Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**Rapport d'inspection prévue 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**

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
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 24, 2019 | 2019_795735_0019 | 012396-19, 012487-19, 013371-19, 015256-19 | Complaint |

### Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Maitland Manor
290 South Street GODERICH ON N7A 4G6

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

KRISTAL PITTER (735), JANETM EVANS (659), KIM BYBERG (729)

### 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): August 12-16, 19-22, and 26, 2019**

**Critical Incident Inspection # 2019_795735_0020 was conducted in conjunction with this inspection.**

**The following intakes were completed in this complaint inspection:**

**Log # 012396-19, AH IL-67766-AH, CI # 0965-000033-19 related to prevention of abuse and neglect.**
**Log # 012487-19, IL-67775-CW, IL-68525-CW related to prevention of abuse and neglect.**
**Log # 013371-19, IL-68235-CW related to sufficient staffing.**
**Log # 015256-19, CI # 0965-000044-19 related to sufficient staffing and improper care.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Interim Office Manager (IOM), Skin and Wound Lead, Behavioural Support Ontario (BSO) Lead, Registered Nurses (RN), a Registered Nursing (RN) Student, Registered Practical Nurses (RPN), Dietary Aides (DA), Personal Support Workers (PSW), Health Care Aides (HCA), Agency Director, Agency Office Administrator, Agency Registered Practical Nurse (RPN), complainants, and residents.**

**The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, dining services, reviewed relevant residents' clinical records, and relevant policies and procedures pertaining to the inspection.**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

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

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

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement.

A complaint was received by the Ministry of Long-Term Care (MOLTC) which stated there were times the home did not have a charge nurse.

Upon arrival to the home on an identified date, the Executive Director (ED) informed inspectors that they did not have a Registered Nurse (RN) in the building.

Review of the staff schedules for a specified time frame identified that for 16 out of 158 partial or full shifts (10.1 per cent) there was no RN in the building who was an employee of the licensee.

The Interim Office Manager (IOM) acknowledged that there were 16 shifts during a specified time frame where there was no RN in the building.

The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement. [s. 8. (3)]

***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. (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 the care set out in the plan of care was provided to an identified resident as specified in the plan.

A complaint received by the MOLTC stated there was an allegation of physical abuse by a staff member towards an identified resident.

The Critical Incident (CI) report submitted by the home stated that a RN and a Registered Practical Nurse (RPN) noted an injury to the identified resident while a Personal Support Worker (PSW) was in the resident's room.

A review of the identified resident's plan of care stated that their level of assistance was total dependence with the assistance of two staff members for their activities of daily living. Staff were to provide gentle persuasive approach and explain everything they were doing before attempting any tasks.

In the home's investigation notes, the identified PSW stated they were providing care to the identified resident alone.

The ED stated that the resident required the assistance of two staff members for all care needs. The ED shared that the PSW understood the requirements of care for the identified resident but did not follow their plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the identified resident as specified in the plan. [s. 6. (7)]

***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 set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that six identified residents were bathed, at a minimum, twice a week by the method of their choice, unless contraindicated by a medical condition.

Complaints were received by the MOLTC related to personal hygiene and residents not being provided a bath.

A PSW stated residents were to receive two baths or showers per week, and if there was a blank in the documentation on the personal care flow sheets, the resident did not receive a bath or shower.

The personal care flow sheets for bathing were reviewed for a 75 day period in 2019, and identified the following:

(A) An identified resident received 18 of 20 baths.

(B) An identified resident received 12 of 20 baths. This resident went a period of nine days without a bath documented as administered.

(C) An identified resident received 10 of 20 baths. This resident went a period of 13 days without a bath documented as administered.

(D) An identified resident received 18 of 20 baths. This resident stated that there had been times when they had not received two baths a week. A PSW stated that the identified resident had complained to them that they had not received their scheduled bath.

(E) An identified resident received 17 of 20 baths. This resident stated that there had been the odd week when they had not received two baths a week. Review of the personal care flow sheets identified two instances where the resident had refused a bath. There was one instance where a bath had been missed.

(F) An identified resident received 17 of 20 showers. This resident stated there had been times when they had not received two showers a week, and they had gone 10 days without a shower in a specified month in 2019. Additionally, there was one instance where a shower had been missed in the identified month.

Upon review of the personal care records, the identified PSW acknowledged that six residents had not received a minimum of two baths or showers per week.

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice, unless contraindicated by a medical condition. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.***

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**WN #4: 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 has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears for wounds, 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 assessments.

i) A complaint was received related to an identified resident not having their dressing changed on a specified date.

An Agency RPN stated that when they were administering medications, the identified resident's Substitute Decision Maker (SDM) informed them that the resident's dressing was saturated and they passed the information to a RN, who changed the dressing.

An Agency RPN, a RN, and the Skin and Wound Lead stated that a skin assessment was usually completed in Point Click Care (PCC) along with a progress note when a wound was identified.

Review of the assessments tab on PCC did not show documented evidence of a skin and wound assessment completed for the identified resident's wound until four days later.

The RN stated they had not documented an assessment for the wound, and acknowledged that an assessment for the identified resident's wound was not documented until four days later.

ii) A progress note entry made by a RPN on a specified date, documented altered skin integrity for the identified resident.

Upon observation of the identified resident's wound, a scabbed area was noted which was left open to air.

There was no documented skin and wound assessment completed for the identified resident's wound.

A RPN and the Skin and Wound Lead acknowledged that an assessment should have been completed for the identified resident's altered skin integrity.

The licensee failed to ensure that the identified resident, who exhibited 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 assessments. [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 to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 assessments, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**
**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that an identified resident's SDM was immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse towards said identified resident.

A complaint received by the MOLTC stated there was an allegation of physical abuse by a staff member towards an identified resident on a specified date. The SDM was not contacted until four and a half hours later.

The identified resident was not able to be interviewed, and the SDM was the person on the home's file to be contacted.

The SDM for the identified resident stated they were notified of the allegation four and a half hours later. They stated that the police and the ED were notified immediately of the incident. The SDM felt they should have been contacted immediately so they could be present with their family member.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect, Response and Reporting" dated April 2017, stated that disclosure of the alleged abuse was to be made to the SDM immediately upon becoming aware of the incident.

The ED stated that when they arrived at the home, they instructed the day shift charge nurse to notify the SDM. The ED stated they were now aware of the home's policy to immediately report the alleged abuse to the SDM.

The licensee failed to ensure that the resident's SDM was immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse towards an identified resident. [s. 97. (1) (a)]

**Issued on this 2nd day of October, 2019**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et 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 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) :** | KRISTAL PITTER (735), JANETM EVANS (659), KIM BYBERG (729) |
| **Inspection No. / No de l'inspection :** | 2019_795735_0019 |
| **Log No. / No de registre :** | 012396-19, 012487-19, 013371-19, 015256-19 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Sep 24, 2019 |
| **Licensee / Titulaire de permis :** | CVH (No. 2) LP<br>766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8 |
| **LTC Home / Foyer de SLD :** | Maitland Manor<br>290 South Street, GODERICH, ON, N7A-4G6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Tanya Adams |

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et 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 CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et 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

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**Order # / Ordre no :** 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. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be complaint with s. 8 (3) of the LTCHA.

Specifically, the licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times, except as provided for in the regulations.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement.

A complaint was received by the Ministry of Long-Term Care (MOLTC) which stated there were times the home did not have a charge nurse.

Upon arrival to the home on an identified date, the Executive Director (ED) informed inspectors that they did not have a Registered Nurse (RN) in the building.

Review of the staff schedules for a specified time frame identified that for 16 out of 158 partial or full shifts (10.1 per cent) there was no RN in the building who was an employee of the licensee.

The Interim Office Manager (IOM) acknowledged that there were 16 shifts during a specified time frame where there was no RN in the building.

The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3, widespread, as it had the potential to affect a large number of LTCH residents. The home had a level 3 history, with previous noncompliance (NC) in last 36 months to the same subsection of the LTCHA that included:

Compliance Order (CO) issued February 11, 2019 (2018_601532_0026)

Voluntary Plan of Correction (VPC) issued August 28, 2017 (2017_628680_0005) (659)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et 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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jan 10, 2020

## 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
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 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)
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 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 24th day of September, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Kristal Pitter

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