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
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## 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 |
|---|---|---|---|
| Dec 20, 2019 | 2019_680687_0036 | 019860-19, 020592-19, 021163-19 | Complaint |

### Licensee/Titulaire de permis

City of Greater Sudbury
200 Brady Street 4th Floor SUDBURY ON P3E 3L9

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

Pioneer Manor
960 Notre Dame Avenue SUDBURY ON P3A 2T4

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

LOVIRIZA CALUZA (687), SHELLEY MURPHY (684)

## 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): December 2 to 6, 2019.**

**The following intakes were inspected during this Complaint Inspection:**

**- Three intakes related to complaints submitted to the Director regarding staff to resident neglect.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Manager (RCM), Program Coordinators (PCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), residents and their families.**

**The Inspectors also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.**

**A Critical Incident System Inspection #2019_680687_0035 was conducted concurrently with this Complaint Inspection.**

**PLEASE NOTE: Non-compliance related to s. 6 (7) of the LTCHA 2007 was identified in concurrent inspection, and was issued in this report.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 :**

The licensee has failed to ensure that resident #001 was not neglected by the staff.

Neglect is defined in the O. Reg. 79/10 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A complaint was submitted to the Director regarding an alleged neglect towards resident #001 on a specified date. In addition, a Critical Incident (CI) report was submitted by the home regarding the same incident.

Inspector #684 reviewed the complaint related to resident #001 who had fallen and sustained an injury as a result of neglect on a specified date. In addition, the Inspector reviewed the CI report regarding the same incident and identified that the staff had signed a specified document prior to knowing where resident #001 was.

A) Inspector #684 interviewed Health Care Aide (HCA) #115 regarding a fall incident of resident #001 which occurred on a specified date. The HCA stated that they assisted the resident with a specific care in a specified area and had provided them with a call bell, but the resident did not use their call bell. The HCA further stated that they had forgotten the resident in the specified area, and that the resident was unattended for a specified amount of time.

Inspector #684 reviewed the residents' documentation record and identified that HCAs were supposed to check the residents, and to document this in the documentation record. The Inspector further identified that resident #001 was documented that they were checked in the specified documentation record by HCA #109 and #117 on a specified date. However, during interviews conducted by Inspector #684 with the HCAs, they stated that they did not check resident #001 prior to signing the specified documentation record.

During a review of the home's investigation file, Inspector #684 reviewed a specific document which indicated that several staff members had failed to conduct their checks and as a result, a resident was left unattended in a specified area. In addition, the Inspector reviewed a document that was issued to HCA #115 which indicated that the staff [HCA #115] had failed to provide the necessary care, and neglect was substantiated.

Inspector #684 and Program Coordinator (PC) #116 reviewed the home's investigation file, specifically the document issued to HCA #115. PC #116 confirmed that as per the document, there was substantiated neglect by HCA #115 towards resident #001.

B) Section 58 of the O. Reg. 79/10, stipulates that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.

Together, Inspector #684 and PC #116 reviewed the home's investigation file and it was documented that HCA #109 and #115 did not perform the specified transfer intervention for resident #001 on a specified date. The PC further stated that the care was not provided to resident #001 as per their care plan when the two HCAs utilized a different transfer intervention. Please refer to WN #4 for additional information.

C) Section 51 subsection 2 of the O. Reg. 79/10, stipulates that each resident who is incontinent has an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Together, Inspector #684 and PC #116 reviewed the home's investigation file, where it was documented that HCA #109 and #115 used the incorrect interventions when providing care specific to the resident's continence care needs. The PC further stated that the care was not provided to resident #001 as per their care plan. Please refer to WN #3 for additional information. [s. 19. (1)]

***Additional Required Actions:***

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

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

**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 there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

Two complaints were submitted to the Director which outlined specific personal care concerns for resident #004.

During a review of resident #004's specified care plan, Inspector #684 identified a specific focus with a specified care interventions "A" and "B".

Inspector #684 interviewed HCA #104 who stated that resident #004's family wanted intervention A for the resident. The Inspector reviewed resident #004's care plan with HCA #104, the HCA stated that the resident's care plan indicated interventions A and B and it was confusing.

Inspector #684 reviewed the home's policy "Documentation Resident Care Plan", last revised September 2, 2018, which indicated "Each resident will have an individualized electronic plan of care that gave clear, current and relevant direction to staff providing care to the residents".

Together, Inspector #684 and Program Coordinator #111 reviewed the current care plan for resident #004, specifically the specified care focus. The PC stated that resident #004's specified care plan identified as interventions A and B was conflicting. The PC further stated that the resident's care plan identified as intervention B should have been

deleted when the staff updated the care plan. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

A CI report was submitted to the Director regarding resident #005’s fall incident which resulted in an injury to the resident.

During resident #005’s room observation conducted by Inspector #687 on specified dates, the Inspector observed multiple items on the floor on both side of the resident's bed.

Inspector #687 reviewed resident #005's current care plan and identified a specified focus which indicated that staff were to ensure that the resident's environment was to be free of clutter.

A review of the home’s policy entitled “Documentation: Resident Care Plan” last revised on September 2, 2018, indicated that each resident would have had an individualized electronic plan of care that gave clear, current and relevant direction to staff providing care to the residents.

During an interview with Registered Practical Nurse (RPN) #102 and Registered Nurse (RN) #110, they both stated and acknowledged that resident #005 was at risk for falls and had specified items on the floor on both sides of their bed. The registered staff both stated that the staff were to ensure that resident #005’s specified interventions were followed.

In an interview with PC #116, they verified that resident #005 had specified items on both sides of the floor in their bedroom and that they were not made aware about it. The PC further stated that their expectation from their staff was to follow the specified interventions in the resident’s plan of care. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident who was incontinent has an individualized plan of care to promote and manage their bowel and bladder continence and that the plan was implemented.

A complaint and CI report were submitted to the Director related to resident #001 who had fallen and sustained an injury as a result of neglect on a specified date  Please refer to WN #1 for additional details.

During a review of resident #001's care plan, Inspector #684 identified a specific continence focus with associated interventions.

In an interview conducted by Inspector #684 with HCA #115, the HCA described that on a specified date, they provided continence care that did not follow the resident's specific continence care interventions

During an interview with HCA #109 on a specified date, the HCA described how resident #001 was provided continence care. [s. 51. (2) (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 a resident who is incontinent has an individualized plan of care to promote and manage their bowel and bladder continence and that the plan is implemented, to be implemented voluntarily.***

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**WN #4:  The Licensee has failed to comply with O.Reg 79/10, s. 58.  Every licensee of a long-term care home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.  O. Reg. 79/10, s. 58.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when transferring and positioning residents, staff would use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.

A complaint and CI report were submitted to the Director related to resident #001 who had fallen and sustained an injury as a result of neglect on a specified date. Please refer to WN #1 for additional details.

Inspector #684 reviewed the home's policy for "Minimal Lift Program", last revised November 21, 2018, the policy stated that, "All staff must adhere to the designated lift/transfer status as identified on each resident care plan (RCP) and Kardex".

During a review of resident #001's care plan, Inspector #684 identified a specified continence focus with specific transfer interventions.

In an interview conducted by Inspector #684 with HCA #115 with HCA #115 on a specified date, the HCA stated that resident #001 was transferred with a different transfer intervention than in the care plan.

During an interview with HCA #109 on a specified date, the HCA described how resident #001 was provided continence care. [s. 58.]

***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 when transferring and positioning residents, staff will use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion, to be implemented voluntarily.***

**Issued on this 6th day of January, 2020**

**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) :** | LOVIRIZA CALUZA (687), SHELLEY MURPHY (684) |
| **Inspection No. / No de l'inspection :** | 2019_680687_0036 |
| **Log No. / No de registre :** | 019860-19, 020592-19, 021163-19 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Dec 20, 2019 |
| **Licensee / Titulaire de permis :** | City of Greater Sudbury<br>200 Brady Street, 4th Floor, SUDBURY, ON, P3E-3L9 |
| **LTC Home / Foyer de SLD :** | Pioneer Manor<br>960 Notre Dame Avenue, SUDBURY, ON, P3A-2T4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Aaron Archibald |

To City of Greater Sudbury, you are hereby required to comply with the following order (s) by the date(s) set out below:

## 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

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**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 be compliant with LTCHA 2007, s. 19 (1).

a) Ensure that resident #001 and all other residents are not neglected by staff;

b) Ensure that resident #001 and all other residents are visually checked by staff members at the beginning and at the end of the shift;

c) Ensure that resident #001 and all other residents are transferred and positioned using devices and techniques as per their plan of care, and

d) Ensure that HCA #115 is retrained on the home's prevention of Abuse and Neglect Policy.

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #001 was not neglected by the staff.

Neglect is defined in the O. Reg. 79/10 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

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and sustained an injury as a result of neglect on a specified date. In addition, the Inspector reviewed the CI report regarding the same incident and identified that the staff had signed a specified document prior to knowing where resident #001 was.

A) Inspector #684 interviewed Health Care Aide (HCA) #115 regarding a fall incident of resident #001 which occurred on a specified date. The HCA stated that they assisted the resident with a specific care in a specified area and had provided them with a call bell, but the resident did not use their call bell. The HCA further stated that they had forgotten the resident in the specified area, and that the resident was unattended for a specified amount of time.

Inspector #684 reviewed the residents' documentation record and identified that HCAs were supposed to check the residents, and to document this in the documentation record. The Inspector further identified that resident #001 was documented that they were checked in the specified documentation record by HCA #109 and #117 on a specified date. However, during interviews conducted by Inspector #684 with the HCAs, they stated that they did not check resident #001 prior to signing the specified documentation record.

During a review of the home's investigation file, Inspector #684 reviewed a specific document which indicated that several staff members had failed to conduct their checks and as a result, a resident was left unattended in a specified area. In addition, the Inspector reviewed a document that was issued to HCA #115 which indicated that the staff [HCA #115] had failed to provide the necessary care, and neglect was substantiated.

Inspector #684 and Program Coordinator (PC) #116 reviewed the home's investigation file, specifically the document issued to HCA #115. PC #116 confirmed that as per the document, there was substantiated neglect by HCA #115 towards resident #001.

B) Section 58 of the O. Reg. 79/10, stipulates that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.

Together, Inspector #684 and PC #116 reviewed the home's investigation file and it was documented that HCA #109 and #115 did not perform the specified transfer intervention for resident #001 on a specified date. The PC further stated that the care was not provided to resident #001 as per their care plan when the two HCAs utilized a different transfer intervention. Please refer to WN #4 for additional information.

C) Section 51 subsection 2 of the O. Reg. 79/10, stipulates that each resident who is incontinent has an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Together, Inspector #684 and PC #116 reviewed the home's investigation file, where it was documented that HCA #109 and #115 used the incorrect interventions when providing care specific to the resident's continence care needs. The PC further stated that the care was not provided to resident #001 as per their care plan. Please refer to WN #3 for additional information. [s. 19. (1)]

The severity of this issue was determined to be a level three, as there was actual harm to resident #001. The scope of the issue was isolated, as it was identified to have impacted one resident in the home. The home had a level three compliance history, as they had previous non-compliance in the previous 36 months within this section of the LTCHA, 2007, which included;

- Compliance Order (CO) #003 issued in report #2017_613609_0001 on March 1, 2017, with a compliance date of April 26, 2017, and

- Director Referral (DR) #003 issued in report #2017_613609_0001 on March 1, 2017.
(684)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jan 31, 2020

## 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
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 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 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 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 20th day of December, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Loviriza Caluza

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