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
Aug 14, 2019	2019_781729_0013	032606-18, 000507-19, 006179-19, 008039-19, 010303-19	Critical Incident System

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

Summit Place
850 - 4th Street East OWEN SOUND ON N4K 6A3

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

KIM BYBERG (729)

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): July 15, 16, 17, 18, and 19, 2019.

The following intakes were completed in this critical incident inspection;
-Log # 032606-18 related to an injury that resulted in the transfer to hospital with significant change in status;
-Log #008038-19, Log #010303-19, Log #006179-19, all related to alleged abuse;
-Log #000507-19, Follow up to compliance order #001, 2018_773155_0017 related to abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Residents.
The Inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004 was protected from abuse by anyone.

The definition of "physical abuse" includes, the use of physical force by anyone other than a resident that causes physical injury or pain or withholding a drug for an inappropriate purpose.

This inspection was completed as a follow-up to CO #001 from inspection #2018_773155_0017 related to abuse.

A CIS report submitted to the Ministry of Long Term Care (MLTC) stated that on a specified date, there was an allegation of abuse by PSW #111 toward resident #004, causing them pain requiring additional analgesic to be administered.

Resident #004 was recently admitted to the home, had a positioning aide and required assistance from staff for transferring and repositioning.

A review of the home's investigation notes stated that resident #004 met with DOC #101 and stated that PSW #111 grabbed their leg, let it drop down and it thumped on the bed. Resident #004 stated she told PSW #111 that it hurt and not to be so rough. Resident #004 stated that they had almost no pain prior to admission to the home and now was experiencing pain.

The home's investigation notes stated that resident #004 told PSW #112 that PSW #111 was loud and rough with them. PSW #111, then came into the room and started to argue with resident #004 causing resident #004 to become upset.

On a specified date, resident #004 complained of pain. A pain assessment was not completed at this time. two hours later, resident #004 requested pain medication but was told that it was too early and it had not been eight hours since their last dose. Resident #004 was administered an analgesic thirteen hours after their last dose was administered. The Physician was notified of resident #004's new complaints of pain and orders were received for further testing.

DOC #101, shared PSW #111 was rude, argumentative and handled resident #004 roughly. They stated that the care provided to resident #004 caused them pain, had a negative emotional outcome for resident #004 and additional support was required.

The licensee failed to ensure that resident #004 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 was treated with respect and dignity.

A critical incident summary (CIS) report submitted to the MLTC stated a personal item was found in the deleted file on one of the home's devices of resident #002.

Resident #002 stated they did not consent to the item to be on the home's device, and it made them feel uncomfortable.

Resident #002 shared with the inspector, that they were joking with staff member #106 when the item was put on the device, and asked staff member #106 to make sure the item was taken off the device.

The licensee failed to ensure that resident #002 was treated with dignity and respect. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #002 and all other residents are treated with respect and dignity, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #003 that set out their planned care.

A CIS report submitted to the MLTC on a specified date stated that PSWs witnessed resident #003's visitor being verbally abusive towards resident #003.

PSW #104 and PSW #105 witnessed resident #003's visitor yelling and swearing at resident #003. Resident #003 was removed from the room away from their visitor.

A review of resident #003's plan of care did not include any safety or security goals, monitoring or interventions to protect them from further incidents involving their visitor.

RPN #110 shared updating the plan of care for residents was multidisciplinary, and the RNs had plan of care meetings to complete the updates. RPN #110 stated the plan of care should have included safety needs of resident #003 related to their visitor, to ensure all staff were aware of interventions to keep resident #003 safe. RPN #110 shared that they were not aware of the outcome of the home's investigation or any communication to staff to ensure that resident #003 was kept safe when their visitor was visiting.

DOC #101 stated resident #003 did not have a plan of care in place to address safety and security interventions to protect resident #003 from further incidents related to their visitor. [s. 6. (1) (a)]

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 plan of care is reviewed and updated with interventions to ensure the safety and security of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A CIS report submitted to the MLTC on a specified date a visitor of resident #003 was verbally abusive towards resident #003.

The home's policy titled "Mandatory Reporting of Resident Abuse or Neglect", effective August 31, 2016 with a review date of March 31, 2019, stated that any person who had reasonable grounds to suspect abuse of a resident must immediately verbally report the suspicion and the information upon which it was based to the person in charge (i.e. the nurse on duty). They together would immediately report this to the Director of the MLTC in accordance with CIS reporting requirements.

RPN #110 stated they were informed of the incident by PSW #104 and PSW #105. RPN #110 shared they reported the incident to RN #109 and together they immediately removed resident #003 from their room.

RPN #110 shared that they were to report incidents of abuse or suspected abuse to the RN on duty or to their DOC. RPN #110 stated they did not report the incident to the MLTC as they reported to the RN on duty.

RN #109 shared they were not aware of the incident and did not report the incident to the DOC or the MLTC.

DOC #101 shared that staff members were to report incidents of abuse or suspected abuse to the registered staff immediately and call the manager on call. DOC #101 stated they were not informed of the incident until two days later.

The licensee failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 all staff comply with the homes' policy to promote zero tolerance of abuse, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident within ten days of becoming aware of an incident, make a report that included immediate and long term actions that have been taken to prevent the recurrence and the name of the person who made the initial report to the Director.

A Critical Incident System (CIS) report submitted to the Director on a specified date, stated that resident #001 suffered an injury that resulted in their transfer to the hospital resulting in a significant change in their health status.

Resident #001 had an unwitnessed fall on a specified date, they were transferred to the hospital and returned the same day with an injury that caused a significant change in their health status.

The CIS report was reviewed on a specified date, and further information was requested by the MLTC that included resident #001's diagnosis, cognitive performance scale, ambulatory and transfer status, history of falls in the last six months, fall risk, fall prevention interventions at the time of the fall, interventions going forward to prevent recurrence and psychotropic drug use.

The home amended the CIS report four months later.

DOC #101 shared they were unsure the rationale for the late report and updated the CIS report as soon as they were made aware. [s. 107. (4)]

Issued on this 3rd day of September, 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) :	KIM BYBERG (729)
Inspection No. / No de l'inspection :	2019_781729_0013
Log No. / No de registre :	032606-18, 000507-19, 006179-19, 008039-19, 010303-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 14, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Summit Place 850 - 4th Street East, OWEN SOUND, ON, N4K-6A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Trish Nolan

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 Revera Long Term Care Inc., 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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_773155_0017, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure that resident #004 and all other residents are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection # 2018_773155_0017 served on January 7, 2019, with a compliance date of February 8, 2019.

The licensee was ordered to ensure that resident #008, #009, #010, #014 and all other residents were protected from abuse by anyone.

The licensee has failed to ensure that resident #004 was protected from abuse by anyone.

The definition of "physical abuse" includes, the use of physical force by anyone other than a resident that causes physical injury or pain or withholding a drug for an inappropriate purpose.

A CIS report submitted to the Ministry of Long Term Care (MLTC) stated that on a specified date, there was an allegation of abuse by PSW #111 toward resident #004, causing them pain requiring additional analgesic to be administered.

Resident #004 was recently admitted to the home, had a positioning aide and

required assistance from staff for transferring and repositioning.

A review of the home's investigation notes stated that resident #004 met with DOC #101 and stated that PSW #111 grabbed their leg, let it drop down and it thumped on the bed. Resident #004 stated she told PSW #111 that it hurt and not to be so rough. Resident #004 stated that they had almost no pain prior to admission to the home and now was experiencing pain.

The home's investigation notes stated that resident #004 told PSW #112 that PSW #111 was loud and rough with them. PSW #111, then came into the room and started to argue with resident #004 causing resident #004 to become upset.

On a specified date, resident #004 complained of pain. A pain assessment was not completed at this time. two hours later, resident #004 requested pain medication but was told that it was too early and it had not been eight hours since their last dose. Resident #004 was administered an analgesic thirteen hours after their last dose was administered. The Physician was notified of resident #004's new complaints of pain and orders were received for further testing.

DOC #101, shared PSW #111 was rude, argumentative and handled resident #004 roughly. They stated that the care provided to resident #004 caused them pain, had a negative emotional outcome for resident #004 and additional support was required.

The licensee failed to ensure that resident #004 was protected from abuse by anyone. [s. 19. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the resident. The scope of the issue was a level 1 as it related to one of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

-Compliance order (CO) #001 issued January 7, 2018 with a compliance due date of February 28, 2018 (2017_580568_0026).
-CO #001 issued January 7, 2019 with a compliance due date of February 8, 2019 (2018_773155_0017).

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

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 30, 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 14th day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kim Byberg

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