legislation. The home's compliance history is as follows:

- a VPC during inspection #2016_264609_0029;
- a CO during inspection #2016_282543_0021 served October 13, 2016, with a compliance due date of November 30, 2016;
- a VPC during the following six inspections:
#2016_282543_0010; #2015_320612_0025; #2015_282543_0014; #2015_380593_0009; #2015_332575_0002; #2014_283544_0031; and #2014_283544_0017.
(617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar 151 Bloor Street West 9th Floor Toronto, ON M5S 2T5	Director c/o Appeals Coordinator Long-Term Care Inspections Branch Ministry of Health and Long-Term Care 1075 Bay Street, 11th Floor TORONTO, ON M5S-2B1 Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 22nd day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sheila Clark

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