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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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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
Nov 20, 25, 2019	2019_779641_0032	006384-18, 025174-18, 007605-19, 008430-19, 013743-19, 016167-19, 019825-19	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Streamway Villa
19 James Street West COBOURG ON K9A 2J8

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

CATHI KERR (641), WENDY BROWN (602)

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): November 14, 15, 18, 19, 20, 21, 2019

This inspection was conducted in reference to intake log #016167-19, CIS #2666-000012-19 related to a medication administration incident; intake log #007605-19, #013743-19 and #019825-19, CIS #2666-000003-19, #2666-000007-19 and #2666-000014-19, related to elopement of residents; intake log #006384-18 and #025174-18, CIS #2666-000004-18 and #2666-000005-18 related to residents having fallen resulting in injury; and intake log #008430-19, CIS #2666-000005-19 related to alleged financial abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Acting Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, families and residents.

During the course of the inspection, the Inspectors observed staff to resident interactions, reviewed resident health care records; Critical Incident System reports (CIS) and relevant licensee investigation notes; and relevant policies and procedures related to falls prevention and medication management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
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)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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:
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.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
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).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to the outside of the home must be kept closed and locked.

This inspection was in reference to intake log #019825-19, CIS #2666-000014-19.

On a specified date, resident #007 eloped through the front doors of the home. The resident was found by paramedics and taken to the hospital with specified injuries.

During an interview with Inspector #641 on November 19, 2019, the Acting Administrator (A Admin) indicated that on the evening of a specified date, there had been quite a few visitors in the home. It was determined that one of the visitors may have used the left-hand door at the entrance to go out, leaving the door unlocked, which would have been how resident #007 had exited the home undetected.

The A Admin demonstrated to the Inspector that when the security code was entered, it would unlock both of the front doors. If only the right-hand door was opened, the door would close, connecting with the magnetic lock and resetting the door alarm. If a person opened the left-hand door, it opened both doors. The right-hand door would automatically close first, resetting the magnetic lock, but the left-hand door wouldn't close completely, leaving it unlocked without an alarm to alert the staff that it was open. The A Admin stated that there had been a sign on the door advising visitors not to open that door, and they had since replaced this sign with a larger sign, surrounded by yellow paper to make it more noticeable.

The licensee failed to ensure that when the left front door was opened, it would automatically close and lock. [s. 9. (1)]

2. The following finding is further evidence to support the immediate compliance order #901 issued on November 20, 2019 under inspection #2019_779641_0032. The incidents below occurred before the compliance due date of November 27, 2019.

The licensee failed to ensure that all doors leading to stairways and the outside of the home must be kept closed and locked.

This inspection was initiated from intake log #007605-19 and #013743-19, critical incidents #2666-000003-19 and #2666-000007-19 related to the elopement of resident #005.

On two specified dates, resident #005 eloped from the home via a service door that had not been closed and locked. The resident was located unharmed and returned to the home on both occasions.

During an interview with Inspector #641 on November 18, 2019, the Director of Care (DOC) advised that resident #005 had exited through the service exit by the kitchen on the two occasions. The DOC indicated that when resident #005 left the building, the resident had likely followed a staff member out the door, as the door had not closed

properly.

During an interview with Inspector #641 on November 19, 2019, the Acting Administrator (A Admin) indicated that at the time of the two incidents, the door at the service entrance was not working properly. The door would at times close but not latch completely, leaving it unlocked. The A Admin stated that resident #005 was known to follow staff around the home and it was expected that the resident had followed a staff out of the service door on these occasions. The A Admin advised that after the resident eloped the first time, the licensee had made two repairs to the door, replacing the magnetic lock and the hydraulic door hinge, but these repairs had not fixed the problem with the door closing properly. The A Admin stated that the licensee had replaced the door after the second elopement of resident #005, with a heavier door which now worked properly.

The licensee failed to ensure that all doors leading to the outside of the home were kept closed and locked. [s. 9. (1)]

Additional Required Actions:

CO # - 901 was 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

This inspection was initiated from intake log #016167-19, CIS #2666-000012-19 related to a medication incident in which resident #001 and #006 received each others medications.

Inspector #641 reviewed the residents' health care records and the licensee's investigative notes related to the incident. On a specified date, the registered nurse (RN) #103 administered resident #001 the medications that were to be given to resident #006, and then administered resident #006, resident #001's evening medications. The medications that resident #006 received were medications that were prescribed to the resident. Three of the medications that resident #001 received were not prescribed to the resident.

During an interview with Inspector #641 on November 15, 2019, the acting DOC indicated that on the evening of the specified date, the RN on duty had been an agency nurse but had worked in the building and was familiar with some of the residents. This RN had known resident #006 but had not worked in the home since resident #001 had been admitted. The DOC stated that resident #001 had received resident #006's medications, which had not been prescribed to that resident. Resident #001 had been sent to the hospital but had no ill effect from the incident.

The licensee failed to ensure that no drug was administered to resident #001 unless the drug had been prescribed for the resident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that written policies and protocols for the medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This inspection was initiated from intake log #016167-19, CIS #2666-000012-19 related to a medication error in which resident #001and #006 received each others medications.

Inspector #641 reviewed the residents' health care records and the licensee's investigative notes related to the incident. On a specified date, the registered nurse (RN) #103 who was on duty, was an agency staff nurse. The RN had identified the two residents by their names on the door of the room and established the placement of who was in which bed in the room by the name placement on the door. The RN had called resident #001 by the room-mates name and resident #001 had not corrected this, so the RN had taken this as a positive identification. RN #103 administered resident #001 the medications that were to be given to resident #006, and then administered resident #006, resident #001's evening medications.

During an interview with Inspector #641 on November 15, 2019, the acting Director or Care (DOC) indicated that all of the residents wore name bands and had their pictures in the eMar as identifiers. The DOC stated that on the evening of the specified date, resident #001 did not have an arm bracelet on, as the resident was new to the home. The DOC specified that resident #001 had been ordered a metal name band and usually, the resident would be given a plastic name band to wear while awaiting the metal name bracelet, but resident #001 was not given a plastic name band. The DOC advised that resident #006 didn't like to wear a name band but usually kept it on the bedside table.

Inspector #641 reviewed the licensee's policies and procedures related to medication administration. Policy #3-6, The medication Pass, outlined under Procedure: "identify resident using two identifiers, such as photo, armband, or other staff, never by verbal response."

The Licensee's Admission Procedures policy #CS-17.1, outlined under Procedure, paragraph two: "Each newly admitted resident will have two resident identifiers; a photo ID with date and name affixed to it which will be renew(ed) annually and after a significant change in status. A resident ID bracelet will be affixed to the newly admitted resident which states the resident name, physician, home, and allergies. These resident identifiers will hereby be used before any medication and or care is initiated."

The Licensee's Admission Documentation Checklist policy #CS-9.13 outlined under Procedure, paragraph three: "Items that are not completed during the first shift shall be communicated to the registered nurse on the next shift (days to evenings, evenings to nights) at shift to shift report with the expectation that all items in the 'Nursing Admission Day 1' section of the form shall be completed and signed off within 24 hours of admission". In the Admission Documentation Checklist, under the Nursing Admission Day 1 section were the items "ID bracelet applied to resident's wrist" and "ID resident photo dated and name affixed to photo."

Inspector #641 reviewed the Admission Documentation Checklist for resident #001. Under ID bracelet applied to resident's wrist there was a note written "measured (on the specified date of admission)" and then "wearing (dated 18 days after the specified date), " with an initial of the registered staff. The checklist did not have the ID resident photo on it.

The Inspector reviewed resident #001's e-Mar. The resident did not have a photo on the e-MAR at the time of the incident, the photo had been added to the e-MAR the next day after the medication incident. The resident didn't have an armband on at the time of the incident as identified by the Director of Care and as noted in the resident's Admission Documentation Checklist.

The licensee failed to ensure that their written policies and protocols for the medication management system were implemented for resident #001. [s. 114. (3) (a)]

Issued on this 25th day of November, 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) :	CATHI KERR (641), WENDY BROWN (602)
Inspection No. / No de l’inspection :	2019_779641_0032
Log No. / No de registre :	006384-18, 025174-18, 007605-19, 008430-19, 013743-19, 016167-19, 019825-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 20, 25, 2019
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	Streamway Villa 19 James Street West, COBOURG, ON, K9A-2J8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Kerry Chapple

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 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, 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

Order # / Ordre no : 901

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 shall be compliant with O. Reg 79/10, s. 9 (1) (1) i.
Specifically, the licensee shall:
1. ensure that the left-hand door at the front entrance is closed and locked at all times.
2. have the door supervised at all times until they can be compliant with O. Reg 79/10, s. 9 (1) (1)i
3. maintained a record documenting this.

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 failed to ensure that all doors leading to the outside of the home must be kept closed and locked.
This inspection was in reference to intake log #019825-19, CIS #2666-000014-19.

On a specified date, resident #007 eloped through the front doors of the home. The resident was found by paramedics and taken to the hospital with specified injuries.

During an interview with Inspector #641 on November 19, 2019, the Acting Administrator (A Admin) indicated that on the evening of the specified date, there had been quite a few visitors in the home. It was determined that one of the visitors may have used the left-hand door at the entrance to go out, leaving the door unlocked, which would have been how resident #007 had exited the home undetected.

The A Admin demonstrated to the Inspector that when the security code was entered, it would unlock both of the front doors. If only the right-hand door was opened, the door would close, connecting with the magnetic lock and resetting the door alarm. If a person opened the left-hand door, it opened both doors. The right-hand door would automatically close first, resetting the magnetic lock, but the left-hand door wouldn't close completely, leaving it unlocked without an alarm to alert the staff that it was open. The A Admin stated that there had been a sign on the door advising visitors not to open that door, and they had since replaced this sign with a larger sign, surrounded by yellow paper to make it more noticeable.

The licensee failed to ensure that when the left front door was opened, it would automatically close and lock.
(641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 27, 2019

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 20th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathi Kerr

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