Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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Télécopieur: (519) 885-2015

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
Sep 13, 2021	2021_800532_0012	007605-21, 007606-21, 007607-21, 008128-21, 010410-21, 010503-21, 011019-21, 012825-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Pinecrest Manor
399 Bob Street P.O. BOX 220 Lucknow ON N0G 2H0

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

NUZHAT UDDIN (532), KATHERINE ADAMSKI (753)

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 3-6, 10-13, 17-20, 2021.

The following intakes were completed during this complaint inspection.
Log # 010503-21, Log # 010410-21, Log # 008128-21, related to staffing.
Log # 007607-21, related to bathing.
Log # 007606-21, related to abuse.
Log # 007605-21, related to Bill of Rights.
Log # 012825-21, related to abuse.

Robert Spizzirri #705751 was present for this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Infection Control Lead, Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, residents and family members.

The inspectors also toured resident home areas, observed resident care provision, dining and resident to staff interaction and reviewed relevant residents' clinical records and IPAC practices.

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

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

6 WN(s)
4 VPC(s)
2 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. 19. (1)	CO #002	2021_800532_0006	753
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2021_800532_0006	532

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that residents were bathed at a minimum of twice a week.

A) A resident was to receive a tub bath twice per week.

Over an eight week period, the resident missed three out of 17 scheduled baths (18%).

The resident expressed frustration as a result of not being provided three of their scheduled baths.

B) A resident's plan of care, indicated the resident was to receive their preference of a bath or a shower twice a week.

Over an eight week period, the resident was not provided a tub bath or shower on one out of 14 scheduled days (7%) and was upset that they had not received their bath /shower.

Not ensuring that residents were bathed twice a week was upsetting to the residents and could result in other health concerns.

Sources; Review of Point of Care (POC) tasks, resident's plan of care, interviews with residents and ADOC.

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. 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 has failed to ensure that drugs were administered to a resident and residents on the North side in accordance with the directions for use as specified by the prescriber.

A complaint was received, alleging that incorrect medications were administered to a resident in addition to medications being administered outside the scheduled time frame.

The home's Long Term Care (LTC)-Medication Administration policy stated that prescribed medications were to be administered according to the scheduled medication administration times. Medication should be given within the following recommended time frames, 60 minutes before or 60 minutes after the scheduled administration time. The policy also referenced the “Eight Rights of Medication Administration Principles" that health care providers must adhere to, one of which was the correct time.

A review of the audit report stated that a resident received their medications that were not prescribed for them and the medications were given outside of the scheduled administration time on two different days. One of the medications was a time-sensitive medication, that was administered 120 minutes late.

2) Further review of the audit report indicated that 13 out of 24 residents on the North side were administered 75 medications between one and half hours (90 minutes) and three hours (180 minutes) late. Included in these medications were time sensitive medications.

Not ensuring residents were administered medications as specified by the prescriber, may have placed the residents at risk for harm.

Sources: Medication Administration Audit Reports, LTC-Medication Administration policy, medication incident report, interview with ADOC.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperatures for at least two resident bedrooms in different parts of the home and one resident common area on every floor were measured and documented at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night.

A memorandum to Long-Term Care Home (LTCH) Stakeholders dated April 1, 2021, advised of the changes to Ontario Regulation 79/10 under the LTCHA, 2007 to help protect the safety and comfort of residents. Licensees were required to measure and document the air temperature at a minimum, in certain specified areas in the LTCH at specified intervals and conditions as outlined in the legislation effective May 15, 2021.

The home's temperature log records showed that temperatures were never measured or documented for the designated cooling areas.

The licensee did not initiate temperature measurement and documentation of resident bedrooms until June11, 2021. On the days when temperatures were measured and documented, the temperatures were not always measured at the required times.

Not measuring and documenting the temperatures of at least two resident bedrooms and designated cooling areas on every floor of the home as required, may have placed residents at risk for heat related illness, as the home may not have been able to identify when there was a temperature concern.

Sources: LTCH’s temperature log records, observations of resident bedrooms, designated cooling areas and lounges, interviews with the Administrator #100, and ADOC #103. [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperatures for at least two resident bedrooms in different parts of the home and one resident common area on every floor are measured and documented at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the organized program of maintenance services ensured there were schedules and procedures in place for routine, preventive and remedial maintenance of the floors within resident home areas.

Between August 17 and 20, 2021, lingering offensive odours were detected in resident living areas including the East hallway and identified rooms.

Observations in several of these rooms showed floors with splitting seams where liquid could penetrate. The odour in one of the rooms remained present after the room was thoroughly cleaned.

The ED attributed the odour to the older flooring in the bathrooms.

The ED acknowledged that the maintenance program did not have a procedure in place for routine, preventative and remedial floor maintenance beyond daily cleaning.

By not having a preventative procedure in place for maintaining the flooring in the home, the integrity of the flooring was compromised and placed residents at potential risk for health and safety concerns.

Sources: Observations conducted August 17-20, 2021, photographs of splitting seams in the flooring, interviews with the ED and other staff.

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 there are schedules and procedures in place for routine, preventive and remedial maintenance of the floors within the resident areas of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that all medication incidents were documented, reviewed and analyzed.

The “Medication Administration Audit Reports” were reviewed for residents residing on the North side, it was noted that 13 out of 24 residents or 75 medications, were administered between one and half hours and three hours late, including time-sensitive medications. Medication incident reports were not completed for the late administration of these medications.

The ADOC acknowledged they had failed to review and analyze the late administration of medications as incidents.

As a result of the medication incidents not being reviewed and analyzed; residents may have been placed at risk for harm.

Sources: Medication Administration Audit Reports, LTC-Medication Administration policy, medication incident report, interview with ADOC.

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 medication incidents are documented, reviewed and analyzed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Between August 3 and 12, 2021, the following infection prevention and control practices were observed:

Multiple observations completed in the dining room and East and West lounges, found that staff did not assist residents with hand hygiene before and after meals. The home's Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands" (JCYH), required that staff assist residents to clean their hands before and after meals.

Alcohol Based Hand Rub (ABHRs) were available at point-of-care and in the dining rooms; however, staff did not assist the residents with hand washing.

Not ensuring residents were assisted or reminded to complete hand hygiene before/after meals, increased the risk of infectious disease transmission throughout the home.

Sources: dining room observations from August 3-12, 2021, interview with PSW and IPAC Lead.

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

Issued on this 16th day of September, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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) :	NUZHAT UDDIN (532), KATHERINE ADAMSKI (753)
Inspection No. / No de l'inspection :	2021_800532_0012
Log No. / No de registre :	007605-21, 007606-21, 007607-21, 008128-21, 010410-21, 010503-21, 011019-21, 012825-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 13, 2021
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Pinecrest Manor 399 Bob Street, P.O. BOX 220, Lucknow, ON, N0G-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Stroeder

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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_800532_0006, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 33. (1) of O. Reg 79/10.
Specifically, the licensee must:
1) Ensure residents are bathed at least twice a week and by a method of their choice.

Grounds / Motifs :

1. Compliance order #003 related to O. Reg 79/10, s. 33. (1) from inspection #2021_800532_0006 issued April 28, 2021, is being re-issued as follows:

The licensee has failed to ensure that residents were bathed at a minimum of twice a week.

A) A resident was to receive a tub bath twice per week.

Over an eight week period, the resident missed three out of 17 scheduled baths (18%).

The resident expressed frustration as a result of not being provided three of their scheduled baths.
(532)

2. A resident's plan of care, indicated the resident was to receive their preference of a bath or a shower twice a week.

Over an eight week period, the resident was not provided a tub bath or shower on one out of 14 scheduled days (7%) and was upset that they had not received their bath /shower.

Not ensuring that residents were bathed twice a week was upsetting to the residents and could result in other health concerns.

Sources; Review of Point of Care (POC) tasks, resident's plan of care, interviews with residents and ADOC.

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

Severity: There was a minimal risk of harm when residents were not bathed at a minimum of twice a week by a method of their choice.

Scope: The scope of this incident was a pattern because two out of three residents reviewed during this inspection were not bathed at a minimum of twice a week by a method of their choice.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 33. (1) of O. Reg 79/10. This subsection was issued as a CO on April 28, 2021, during inspection #2021_800532_0006 with a compliance due date of June 4, 2021. (532)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2021

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must comply with s. 131 (2) of O. Reg 79/10.

Specifically, the licensee must ensure:

1) Training is provided to the identified agency Registered Nurse regarding the Medication Administration policy related to the "Eight Rights of Medication Administration Principles".

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to a resident and residents on the North side in accordance with the directions for use as specified by the prescriber.

A complaint was received, alleging that incorrect medications were administered to a resident in addition to medications being administered outside the scheduled time frame.

The home's Long Term Care (LTC)-Medication Administration policy stated that prescribed medications were to be administered according to the scheduled medication administration times. Medication should be given within the following recommended time frames, 60 minutes before or 60 minutes after the scheduled administration time. The policy also referenced the "Eight Rights of Medication Administration Principles" that health care providers must adhere to, one of which was the correct time.

A review of the audit report stated that a resident received their medications that were not prescribed for them and the medications were given outside of the

scheduled administration time on two different days. One of the medications was a time-sensitive medication, that was administered 120 minutes late.

2) Further review of the audit report indicated that 13 out of 24 residents on the North side were administered 75 medications between one and half hours (90 minutes) and three hours (180 minutes) late. Included in these medications were time sensitive medications.

Not ensuring residents were administered medications as specified by the prescriber, may have placed the residents at risk for harm.

Sources: Medication Administration Audit Reports, LTC-Medication Administration policy, medication incident report, interview with ADOC.

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

Severity: There was potential risk of harm when the medications were administered to a resident that were not prescribed and when the nurse administered evening medications up to three hours late to 13 residents.

Scope: This non-compliance was a pattern as number of residents reviewed had their medications administered late as prescribed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 131 (2) and one voluntary plan of correction was issued to the home. (532)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 04, 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 13th day of September, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Nuzhat Uddin

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