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

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 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
Mar 3, 2021	2021_792659_0003	023534-20, 023778-20, 000637-21, 001367-21, 001772-21	Critical Incident System

Licensee/Titulaire de permis

Saint Luke's Place
1624 Franklin Blvd. Cambridge ON N3C 3P4

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

Saint Luke's Place
1624 Franklin Boulevard Cambridge ON N3C 3P4

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

JANETM EVANS (659)

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): January 28, 29 and February 1, 2, 3, and 4, 2021.

The following intakes were included in this inspection:
Log #023778-20, related to alleged staff to resident.
Log #000637-21, related to alleged staff to resident abuse.
Log #023534-20, related to alleged agency staff to resident abuse.
Log #001772-21, related to a resident fall with injury.
Log #001367-21, related to an outbreak.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Administrator, Director of Nursing and Personal Care (DONPC), Assistant Director of Nursing and Personal Care (ADONPC), Human Resource Associate (HR), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), hospital staff, Housekeepers, an essential visitor and residents.

The Inspector also conducted a tour of the home. Observations of resident dining, staff to resident interactions, secure doors, social distancing, hand sanitizing and PPE use were made. A review of relevant clinical documentation and policies and procedures was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to ensure that all doors leading to non-residential areas were closed, locked or supervised by staff.

In January 2021, a resident was mobilizing on their unit when they went through an unsupervised/unsecured door and fell down the stairs. The resident sustained injuries which required transfer to hospital. Staff said the door was left open to allow for the observation of residents.

In February 2021,observations over a three day period showed the door between two areas was ajar. On two instances there were residents mobilizing in the hall and no visible staff in attendance supervising the immediate area. Staff said they had been provided a key to secure the doors, but the door had been left ajar.

The Administrator acknowledged that the door should be secured if staff were not supervising the area.

Sources: Observations, Critical Incident (CI) 3014-000003-21; resident #003's progress notes; interviews with PSW #113, RPN #111, and the Administrator [s. 9. (1) 2.]

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. 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 :

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or risk of harm had occurred, immediately report the suspicion and the information upon which it was based to the Director.

Pursuant to the LTCHA, 2007, s. 152 (2), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) In November 2020, a staff member observed an incident of suspected abuse. They reported the incident to a registered staff the same day. The registered staff delayed reporting the incident to the DONPC, and a Critical Incident (CI) Report was submitted to the Ministry of Long Term Care (MLTC), three days after the incident.

B) In January 2021, a staff member observed an incident of suspected abuse. The staff member reported the incident to a registered staff. The registered staff did not immediately report the incident to the DONPC. A CI was submitted to the MLTC three days after the incident.

Not immediately reporting suspected abuse, may increase the potential for risk of harm to residents.

Sources: CI # 3014-000033-20; CI#3014-000001-21; Review of Prevention, Reporting and Elimination of Resident Abuse. Policy # A-F-06. Dated June 2020; Prevention, Reporting and Elimination of Resident Abuse. Policy # A-F-06. Dated January 2021; interview with RPN #109, RN #122 and the DONPC. [s. 24. (1)]

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. 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 :

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program for the home.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that all residents of LTCHs and retirement homes were at increased risk of COVID-19. A requirement was made for LTCHs to review their IPAC procedures and implement measures, which included PPE use and hand hygiene.

In January 2021, the Region of Waterloo Public Health unit declared a COVID-19 outbreak in the home when a staff member tested positive. Later there were active resident cases of COVID-19, which were cohorted in the home.

During the inspection, staff were not observed assisting residents with hand hygiene before their meal. Best practice for hand hygiene advises that residents' hands should be cleaned before and after meals/snacks.

By not following best practice for hand hygiene, staff and residents were at increased risk for disease transmission. [s. 229. (4)]

Sources: Observations, PHO – PIDAC - Best Practices for Hand Hygiene in all Health Care Settings. 4th Edition, April 2014. Interview with 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 staff assist residents to wash or sanitize their hands before and after meals and snacks, to be implemented voluntarily.

Issued on this 5th day of March, 2021

[redacted]

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) :	JANETM EVANS (659)
Inspection No. / No de l’inspection :	2021_792659_0003
Log No. / No de registre :	023534-20, 023778-20, 000637-21, 001367-21, 001772-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 3, 2021
Licensee / Titulaire de permis :	Saint Luke's Place 1624 Franklin Blvd., Cambridge, ON, N3C-3P4
LTC Home / Foyer de SLD :	Saint Luke's Place 1624 Franklin Boulevard, Cambridge, ON, N3C-3P4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Maureen Toth

To Saint Luke's Place, 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 :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with s. 9. (1) 2.

Specifically, the licensee must :
1. Complete a monthly audit of all doors leading from residential to non residential areas to ensure each door is closed and locked when it is not supervised by staff. Audits should continue until the licensee has determined there is no further issue with doors to non-residential areas being left open or unlocked when unsupervised.
2. Document the date the audit was completed, the name of the person responsible for completing the audit, the findings of the audit, and actions taken.

Grounds / Motifs :

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

1. The licensee has failed to ensure that all doors leading to non-residential areas were closed, locked or supervised by staff.

In January 2021, a resident was mobilizing on their unit when they went through an unsupervised/unsecured door and fell down the stairs. The resident sustained injuries which required transfer to hospital. Staff said the door was left open to allow for the observation of residents.

In February 2021,observations over a three day period showed the door between two areas was ajar. On two instances there were residents mobilizing in the hall and no visible staff in attendance supervising the immediate area. Staff said they had been provided a key to secure the doors, but the door had been left ajar.

The Administrator acknowledged that the door should be secured if staff were not supervising the area.

Sources: Observations, Critical Incident (CI) 3014-000003-21; resident #003’s progress notes; interviews with PSW #113, RPN #111, and the Administrator.

An order was made taking the following factors into account:

Severity: There was actual harm to resident #003, when they went through doors that should have been closed, locked or supervised, and fell down the stairs, sustaining injuries which required hospitalization.

Scope: The scope of this non-compliance was a isolated with only one door leading to a non residential area open, unlocked and unsupervised.

Compliance history: Three Written notifications (WN), 16 Voluntary Plans of Correction (VPC), five Compliance orders (CO) and one Director Referral have been issued to the home related to different sections of the legislation in the past 36 months.
(659)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 05, 2021

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must be compliant with LTCHA s. 24 (1).

Specifically, the licensee must:
1. Provide retraining to two registered staff, related to mandatory reporting of suspected, witnessed and alleged abuse.
2. Maintain documentation of the training, which includes details of the content of the training, the date of the training, first and last name of participant, and the name of the person who provided the training.

Grounds / Motifs :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or risk of harm had occurred, immediately report the suspicion and the information upon which it was based to the Director.

Pursuant to the LTCHA, 2007, s.152 (2), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) In November 2020, a staff member observed an incident of suspected abuse. They reported the incident to a registered staff the same day. The registered

staff delayed reporting the incident to the DONPC, and a Critical Incident (CI) Report was submitted to the Ministry of Long Term Care (MLTC), three days after the incident.

B) In January 2021, a staff member observed an incident of suspected abuse. The staff member reported the incident to a registered staff. The registered staff did not immediately report the incident to the DONPC. A CI was submitted to the MLTC three days after the incident.

Not immediately reporting suspected abuse, may increase the potential for risk of harm to residents.

Sources: CI # 3014-000033-20; CI#3014-000001-21; Review of Prevention, Reporting and Elimination of Resident Abuse. Policy # A-F-06. Dated June 2020; Prevention, Reporting and Elimination of Resident Abuse. Policy # A-F-06. Dated January 2021; interview with RPN #109, RN #122 and the DONPC. [s. 24. (1)]

An order was made taking the following into account:

Severity: There was actual risk of harm to residents when staff did not immediately report the concern to the ADONPC, as staff involved in the incidents were left on the units to continue working with the residents. This resulted in two additional reported incidents involving the agency staff.

Scope: The scope of this was a pattern as two of three resident abuse incidents reviewed, were not immediately reported to the Director.

Compliance history: In the last 36 months, the home was found to be non compliant with the same subsection, and a Written notification (WN) and two Voluntary Plans of Correction (VPC) were issued to the home.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 05, 2021

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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 3rd day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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