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 prévue le Loi de 2007 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 26, 2018;	2017_660218_0013 (A1)	028450-17	Critical Incident System

Licensee/Titulaire de permis

LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE WALLACEBURG ON N8A 4M2

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

LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET GUELPH ON N1E 4Y8

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

APRIL TOLENTINO (218) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Due Date Amended

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 26 day of January 2018 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 26, 2018;	2017_660218_0013 (A1)	028450-17	Critical Incident System

Licensee/Titulaire de permis

LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE WALLACEBURG ON N8A 4M2

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

LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET GUELPH ON N1E 4Y8

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

APRIL TOLENTINO (218) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 28, 2017.

The following Critical Incident (CI) was related to a falls incident that resulted in death:

Log #028450-17

The Inspector reviewed relevant clinical records, policies and procedures, and spoke with family and staff members.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, a Registered Practical Nurse, and a Personal Support Worker.

The following Inspection Protocols were used during this inspection:

Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was

assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC).

A review of the Progress Notes documented on PointClickCare (PCC) showed that the resident was lowered to the ground by a Personal Support Worker (PSW). The Registered Nurse (RN) was notified of the incident and documentation written by the Registered Practical Nurse (RPN) showed that the RN assessed the resident and stated that the incident was not considered a fall.

A review of the Long-Term Care Home's (LTCH) policy titled, 'Fall Prevention Program' in Section F. page 5.5 defined a fall to be "when a resident loses balance and would have fallen if staff did not intervene". It also stipulated that "in the event of a fall the registered staff will immediately complete a Risk Assessment Report on PCC (post fall)".

In an interview, the RN acknowledged that they did not complete a post-fall assessment on the resident because they did not consider the situation to be a fall. The RN stated that their understanding of a fall would be if the resident had fallen on their own and not with the assistance of another staff member.

In an interview, the RPN stated that they were immediately notified of the fall by the PSW. The RPN stated that they had to consult with the RN for assistance because they were in the middle of a nursing task. The RPN acknowledged that they did not complete an assessment for the falls incident.

In an interview, the Administrator and Director of Care (DOC) both agreed that the incident should have been classified as a fall. The DOC stated that the expectation was for registered staff members to complete a "Risk Management" assessment on PCC following every falls incident. The Administrator and DOC acknowledged that a post-falls assessment was not completed for the resident when they had fallen.

Clinical record reviews further documented that the resident began to demonstrate responsive behaviours and had difficulty with their mobility the following day. The Physician was notified and medical results revealed a significant injury.

The Administrator and DOC stated that they were not aware that the resident's significant injury was related to another specific falls incident, until after completing an internal investigation. Both acknowledged that the RPN and RN failed to complete a post-falls assessment for the resident as required.

The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted. [s. 49. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation required the licensee of a LTCH to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy was complied with.

In an interview, the DOC stated that the expectation for all nursing staff members were to complete a post-falls assessment on PCC under the 'Risk Management' tab immediately following a falls incident. Additionally, the DOC stated that it was also required for staff to complete a paper copy of the 'Post Fall Huddle Form', a Pain Assessment on PCC, and a Head-to-Toe Assessment on PCC to record any negative impacts and injuries. Staff were also expected to complete a Head Injury Routine Assessment for unwitnessed falls and for witnessed falls with head impact on paper copy.

A review of the LTCH's 'Falls Prevention Program' was conducted and there was no documentation outlining the additional expectations mentioned above related to post-fall assessments. The DOC acknowledged that the LTCH's falls program did not clearly identify all of their expectations in completing the required post-fall assessments.

Secondly, the LTCH's 'Falls Prevention Program' documented that an analysis for every fall will be reviewed at the monthly Falls Prevention Team Meeting. The DOC shared that this was not completed for November and December 2017.

The DOC acknowledged that their policy related to falls prevention was not complied with as required.

The licensee failed to ensure that the policy related to falls prevention was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 LTCH's policy related to falls prevention is complied with,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the falls program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Record reviews showed that there was a falls program evaluation conducted in 2016. There was no documentation to demonstrate any changes made to the program.

In an interview, the DOC shared that they had not completed their annual falls program evaluation for 2017. The DOC stated that they will complete an evaluation for the falls program in the near future.

The licensee failed to ensure that the falls program was evaluated and updated annually. [s. 30. (1) 1.]

Issued on this 26 day of January 2018 (A1)

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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : APRIL TOLENTINO (218) - (A1)

Inspection No. / No de l'inspection : 2017_660218_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 028450-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jan 26, 2018;(A1)

Licensee / Titulaire de permis : LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE, WALLACEBURG, ON, N8A-4M2

LTC Home / Foyer de SLD : LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET, GUELPH, ON, N1E-4Y8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Dahlia Burt-Gerrans

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 LAPOINTE-FISHER NURSING HOME, LIMITED, 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. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

(A1)
The licensee shall ensure that when a resident has fallen, they are assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted.

The licensee shall ensure that all registered staff members are aware of what constitutes a fall, and that they are provided with education/training related to its definition, and the staff's responsibilities should they encounter a falls incident.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

The severity of the issue was determined to be a level three with actual risk / harm related to falls assessments. The scope of the issue was isolated and the LTCH had a history of multiple unrelated non-compliances.

A Critical Incident (CI) report #2358-000016-17 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on December 11, 2017, regarding an unexpected death of resident #001. The cause of death was due to complications of a fracture related to a fall that occurred on November 27, 2017.

A review of the Progress Notes documented on PointClickCare (PCC) dated November 27, 2017, at 0020 hours (hrs) showed that resident #001 was feeling weak in the legs and was lowered to the ground by Personal Support Worker (PSW) #103. The Registered Nurse (RN) #105 was notified of the incident and documentation written by Registered Practical Nurse (RPN) #104 showed that RN #105 assessed the resident and stated "this is not a fall and won't be put under Risk Management".

A review of the Long-Term Care Home's (LTCH) policy titled, 'Fall Prevention Program' in Section F. page 5.5 stated that a fall was considered to be "when a resident loses balance and would have fallen if staff did not intervene". It also stipulated that "in the event of a fall the registered staff will immediately complete a Risk Assessment Report on PCC (post fall)".

In an interview conducted on January 10, 2018, RN #105 acknowledged that they did not complete a post-fall assessment on resident #001 because they did not consider the situation to be a fall. RN #105 stated that they would only consider the situation to be a fall if the resident had fallen on their own.

In an interview conducted on December 28, 2017, PSW #103 clarified that resident #001 began to lose their balance and caught them before hitting the ground. PSW #103 stated that they attempted to catch the resident as they began to lose their balance while walking but was unable to do so because their feet was shuffling. PSW #103 stated that their description of the incident was shared with RN #105.

In an interview conducted on December 28, 2017, RPN #104 stated that they were immediately notified of the fall by PSW #103. RPN #104 stated that they had to consult with RN #105 for assistance because they were in the middle of a nursing task. RPN #104 stated that they considered the situation as a fall but was informed by RN #105 that it was not. RPN #104 stated that they were not in the position to question or challenge the RN #105's assessment. RPN #104 acknowledged that they did not complete an assessment for the falls incident that occurred on November 27, 2017.

In an interview conducted on December 28, 2017, the Administrator #100 and Director of Care (DOC) #101 both agreed that the incident should have been classified as a fall. DOC #101 stated that the expectation was for registered staff members to complete a "Risk Management" assessment on PCC following every falls incident. The Administrator #100 and DOC #101 acknowledged that a post-falls assessment was not completed for resident #001 when they had fallen on November 27, 2017.

Clinical record reviews further demonstrated that resident #001 became resistive with care, presented with an elevated temperature, and was unable to weight bear the following day. The Physician was notified and an x-ray was ordered with results that revealed a fracture of the left femur.

DOC #101 shared that the Physician was not made aware of the falls incident that occurred on November 27, 2017. DOC #101 clarified that x-ray orders were made because the Physician was correlating the resident's symptoms with a separate falls incident that occurred on November 22, 2017.

Collaborative care decisions were made with the resident #001's Power of Attorney to implement pain and comfort measures. On December 8, 2017, resident #001 was placed on palliative status and deceased on December 9, 2017.

A review of resident #001's 'Medical Certificate of Death – Form 16' dated December 9, 2017, documented that the death was accidental and the immediate cause was due to complications of a fracture related to a fall.

The Administrator #100 and DOC #101 acknowledged that the falls incident constituted improper care related to failure in completing a falls assessment as required for every falls incident. They stated that they were not aware that resident #001 had fallen on November 27, 2017, until after completing an internal investigation when resident #001 had already passed away.

DOC #101 stated that a 'General Staff Meeting' was held on December 22, 2017, at 1000 hours to discuss scenarios in which constituted a fall and roles in attending to a resident that had fallen. A review of the attendance list showed that PSW #103, RPN #104, and RN #105 did not attend this meeting.

During staff interviews, PSW #103, RPN #104 and RN #105 shared that they

provided their statements to the leadership team but had not received additional education related to falls prevention. DOC #101 stated that they did not have documented evidence to support that feedback or additional training and education was provided to the staff members involved in the incident.

The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted. (218)

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

Feb 27, 2018(A1)

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

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

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 26 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : APRIL TOLENTINO

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

Service Area Office / Bureau régional de services : London