Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2018	2018_420643_0012	027234-17, 009858-18, 014854-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

ADAM DICKEY (643)

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): June 25 - 29, 2018

The following Critical Incident System (CIS) intakes were inspected concurrently with this inspection:
Log #027234-17, CIS #2945-000037-17 - related to continence care; and
Log #009858-18, CIS #2945-000020-18 - related to injury with unknown cause.

The following complaint intakes were inspected concurrently with this inspection:
Log #014854-18 - related to alleged staff to resident abuse/ neglect, and transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Associate Director(s) of Care (ADOC), Physician, Registered Practical Nurses (RPN), Registered Dietitian (RD), Director of Dietary Services, Resident Program team member, Personal Support Workers (PSW), Dietary Aides, residents, resident Substitute Decision Makers (SDM) and resident family members.

During the course of the inspection, the inspector conducted observations of meal service, staff and resident interactions and the provision of care, record review of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	Legendé 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home.

a. An after-hours Spills Action Center (SAC) incident report and critical incident system (CIS) report were submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an incident in which resident #001 was found with a suspected injury with cause unknown, resulting in an area of impaired skin integrity. A complaint was additionally submitted by resident #001's family member regarding the incident, and the home's handling of the investigation. Review of the CIS indicated that the resident was in the dining room for an identified meal and no accidents were observed by staff; the exact cause of the injury was not identified.

Review of resident #001's progress notes and assessments indicated that a skin assessment was completed on an identified date, at which time a nutrition referral was initiated for the Registered Dietitian (RD) to assess the resident's nutrition status in relation to the area of impaired skin integrity. The nutrition referral was addressed the same day by the Part-Time Food Service Supervisor which indicated the referral had been seen, and indicated RD to follow-up. No assessment by the RD was completed related to resident #001's area of impaired skin integrity.

In interviews, Registered Practical Nurses (RPNs) #108 and #109 indicated that a referral to the RD would be initiated when a resident was found to have a new area of impaired skin integrity. The RPNs indicated that the nutrition referral would be initiated using the assessment tab in the electronic documentation system to be addressed by the RD.

In an interview, RD #118 indicated that it was the expectation of the home for residents exhibiting impaired skin integrity including wounds to be assessed by the RD for nutrition needs and interventions for wound healing. The RD indicated that a resident who exhibited an area of impaired skin integrity would have increased nutrition needs to promote healing. The RD acknowledged that resident #001, who was exhibiting altered skin integrity, was not assessed by an RD who was a member of the staff of the home.

b. Due to identified noncompliance with O. Reg. 79/10, s. 50. (2) (b) (iv), the sample of residents was expanded to include resident #002.

A review of resident #002's progress notes indicated that they were admitted to the home on an identified date, and had nutrition and hydration needs assessed by the RD on the same day of admission. Following the assessment by the RD, a head to toe skin assessment was carried out, which revealed an area of impaired skin integrity which was not noted previously. A nutrition referral was initiated for the RD to complete an assessment related to the resident's area of impaired skin integrity. Progress note from the following day indicated that the nutrition referral was addressed by the Food Services Supervisor showing the referral had been received and would be followed-up on by the RD. Review of progress notes and assessments failed to reveal an assessment of resident #002's nutrition status as it related to the above mentioned area of impaired skin integrity.

In an interview, RD #118 indicated that they were not aware of the nutrition referral for resident #002's area of impaired skin integrity. The RD acknowledged that resident #002, who was exhibiting altered skin integrity, was not assessed by an RD who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

A SAC incident report and CIS report were submitted to the MOHLTC regarding an incident in which resident #001 suffered a suspected injury with cause unknown, which resulted in an area of impaired skin integrity. A complaint was additionally submitted by resident #001's family member regarding the above incident, and the home's handling of the investigation. Review of the CIS indicated that the resident was in the dining room for an identified meal service and no accidents were observed by staff; the exact cause of the injury was not identified.

Review of resident #001's progress notes revealed that on an identified date, staff had reported to RPN #102 that resident #001 had a new area of impaired skin integrity found on an identified body area. An area of impaired skin integrity was noted by the RPN, with additional evidence of impaired skin integrity noted to the identified area of resident #001's body. Resident #001 was assessed by Director of Care (DOC) #121 and Physician #120 suspecting a possible injury resulting in the area of impaired skin integrity. The progress note indicated RPN #102 completed an assessment of resident #001's skin impairment at the same time.

Review of resident #001's assessments showed an assessment entitled "Leisureworld Skin Assessment" was completed on the above mentioned identified date by RPN #102. Further review of resident #001's assessments showed a "Weekly skin assessment" was completed 16 days later, by RPN #109 which indicated an area of impaired skin integrity to the same identified area of resident #001's body, with serous drainage upon assessment. In comparison with the initial assessment the area of impaired skin integrity had increased in size and was draining upon the second assessment. No assessment of resident #001's area of impaired skin integrity was found between the above mentioned dates. Review of resident #001's electronic medication administration record (EMAR) showed a weekly skin assessment for the above mentioned area of impaired skin integrity was not ordered until 24 days following the initial assessment.

In interviews, Associate Director of Care (ADOC) # 113 and #115 indicated that the expectation of the home was that upon becoming aware of a new area of impaired skin integrity that the registered staff would initiate a "Weekly Skin Assessment" and write an order for weekly skin assessments into the physician orders to be transferred to the resident's EMAR. The ADOCs indicated that once a weekly assessment was entered in the EMAR, the registered staff would know to complete the assessment on the scheduled day. Both ADOC #113 and #115 acknowledged that the weekly skin assessment had not been completed over a two week period, while the area increased in size and had drainage observed. ADOC #115 indicated that the "Weekly skin

assessment" should have been used for the initial assessment, and an order for weekly skin assessment written to be completed using the clinically appropriate tool starting the following week. Both ADOCs acknowledged that for resident #001 who was exhibiting altered skin integrity, the licensee failed to ensure the resident was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as set out in the plan.

A written complaint was submitted to the home regarding the continence care of resident #001 not being addressed by the staff of the home. The complaint was forwarded by the home to the Director of the MOHLTC. The complainant indicated that the resident was found with evidence of incontinence on an identified date, and the family was under the impression that the resident had not been changed. A CIS report was initiated detailing the complaint and response from the home. The CIS report indicated that resident #001 had an intervention initiated to check the resident's incontinent product every two hours, to identify the need for changes of the product.

Review of resident #001's current plan of care indicated that the resident required frequent incontinent product changes and the above intervention was in place to check the resident's incontinent product every two hours, to identify the need for changes of their incontinent product. Resident #001 required the assistance of two staff members for the process of toileting. The care plan additionally indicated that the resident had the potential for skin breakdown related to incontinence.

In an interview on an identified date, resident #001's substitute decision maker (SDM) #202 indicated that on occasions they would visit the resident and note that there was an odor and that many times family members would have to ask staff to change resident #001. SDM #202 stated that on the day of the interview they had come to visit resident #001 and assist them with feeding. Resident #001 was found in an identified common area of the home, and SDM #202 brought the resident back to their room. SDM #202 indicated that as of the time of the interview no staff member had checked or changed the resident's incontinent product.

Observations by the inspector on the above mentioned identified date, showed that resident #001 was brought directly to the identified common home area following an identified meal service. Staff did not bring resident #001 to their room to check or change their incontinent product, and left the resident in the common area where they were resting. The inspector did not observe staff to have checked resident #001's incontinent product while they remained in the common area for approximately 90 minutes following the meal service.

In an interview, PSW #117 indicated that resident #001 had the above mentioned identified intervention to check the resident's incontinent product every two hours, to manage incontinent was in place. In an interview on the above mentioned date, PSW #110 indicated that they had been caring for resident #001 that day, and had not checked the resident's incontinent product for approximately six hours, since before the above mentioned identified meal service. PSW #110 indicated that they were not aware that resident #001's plan of care included the intervention to check the resident's incontinent product every two hours. At the conclusion of the interview with PSW #110, resident #001 was observed in bed while PSW #110 prepared to change their incontinent product and an odor was noted. PSW #110 indicated that resident #001 was soiled.

In an interview, ADOC #115 indicated that their expectation was for staff to follow the resident care plan. ADOC #115 acknowledged that based on the observations of the inspector and interview with PSW #110 that resident #001's incontinent product was not checked every two hours as set out in their plan of care. ADOC #115 acknowledged that the licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as set out in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to residents as set out in the plan, to be implemented voluntarily.

Issued on this 15th day of August, 2018

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

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

Ministére de la Santé et 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

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) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2018_420643_0012
Log No. / No de registre :	027234-17, 009858-18, 014854-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 30, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 50 (2) (b) (iii).
Specifically, the licensee must:
1. Ensure that for residents #001, #002 and all other residents exhibiting altered skin integrity are referred to the Registered Dietitian for assessment;
2. Ensure a system is developed to audit referrals to the Registered Dietitian are received and addressed by the Registered Dietitian for residents exhibiting altered skin integrity; and
3. Ensure that for residents #001, #002 and all other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed by a Registered Dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home.

a. An after-hours Spills Action Center (SAC) incident report and critical incident system (CIS) report were submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an incident in which resident #001 was found with a suspected injury with cause unknown, resulting in an area of impaired skin integrity. A complaint was additionally submitted by resident #001's family member regarding the incident, and the home's handling of the investigation. Review of the CIS indicated that the resident was in the dining room for an identified meal and no accidents were observed by staff; the exact cause of the injury was not identified.

Review of resident #001's progress notes and assessments indicated that a skin assessment was completed on an identified date, at which time a nutrition referral was initiated for the Registered Dietitian (RD) to assess the resident's nutrition status in relation to the area of impaired skin integrity. The nutrition referral was addressed the same day by the Part-Time Food Service Supervisor which indicated the referral had been seen, and indicated RD to follow-up. No assessment by the RD was completed related to resident #001's area of impaired skin integrity.

In interviews, Registered Practical Nurses (RPNs) #108 and #109 indicated that a referral to the RD would be initiated when a resident was found to have a new

area of impaired skin integrity. The RPNs indicated that the nutrition referral would be initiated using the assessment tab in the electronic documentation system to be addressed by the RD.

In an interview, RD #118 indicated that it was the expectation of the home for residents exhibiting impaired skin integrity including wounds to be assessed by the RD for nutrition needs and interventions for wound healing. The RD indicated that a resident who exhibited an area of impaired skin integrity would have increased nutrition needs to promote healing. The RD acknowledged that resident #001, who was exhibiting altered skin integrity, was not assessed by an RD who was a member of the staff of the home.

b. Due to identified noncompliance with O. Reg. 79/10, s. 50. (2) (b) (iv), the sample of residents was expanded to include resident #002.

A review of resident #002's progress notes indicated that they were admitted to the home on an identified date, and had nutrition and hydration needs assessed by the RD on the same day of admission. Following the assessment by the RD, a head to toe skin assessment was carried out, which revealed an area of impaired skin integrity which was not noted previously. A nutrition referral was initiated for the RD to complete an assessment related to the resident's area of impaired skin integrity. Progress note from the following day indicated that the nutrition referral was addressed by the Food Services Supervisor showing the referral had been received and would be followed-up on by the RD. Review of progress notes and assessments failed to reveal an assessment of resident #002's nutrition status as it related to the above mentioned area of impaired skin integrity.

In an interview, RD #118 indicated that they were not aware of the nutrition referral for resident #002's area of impaired skin integrity. The RD acknowledged that resident #002, who was exhibiting altered skin integrity, was not assessed by an RD who was a member of the staff of the home.

The severity of this issue was determined to be a level 2 as there was potential for harm to residents #001 and #002. The scope of the issue was a level 2 as it was identified as affecting two out of three residents inspected. The home had a level 2 compliance history as they had one or more unrelated noncompliance issued in the last three years. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 30th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and 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

Ministére de la Santé et 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

Name of Inspector / Nom de l'inspecteur : Adam Dickey

Service Area Office / Bureau régional de services : Toronto Service Area Office