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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 15, 2021	2021_560632_0004	012504-20, 019434-20	Complaint

Licensee/Titulaire de permis

Heritage Green Nursing Home
353 Isaac Brock Drive Stoney Creek ON L8J 2J3

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

Heritage Green Nursing Home
353 Isaac Brock Drive Stoney Creek ON L8J 2J3

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

YULIYA FEDOTOVA (632), EMMY HARTMANN (748)

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 21, 22, 25, 26, 27, 28, February 1, 2, 3 and 4, 2021.

The following Complaint Inspection intakes were completed:
log #012504-20 - related to prevention of abuse and neglect, skin and wound,
log #019434-20 - related to skin and wound, resident charges.

The following Critical Incident System (CIS) Inspection #2021_560632_003 intakes were completed concurrently with this Complaint Inspection::
log #010642-20 - related to prevention of abuse and neglect, skin and wound,
log #014127-20 - related to medication,
log #016671-20 - related to falls prevention,
log #019774-20 - related to skin and wound, nutrition and hydration, dining observations,
log #024154-20 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Staff Development Co-ordinator /Assistant Director of Care #1 (ADOC #1), Clinical Co-ordinator /ADOC#2, Physician #1, Physician #2, Food Service Manager, Ward Clerk #1, Ward Clerk #2, Activity, Wound Care Nurse, Pharmacist, registered nurses (RNs), registered practical nurses (RPNs), Physiotherapist, personal support workers (PSWs), Housekeeper and an Infection Control Public Health Inspector.

During the course of the inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Skin and Wound Care

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

5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 staff and others involved in the different aspects of the resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The resident's progress notes identified that on an identified date in 2020, the resident had an altered skin integrity on their identified area, which was later specifically diagnosed.

The resident's medication list identified the specified medications.

An interview with a Physician identified that the specified medications predisposed the resident to specified disease. The Physician indicated that they knew the resident was susceptible related to their medication, but that the nursing staff was not informed.

A review of the resident's written plan of care did not identify the specified disease as a

possible side effect to their specified medications and did not include additional interventions related to the risk.

An ADOC #1 identified that risk factors or side effects related to the specified medications were communicated to the nursing staff by the doctor or the pharmacist; and that the nursing staff could not add these to the plan of care, if it were not communicated to them.

The resident was at increased risk of the specified disease as there was a lack of collaboration between staff and others involved in the different aspects of the resident's care.

Sources: the resident's progress notes, Medication Administration Records, care plan; interviews with Physician #1, ADOC #1. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident’s substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Progress note documentation identified that, on an identified date in 2021, the resident developed an altered skin integrity on their identified body part. A review of progress notes for an identified period of time in 2020, did not contain documentation about contacting the SDM regarding, which was acknowledged by the Wound Care Nurse. Progress notes documentation on an identified date in June 2020, identified the altered skin integrity and that the SDM was contacted on the same date.

The resident was at risk of not receiving the treatment according to their best interest being represented by their SDM, who was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: the resident's progress notes; interviews with the resident’s SDM and the Wound Care Nurse. [s. 6. (5)]

3. The licensee failed to ensure that specified care to the residents was provided as specified in their plan.

A. Resident #004’s progress notes indicated that a PSW was providing specified assistance to the resident on an identified date in 2020. It was found that the resident

had an altered skin integrity following the care provided. Care plan review indicated to provide specified assistance by an identified number of staff to the resident.

Interview with the PSW, indicated that they provided the specified care and the resident's previously acquired altered skin integrity reopened during the specified care. ADOC #1 indicated that the identified number of staff was to provide the specified care to the resident.

The resident's skin integrity was altered when the specified care was not provided by the identified number staff, as required.

Sources: the resident's progress notes, written plan of care, interview with PSW #133 and ADOC #1.

B. Resident #005's progress notes indicated that the resident complained to a RPN that a PSW specifically provided care to the resident. Interview with the PSW, who provided care to the resident, indicated that they provided a specified care to the resident on their own. ADOC #1 indicated that the specified care was to be provided to the resident by an identified number of staff.

The resident was at risk of specified injury as a result of the specified care not being provided by the identified number of staff, as required.

Sources: the resident's progress notes, written plan of care, interview with PSW #133 and ADOC #1. [s. 6. (7)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The resident developed an altered skin integrity on an identified month in 2020. A review of the clinical records identified a skin and wound assessment had not been conducted during an identified period of time during the identified month. 20 days later, there was a progress note related to the identified altered skin integrity and the resident's care written plan of care interventions were reviewed on that date.

A Wound Care Nurse acknowledged that no skin and wound assessment was conducted to the resident’s identified body part during the identified period of time in June 2020, using clinically appropriate assessment instrument.

The resident was at risk of their altered skin integrity worsening, when earlier interventions were not in place as a result of skin and wound assessment using clinically appropriate assessment instrument not being completed.

Sources: the resident’s progress notes, written plan of care; interview with the Wound Care Nurse. [s. 50. (2) (b) (i)]

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 and ensuring that resident exhibiting altered skin integrity, including pressure ulcers, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

a) Physician Order form review directed registered staff to specifically treat the resident's identified altered skin integrity. Electronic Treatment Administration Record (eTAR) review did not contain documentation that the treatment occurred on an identified date in June 2020.

b) Physician Order form review directed registered staff to specifically treat the resident's identified altered skin integrity. A review of the progress notes and eTAR did not contain documentation that the treatment occurred on an identified date in August 2020.

A Wound Care nurse acknowledged that the documentation and the treatment were not competed on the identified dates in June and in August in 2020.

The resident’s specified altered skin integrity was at risk of becoming worse, when the treatments were not completed as ordered by a Physician.

Sources: Physician Order, the resident's progress notes and electronic Treatment Administration Records; interview with the Wound Care Nurse. [s. 131. (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 and ensuring that drugs are administered to resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with s. 24 (1) (1) in that a person who had reasonable grounds to suspect improper or incompetent treatment or care of the resident, that resulted in harm or risk of harm to the resident, failed to report immediately to the Director in accordance with s. 24 (1) of the LTCHA. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

A review of the home's investigation notes identified that the home received a written complaint related to a delay in response to an altered skin integrity on the resident's specified body part. The email was received on an identified date in June 2020. A CIS report in the investigation package was noted to have been submitted to the Ministry of Long-Term Care (MLTC) 20 days later.

The Administrator identified that the home addressed the complaint and completed an investigation into the concerns; however, the issue was not immediately reported to the Director.

Sources: the home's investigation notes; interview with the Administrator. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 99. Evaluation (b) that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Interview with ADOC #1 identified that the home did not complete the Prevention of Abuse and Neglect annual program evaluation in 2020.

Sources: interview with ADOC #1. [s. 99. (b)]

Issued on this 16th day of March, 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) :	YULIYA FEDOTOVA (632), EMMY HARTMANN (748)
Inspection No. / No de l’inspection :	2021_560632_0004
Log No. / No de registre :	012504-20, 019434-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 15, 2021
Licensee / Titulaire de permis :	Heritage Green Nursing Home 353 Isaac Brock Drive, Stoney Creek, ON, L8J-2J3
LTC Home / Foyer de SLD :	Heritage Green Nursing Home 353 Isaac Brock Drive, Stoney Creek, ON, L8J-2J3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	J. Scott Kozachenko

To Heritage Green Nursing Home, 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 :

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 LTC Homes Act, 2007, s. 6. (7):

Specifically the licensee must:
a) ensure resident #004 and #005's personal hygiene care is provided as specified in their plan of care;
b) perform an audit to ensure residents #004 and #005 receive their personal hygiene care as specified in their plans of care. The audit must be documented and identify who completed the audit.

Grounds / Motifs :

1. The licensee failed to ensure that specified care to the residents was provided as specified in their plan.

A. Resident #004's progress notes indicated that a PSW was providing specified assistance to the resident on an identified date in 2020. It was found that the resident had an altered skin integrity following the care provided. Care plan review indicated to provide specified assistance by an identified number of staff to the resident.

Interview with the PSW, indicated that they provided the specified care and the resident's previously acquired altered skin integrity reopened during the specified care. ADOC #1 indicated that the identified number of staff was to provide the specified care to the resident.

The resident's skin integrity was altered when the specified care was not provided by the identified number staff, as required.

Sources: the resident's progress notes, written plan of care, interview with PSW #133 and ADOC #1.

B. Resident #005's progress notes indicated that the resident complained to a RPN that a PSW specifically provided care to the resident. Interview with the PSW, who provided care to the resident, indicated that they provided a specified care to the resident on their own. ADOC #1 indicated that the specified care was to be provided to the resident by an identified number of staff.

The resident was at risk of specified injury as a result of the specified care not being provided by the identified number of staff, as required.

Sources: the resident's progress notes, written plan of care, interview with PSW #133 and ADOC #1.

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

Severity: there was a minimal harm to resident #004 as the personal hygiene care was not provided to the resident as it was specified in their written plan of care and the resident had altered skin integrity.

Scope: the scope of this non-compliance was pattern, because the personal hygiene care was not completed for two out of four residents.

Compliance history: in the last 36 months, the licensee was found to be non-compliant with LTCH Act, 2007, s. 6. (7) and one Voluntary Plan of Correction (VPC) was issued to the home. (632)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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:

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.

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 15th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Yuliya Fedotova

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