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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Téléphone: (705) 564-3130
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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
Oct 28, 2021	2021_879621_0014	011944-21, 012844-21	Complaint

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street Thunder Bay ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street Thunder Bay ON P7A 4J2

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

JULIE KUORIKOSKI (621), MELISSA HAMILTON (693)

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): October 18 - 20, 2021.

The follow intakes were inspected upon during this Complaint Inspection:

- One intake related to alleged improper care; and
- One intake related to alleged resident neglect.

During the course of the inspection, the inspector(s) spoke with the VP of Seniors' Health, the Administrator, Registered Nurses (RNs), Personal Support Workers (PSWs), the Registered Social Worker (RSW), a Housekeeping Aide (HA) and residents.

The Inspectors also completed daily tours of the resident care areas, observed the provision of care and services to residents, observed staff-to-resident interactions, reviewed relevant resident healthcare records, home's investigation records, and applicable policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 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 a resident was not neglected.

Ontario Regulation (O. Reg.) 79/10, s.5, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

On a particular shift, a Registered Nurse heard a resident's safety device alarming. The RN stated that PSWs were to answer these safety devices, however, when they heard it alarming for a period of time, they went to check on the resident. On route to responding to the alarm, the RN observed a PSW not responding to the alarm. The RN proceeded to the resident room, and noted that an incident had occurred with the resident.

A response system report reviewed from the time of the incident, indicated that the safety device had alarmed for specified period of time, and an additional safety alarm had sounded for a further period of time.

The Administrator indicated that if the PSW had responded to the resident's safety alarm immediately, the resident may not have had an incident, and that the inaction of the PSW jeopardized the resident's health, safety and well-being.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; a PSW's employee file; a resident's care plan; policy titled, " Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01"; a response system report; interviews with the Administrator and other relevant staff members. [s. 19. (1)]

2. The licensee failed to ensure that a resident was protected from neglect.

A Complaint to the Director identified that a resident was found in a certain condition, in a specified location of the resident home area.

The home's investigation identified that unit staff had not located the resident throughout the shift, but instead found by staff on the next shift.

The Administrator identified that PSWs were to perform care and comfort checks of residents at specified time intervals. They further indicated that failure to complete the resident checks at the required intervals, and failure to follow up to confirm the resident's whereabouts throughout the shift, placed the resident's safety and well-being at risk. The Administrator confirmed that by definition, the pattern of inaction by the PSW and RN

staff over a period of time to ascertain the resident's whereabouts during the shift, constituted neglect.

Sources: A complaint submitted to the Director; review of home's investigation notes, resident healthcare records, staff schedule, Care and Comfort Round Policy LRC-12-01-06, St. Joseph's Care Group Missing Resident Procedures, Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01; and interviews with PSWs, RNs, the Administrator, and other relevant staff. [s. 19. (1)]

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 :

1. The licensee has failed to ensure that neglect of a resident, was immediately reported to the Director.

A Complaint to the Director identified that a resident was discovered in a certain condition, in a specified location of the resident's home area.

The home’s investigation identified that unit staff had not located the resident throughout the shift, but instead found by staff on the next shift.

The Administrator indicated that they should have reported this incident of neglect to the Director.

Sources: Review of home’s investigation notes, Care and Comfort Round Policy LRC-12-01-06, St. Joseph’s Care Group Missing Resident Procedures, Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01; and Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-02; and interviews with the Administrator, and other relevant staff. [s. 24. (1)]

2. The licensee has failed to ensure that neglect of a resident was immediately reported the to the Director.

A PSW was found in a certain location of the home, while a resident safety device was sounding. The PSW did not respond to the alarm, resulting in an RN attending to the alarm, and discovering an incident had occurred with the resident.

The Administrator indicated that they should have reported this incident of neglect to the Director.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; PSW employee file; policy titled, "Critical Incident Reporting (ON), LRC-09-01-06"; policy titled, " Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01"; a response system report; interviews with the Administrator and other relevant staff members. [s. 24. (1)]

3. The licensee has failed to ensure that improper care of a resident was immediately reported the to the Director.

A PSW transferred a resident, utilizing a mechanical lift without assistance from a second staff member.

The Administrator indicated that the improper transfer created actual risk to the resident, and it was not reported to the Director.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; PSW employee file; a resident's care plan; policy titled, "Critical Incident Reporting (ON), LRC-09-01-06"; interviews with the Administrator and other relevant staff members. [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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

A PSW was found to have transferred a resident, utilizing a mechanical lift without assistance from a second staff member. The resident's care plan indicated that they required the use of a mechanical lift for transferring, and two staff members were required to complete the transfer.

The Administrator indicated that the PSW completed an improper transfer of the resident, and actual risk occurred as a result of the transfer.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; PSW employee file; a resident's care plan; policy titled, "Mechanical Lifts Procedure, LLP-01-01-03"; interviews with the Administrator and other relevant staff members. [s. 36.]

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 use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 9th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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) :	JULIE KUORIKOSKI (621), MELISSA HAMILTON (693)
Inspection No. / No de l’inspection :	2021_879621_0014
Log No. / No de registre :	011944-21, 012844-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 28, 2021
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, Thunder Bay, ON, P7B-5G7
LTC Home / Foyer de SLD :	Bethammi Nursing Home 63 Carrie Street, Thunder Bay, ON, P7A-4J2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Randy Middleton

To St. Joseph's Care Group, 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 :

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 comply with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must ensure that:

1) Personal Support Workers (PSWs) complete resident care and comfort rounds at intervals established and consistent with the home's policy; and

2) Training/Re-training is completed with all PSWs, Registered Practical Nurses (RPNs) and Registered Nurses (RNs) on the licensee's procedures for exercising an emergency response for a missing resident. Records are to be maintained on the date of the training, who completed the training, what the training entailed.

Grounds / Motifs :

1. The licensee failed to ensure that a resident was not neglected.

Ontario Regulation (O. Reg.) 79/10, s.5, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

On a particular shift, a Registered Nurse heard a resident's safety device alarming. The RN stated that PSWs were to answer these safety devices, however, when they heard it alarming for a period of time, they went to check on the resident. On route to responding to the alarm, the RN observed a PSW not responding to the alarm. The RN proceeded to the resident room, and noted that

an incident had occurred with the resident.

A response system report reviewed from the time of the incident, indicated that the safety device had alarmed for specified period of time, and an additional safety alarm had sounded for a further period of time.

The Administrator indicated that if the PSW had responded to the resident's safety alarm immediately, the resident may not have had an incident, and that the inaction of the PSW jeopardized the resident's health, safety and well-being.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; a PSW's employee file; a resident's care plan; policy titled, " Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01"; a response system report; interviews with the Administrator and other relevant staff members. (693)

2. The licensee failed to ensure that a resident was protected from neglect.

A Complaint to the Director identified that a resident was found in a certain condition, in a specified location of the resident home area.

The home's investigation identified that unit staff had not located the resident throughout the shift, but instead found by staff on the next shift.

The Administrator identified that PSWs were to perform care and comfort checks of residents at specified time intervals. They further indicated that failure to complete the resident checks at the required intervals, and failure to follow up to confirm the resident's whereabouts throughout the shift, placed the resident's safety and well-being at risk. The Administrator confirmed that by definition, the pattern of inaction by the PSW and RN staff over a period of time to ascertain the resident's whereabouts during the shift, constituted neglect.

Sources: A complaint submitted to the Director; review of home's investigation notes, resident healthcare records, staff schedule, Care and Comfort Round Policy LRC-12-01-06, St. Joseph's Care Group Missing Resident Procedures, Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01; and interviews with PSWs, RNs, the Administrator, and other relevant staff.

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

Severity: There was actual risk to a resident, with findings neglect of the resident by a PSW and an RN; and actual risk to another resident, with findings of neglect by another PSW.

Scope: The scope of this non-compliance was a pattern, as neglect was identified in two out of three residents reviewed during this inspection.

Compliance History: The home’s compliance history over the past 36 months identified non-compliance including, three previously complied Compliance Orders (CO's) and one Director's Referral with the same subsection. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 03, 2021

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 comply with s. 24 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Grounds / Motifs :

1. The licensee has failed to ensure that neglect of a resident, was immediately reported to the Director.

A Complaint to the Director identified that a resident was discovered in a certain condition, in a specified location of the resident's home area.

The home's investigation identified that unit staff had not located the resident throughout the shift, but instead found by staff on the next shift.

The Administrator indicated that they should have reported this incident of neglect to the Director.

Sources: Review of home's investigation notes, Care and Comfort Round Policy LRC-12-01-06, St. Joseph's Care Group Missing Resident Procedures, Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01; and Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-

02; and interviews with the Administrator, and other relevant staff. (621)

2. The licensee has failed to ensure that neglect of a resident was immediately reported the to the Director.

A PSW was found in a certain location of the home, while a resident safety device was sounding. The PSW did not respond to the alarm, resulting in an RN attending to the alarm, and discovering an incident had occurred with the resident.

The Administrator indicated that they should have reported this incident of neglect to the Director.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; PSW employee file; policy titled, "Critical Incident Reporting (ON), LRC-09-01-06"; policy titled, " Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01"; a response system report; interviews with the Administrator and other relevant staff members. (621)

3. The licensee has failed to ensure that improper care of a resident was immediately reported the to the Director.

A PSW transferred a resident, utilizing a mechanical lift without assistance from a second staff member.

The Administrator indicated that the improper transfer created actual risk to the resident, and it was not reported to the Director.

Sources: A complaint submitted to the Director; Electronic Mail (Email) message; PSW employee file; a resident's care plan; policy titled, "Critical Incident Reporting (ON), LRC-09-01-06"; interviews with the Administrator and other relevant staff members.

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

Severity: There was minimal risk associated with reporting requirements to the

Director related to neglect of three residents.

Scope: The scope of this non-compliance was wide-spread, as an immediate mandatory report to the Director was not made in three out of three (100 per cent) of residents reviewed during this inspection.

Compliance History: The home’s compliance history over the past 36 months identified non-compliance including, one previously complied Written Notification (WN) and two Voluntary Plans of Correction (VPN's) with the same subsection. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 08, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

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