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

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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 15, 2019	2019_818502_0025	017469-19, 019061-19, 019126-19, 019856-19, 020223-19	Critical Incident System

Licensee/Titulaire de permis

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

JULIENNE NGONLOGA (502)

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): October 29, 30, 31 and November 1, 2019.

During the course of the inspection, the following Critical Incident System (CIS) reports were inspected:
- CIS #C516-000013-19 (017469-19) related to fall,
- CIS #C516-000016-19 (log #019126-19), CIS #C516-000015-19 (019061-19), and CIS #C516-000018-19 (log #020223-19) related to staff to resident abuse, and
- CIS #C516-000017-19 (log #019856-19) related to unexpected death.

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

During the course of this inspection, the inspector observed resident care, staff and resident interactions, interviewed staff and reviewed the residents' health care records, staff schedules, the licensee investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that on an identified date, resident #003 was not restrained for the convenience of PSW #103.

The Ministry of Long-Term Care (MLTC) received Critical Incident System report (CIS) related to Personal Support Worker (PSW) #103 abuse toward resident #003.

A review of the CIS indicated that on an identified date and time, resident #003 was observed with specified injury.

A review of the home's quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) indicated that resident #003 was assessed to be severely cognitively impaired, with specified diagnosis.

Review of the resident's current written plan of care indicated that the resident required specified care. Further review of the plan of care indicated that resident #003 displays identified behaviours during care and specified interventions were implemented.

In an interview, PSW #107 indicated that two PSWs were scheduled to work during the

night shift on the day of the incident, they care for the residents in one side of the unit and PSW #103 care for the residents in the other side of the unit. Toward the end of their shift, they observed an identified injury on PSW #103's hand which they did not have at the beginning of their shift. PSW #107 inquired about the injury and PSW #103 told them that resident #003 displayed an identified behaviour.

In an interview, PSW #103 indicated that they were assigned to resident #003 at the time of incident. They indicated that the resident sometimes displays specified behaviour and required assistance of two staff for identified care. The PSW indicated the used the resident's bedding to immobilize the resident and protect themselves from the resident's behaviour, because they second staff was not available to assist. PSW #103 indicated they hurt themselves while walking, which resulted in injury, but denied telling PSW #107 that resident #003 displayed an identified behaviour toward them.

In an interview, DOC indicated that staff were expected to provide care to the resident in pair, one staff hold the resident's hands while the other staff provides care. The DOC indicated that resident #003 was not assessed for any type of restrain and there was no consent by the resident's SDM to immobilize the resident, therefore, staff should have not immobilized the resident in order to safe during care, they should have called for assistance to provide care. [s. 30. (1) 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. 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006's right to be protected from abuse was fully respected and promoted.

The MLTC received a CIS on an identified date related to PSW #107 abuse toward resident #006.

Review of the CIS indicated PSW #103 told the Administrator that on an identified date and time they were changing resident #006's continence care product with the assistance of PSW #107. Resident #006 was exhibiting their identified responsive behaviour during care. PSW #103 stated that they observed PSW #107 take a wet facecloth and put it in the resident's mouth and removed it only when PSW #103 looked at them. Resident #006 continued to exhibit their identified behaviour and for the second time PSW #107 took a small facecloth and put it in the resident's mouth to stop them from exhibiting the behaviour.

Review of the resident's current plan of care indicated that resident #006 identified the resident's responsive behaviour and outline specified interventions.

In an interview, PSW #103 confirmed the above statement of facts reported in the CIS by the Administrator. PSW #103 stated that they did not report the incident immediately as the management did not act in the past when similar incidents were reported.

In an interview, PSW #107 stated that they used the resident's bedding as attempt to decrease their identified responsive behaviour during care and to prevent them from waking other residents up. They denied putting a facecloth inside resident #006's mouth.

In an interview, the DOC indicated that PSW #107's action was not acceptable as they appeared to be abusive toward resident #006.

Although PSW #107 was aware of resident #003's identified responsive behaviour during care, and the interventions in place, they used the resident's bedding to stop the resident behaviour, PSW #103 did not intervene, stop PSW #107's action or report it immediately, therefore the resident's right to be protected from abuse was not fully respected and promoted. [s. 3. (1) 2.]

2. The licensee has failed to ensure that resident #007's right not to be neglected by the licensee or staff was fully respected and promoted.

The MLTC received a CIS related to abuse.

Review of the CIS indicated that on an identified date and time, registered nurse (RN) #104 was observed sitting at the nursing station. Resident #007 was observed seeking RN's attention. On every occasion the RN did not look at the resident, did not acknowledged the resident's presence, and ignored them. As a result, the resident displayed specified behaviour.

Review of the resident's current written plan of care indicated that resident #007's identified signs of distress. The plan of care outline specified strategies to reduce the responsive behaviour.

RN #104 was not available for interview. Therefore, the statement given during the home's investigation was considered. The RN indicated that they had answered the resident's questions, but they did not stop.

In an interview, DOC indicated that the charge nurse RN #104 had previous incidents related to not monitoring the resident. The DOC acknowledged that RN #104 did not respect the resident's right not to be neglected by not applying strategies outlined in the plan of care. [s. 3. (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:
- rights of residents to be protected from abuse and not to be neglected by the licensee or staff are fully respected and promoted, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident #002's SDM, and the designate of the resident's SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

Critical Incident System report (CIS) related to an unexpected death was received by the Ministry of Long-Term Care (MLTC).

Review of the CIS report and resident #001's progress notes indicated that on an identified date and time resident #001 complained of an identified symptom. On the same day the attending physician ordered a specified treatment.

The next day the attending physician changed the treatment.

Two days after a PSW reported to the charge nurse that resident #001 was not well. The

charge nurse assessed the resident and they called the paramedics. They arrived and found the resident with no pulse and no respiration. The advanced directive was level three, which means transfer to hospital with no Cardiopulmonary resuscitation (CPR).

Further review of the progress notes indicated that the resident's Substitute Decision Maker (SDM) was informed of their death the same day. The SDM questioned why they were not notified earlier when the resident started feeling unwell.

In an interview, RN #102 indicated that the SDM should be contacted when there is a change in physician order, or when the treatment change. After a review of the progress notes the RN indicated that the resident's SDM was not notified when the resident treatment changed on the date identified above.

In an interview, the DOC stated that the home expectation was for registered nursing staff to contact the resident's SDM after the physician made change in the resident treatment. They acknowledged that the SDM was not given opportunity to participate in the development and implementation of resident #001's care plan. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The MLTC received a CIS related to PSW #103 abuse toward resident #003.

A review of the CIS indicated that on an identified date and time, resident #003 was observed with specified injury.

Review of the resident's current written plan of care indicated that resident #003 exhibit specified responsive behaviour during care. The plan of care indicated that two to three staff provide care to the resident at all time.

In an interview, PSW #107 indicated that two PSWs were scheduled to work on an identified shift on the day of incident. They care for the residents in one part of the unit and PSW #103 care for the resident in the other part of the unit. PSW #107 stated that PSW #103 did not ask for assistance with resident #003's care during the shift.

In an interview, PSW #103 indicated that they were assigned to resident #003 on that specific day and shift. PSW #103 stated that they provided identified care during that shift unassisted, as the second PSW was not available to assist.

In an interview, DOC indicated that staff are expected to provide care to the resident in pair, one staff hold the resident's hands while the other staff provides care. The DOC acknowledged that PSW #103 did not provide care as specified in the plan of care when they did not ask for assistance to change the resident's continence care product. [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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #103 who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in the following areas:
1. Abuse recognition and prevention
2. Mental health issues, including caring for persons with dementia
3. Behaviour management
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations

The MLTC received a CIS related to PSW #103 abuse toward resident #003.

In an interview, PSW #103 stated that they returned to work after two years of a leave of absence and had not received a training on the areas identified above.

In an interview, the DOC indicated that there was no record on Surge Learn to indicated that the PSW completed the training on the areas identified above. The DOC also stated that they have been working in the home for an identified period and was not aware if the PSW received a training upon their return to work.

During this inspection, records were not provided to indicate that PSW #103 had received training on the areas identified above as a condition of continuing to have contact with residents. [s. 76. (7)]

Issued on this 20th 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) :	JULIENNE NGONLOGA (502)
Inspection No. / No de l’inspection :	2019_818502_0025
Log No. / No de registre :	017469-19, 019061-19, 019126-19, 019856-19, 020223-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 15, 2019
Licensee / Titulaire de permis :	Centre d'Accueil Roger Seguin 435 Lemay Street, Clarence Creek, ON, K0A-1N0
LTC Home / Foyer de SLD :	Centre d'Accueil Roger Seguin 435 Lemay Street, Clarence Creek, ON, K0A-1N0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Joanne Henrie

To Centre d'Accueil Roger Seguin, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee shall complied with s. 30. (1) 1 of LTCHA 2007.

Specifically the licensee shall ensure that resident #003 and any other resident of the home is restrained, in any way, for the convenience of the staff.

Grounds / Motifs :

1. The licensee has failed to ensure that on an identified date, resident #003 was not restrained for the convenience of PSW #103.

The Ministry of Long-Term Care (MLTC) received Critical Incident System report (CIS) related to Personal Support Worker (PSW) #103 abuse toward resident #003.

A review of the CIS indicated that on an identified date and time, resident #003 was observed with specified injury.

A review of the home's quarterly Resident Assessment Instrument-Minimum

Data Set (RAI-MDS) indicated that resident #003 was assessed to be severely cognitively impaired, with specified diagnosis.

Review of the resident's current written plan of care indicated that the resident required specified care. Further review of the plan of care indicated that resident #003 displays identified behaviours during care and specified interventions were implemented.

In an interview, PSW #107 indicated that two PSWs were scheduled to work during the night shift on the day of the incident, they care for the residents in one side of the unit and PSW #103 care for the residents in the other side of the unit. Toward the end of their shift, they observed an identified injury on PSW #103's hand which they did not have at the beginning of their shift. PSW #107 inquired about the injury and PSW #103 told them that resident #003 displayed an identified behaviour.

In an interview, PSW #103 indicated that they were assigned to resident #003 at the time of incident. They indicated that the resident sometimes displays specified behaviour and required assistance of two staff for identified care. The PSW indicated the used the resident's bedding to immobilize the resident and protect themselves from the resident's behaviour, because they second staff was not available to assist. PSW #103 indicated they hurt themselves while walking, which resulted in injury, but denied telling PSW #107 that resident #003 displayed an identified behaviour toward them.

In an interview, DOC indicated that staff were expected to provide care to the resident in pair, one staff hold the resident's hands while the other staff provides care. The DOC indicated that resident #003 was not assessed for any type of restrain and there was no consent by the resident's SDM to immobilize the resident, therefore, staff should have not immobilized the resident in order to safe during care, they should have called for assistance to provide care.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1 as one out of three residents reviewed was affected. The home had a level 2 history as they had previous noncompliance to a different subsection of the LTCHA.

Due to the severity, scope, and history, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 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 15th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

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