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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
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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
Nov 16, 2021	2021_938758_0002	005054-21, 006412-21, 007220-21, 007221-21, 007222-21, 009560-21, 016825-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Norfinch Care Community
22 Norfinch Drive North York ON M3N 1X1

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

NOREEN FREDERICK (704758), JULIEANN HING (649)

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): October 14, 15, 18, 19, 20, 21, and 22, 2021.

The following Compliance Orders (CO) follow-up intakes were completed during this Critical Incident System (CIS) inspection:
Log #006412-21 related to pest control,
Log #007220-21 related to collaboration,
Log #007221-21 related to abuse and neglect,
Log #007222-21 related to abuse policy, and
Log #009560-21 related to safe transferring and positioning.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Log #005054-21 related to Residents' Bill of Rights, plan of care, prevention of abuse and neglect, and
Log #016825-21 related to duty to protect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim Director of Care (IDOC), Assistant Director of Care (ADOC), Director of Environmental Services (DES), Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide (DA), Housekeeper, and residents.

During the course of the inspection, the inspectors observed staff to resident interactions, reviewed residents' clinical records, staffing schedules, pertinent policies and procedures, and observed IPAC practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2021_751649_0004	649
O.Reg 79/10 s. 36.	CO #001	2021_804649_0009	704758
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2021_751649_0004	649
O.Reg 79/10 s. 88. (2)	CO #001	2021_751649_0005	704758

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #013 and #009 were protected from

sexual abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “sexual abuse” means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On April 14, 2021, a compliance order (CO) was issued under inspection report #2021_751649_0004 made under LTCHA, 2007 S.O. c.8, s. 19. (1) as follows:

1. Ensure that all residents including residents #007, #005, #006, #008, and #020 are protected from physical abuse.
2. Ensure that all residents including residents #017, #011, #012, #013, and #016 are protected from sexual abuse.

The compliance order due date was August 24, 2021.

During this inspection, it was found that the home completed step one but failed to complete step two. Therefore, this order will be re-issued with the following evidence.

Resident #009 was involved in above mentioned order. A review of resident #009’s progress notes indicated that there was an incident involving them and resident #013. According to this progress note Housekeeper reported resident #009 displayed inappropriate behaviour towards resident #013.

Review of resident #009 and #013’s Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessments prior to the above mentioned incident indicated that both residents had moderate cognitive impairment. Staff interviews confirmed that neither residents were able to provide informed consent to sexual activity.

Resident #009’s plan of care indicated that they required 1:1 staff related to inappropriate behavior towards co-residents and staff. This intervention was updated in resident #009’s care plan. The home’s records indicated that there was no 1:1 staff for resident #009 on an identified day, when the above incident had occurred.

An observation of resident #009 was conducted by Inspector #649. The inspector noted that resident #009 made a couple of attempts of inappropriate behaviour towards co-residents as they walked past with the 1:1 staff present. On one occasion resident #009

made contact with a co-resident.

According to Housekeeper, they observed on an identified day that residents #009 and #013 were displaying inappropriate behaviour. The housekeeper had made this observation from the hallway but was unable to say which resident had initiated the behaviour. Due to miscommunication between the housekeeper and the nurse this incident was not recognized as sexual abuse. Housekeeper stated that they had gone into resident #009's room to remove the garbage and had observed that there was no 1:1 staff present with resident #009.

Registered Practical Nurse (RPN) told the inspector that the Housekeeper reported to them that resident #013 displayed inappropriate behaviour at resident #009. According to the RPN this was an attempt and the behaviour did not occur. RPN confirmed that they had not clarified with Housekeeper what they had observed, and therefore had not reported this incident as sexual abuse. RPN acknowledged that the 1:1 staff was not there with resident #009 when the above mentioned incident occurred. It was also at this time that the RPN became aware that the previous 1:1 staff had left before the next 1:1 staff had arrived. They stated that when they received shift report they were not aware that the 1:1 staff for resident #009 had not arrived.

Assistant Director of Care (ADOC) told the inspector that they were called by RPN and informed that there was no 1:1 staff for resident #009. The ADOC called the company who advised that 1:1 staff was on their way.

This incident was brought to the interim DOC and Executive Director (ED) 's attention and during separate interviews both acknowledged that sexual abuse had occurred. The interim DOC stated that a PSW should have been assigned to monitor the resident until the 1:1 staff arrived.

Sources: review of resident #009 and #013's clinical records, interviews with Housekeeper, RPN , and other staff. [s. 19. (1)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

A Critical Incident System (CIS) was reported to Ministry of Long-Term Care (MLTC) related to an allegation of staff to resident abuse.

According to the CIS, resident alleged that PSW was rough with them during the provision of care which caused them pain. Resident was upset and shaking when they reported this incident to the home.

During the course of this inspection, resident refused an interview about the above mentioned incident.

PSW involved in the above allegation was unavailable for an interview.

According to the home’s investigation notes, resident reported to the home that they felt physically assaulted when a PSW had provided care to them. Resident did not want care but the PSW insisted and cared for them. During the care, rough care was provided to the resident.

Interview with the ED confirmed that the Residents’ Bill of Rights was not respected, and resident was not treated with dignity and respect by the PSW for above mentioned incident. PSW was rushing and was rough during resident’s care. The ED further explained that resident did not wish to cared for but PSW did not respect their wishes and took them to do a care task.

Sources: resident's clinical records, home’s investigation notes, and interview with the ED. [s. 3. (1) 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 following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: 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 all staff participated in the implementation of the home's infection prevention and control program related to residents' hand hygiene.

On an identified day, meal observations were conducted on several resident home areas by Inspector # 704758 which revealed that staff (PSWs and RPNs) did not offer or assist residents with hand hygiene upon entry to the dining room.

An RPN and a PSW acknowledged that residents' hands were not cleaned prior to meal on their units.

The home's hand hygiene policy directed staff to have residents use alcohol-based hand rub prior to eating. The same policy required staff to wash residents' hands before and after eating.

Observations were brought to attention of the home's Infection Prevention and Control (IPAC) Lead, and they confirmed that the staff should have offered and assisted residents with hand hygiene as was indicated in the home's policy.

Sources: Inspector's observations on multiple resident home areas, home's Hand Hygiene policy, and interviews with IPAC Lead and other staff. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 22nd day of November, 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) :	NOREEN FREDERICK (704758), JULIEANN HING (649)
Inspection No. / No de l’inspection :	2021_938758_0002
Log No. / No de registre :	005054-21, 006412-21, 007220-21, 007221-21, 007222-21, 009560-21, 016825-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 16, 2021
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Norfinch Care Community 22 Norfinch Drive, North York, ON, M3N-1X1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Gajany Sivalingam

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 2063414 Ontario Limited as General Partner of 2063414 Investment 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

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_751649_0004, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19. (1) of the LTCHA 2007.

Specifically, the licensee must:

1. Ensure that all residents including residents #013 and #009 are protected from sexual abuse.

2. Implement a process to ensure that every alleged or witnessed incident of resident to resident sexual abuse is immediately reported and thoroughly investigated.

3. Ensure that 1:1 staff are informed of their role and responsibility when working with resident #009. This should include but not be limited to providing re-direction to resident #009 when in close proximity to co-residents, distracting resident #009 when they attempt to reach out and touch co-residents, provide constant supervision to resident #009 at all times, and never leave the resident unattended during the shift..

4. The home must maintain a documentation record for the above processes implemented, including the person responsible, date and time, and outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #013 and #009 were protected from sexual abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On April 14, 2021, a compliance order (CO) was issued under inspection report #2021_751649_0004 made under LTCHA, 2007 S.O. c.8, s. 19. (1) as follows:

1. Ensure that all residents including residents #007, #005, #006, #008, and #020 are protected from physical abuse.
2. Ensure that all residents including residents #017, #011, #012, #013, and #016 are protected from sexual abuse.

The compliance order due date was August 24, 2021.

During this inspection, it was found that the home completed step one but failed to complete step two. Therefore, this order will be re-issued with the following evidence.

Resident #009 was the perpetrator in part two of the above mentioned order. A review of resident #009's progress notes indicated that on September 20, 2021, at approximately 0720 hours there was an incident involving them and resident #013. According to this progress note Housekeeper #114 reported resident #009 "kissed at" resident #013.

Review of resident #009 and #013's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessments prior to the above mentioned incident indicated that both residents had Cognitive Performance Scale (CPS) scores of three out of six indicating moderate impairment. Staff interviews confirmed that neither residents were able to provide informed consent to sexual activity.

Resident #009's plan of care indicated that they required 1:1 staff on all shifts related to sexually inappropriate behavior of touching co-residents and staff. This intervention was updated in resident #009's care plan on June 30, 2021. The home's records indicated that there was no 1:1 staff for resident #009 on the morning of September 20, 2021, when the above incident had occurred, as the 1:1 staff arrived late at 0810 hours.

An observation of resident #009 was conducted by Inspector #649 on October 21, 2021 from 1600 to 1630 hours. The inspector noted that resident #009 made a couple of attempts to touch co-residents as they walked past with the 1:1 staff present. On one occasion resident #009 made contact with a co-resident.

According to Housekeeper #114, they observed on the morning of September 20, 2021, residents #009 and #013 were kissing on the lips, outside of resident #009's room. The housekeeper had made this observation from the hallway but was unable to say which resident had initiated the kissing. Due to miscommunication between the housekeeper and the nurse this incident was not recognized as sexual abuse. Housekeeper #114 stated that they had gone into resident #009's room at the start of their shift (0700 hours) to remove the garbage and had observed that there was no 1:1 staff present with resident #009.

Registered Practical Nurse (RPN) #111 told the inspector that the Housekeeper #114 reported to them that resident #013 "made kiss at" resident #009. According to the RPN this was an attempt by resident #013 to kiss resident #009 but no kissing had occurred. RPN #111 confirmed that they had not clarified with Housekeeper #114 what they had observed, and therefore had not reported this incident as sexual abuse. RPN #111 acknowledged that the 1:1 staff was not there with resident #009 when the above mentioned incident occurred on September 20, 2021. It was also at this time that the RPN became aware that the previous 1:1 staff had left before the next 1:1 staff had arrived. They stated that when they received shift report they were not aware that the 1:1 staff for resident #009 had not arrived.

Assistant Director of Care (ADOC) #116 told the inspector that they were called by RPN #111 at approximately 0710 hours on September 20, 2021 and informed that there was no 1:1 staff for resident #009. The ADOC called the security company who advised that the security guard providing 1:1 staff was on their way.

This incident was brought to the interim DOC #115 and Executive Director (ED) #109's attention and during separate interviews both acknowledged that sexual abuse had occurred. The interim DOC stated that a PSW should have been

assigned to monitor the resident until the 1:1 staff arrived.

Sources: review of resident #009 and #013's clinical records, interviews with Housekeeper #114, RPN #111, and other staff.

An order was re-issued based on the following factors:

Severity: As a result of the incident in question, a resident experienced sexual abuse.

Scope: This was an isolated incident as no other incidents of sexual abuse were identified during this inspection.

Compliance history: The licensee continues to be in non-compliance with LTCHA 2007 s.19 (1), warranting the re-issue of a compliance order (CO). A CO was issued on April 14, 2021, during inspection #2021_751649_0004, and had a compliance due date of August 24, 2021. A CO in the same subsection was also issued and complied with in the last 36 months.

(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 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
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 16th day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Noreen Frederick

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