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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée 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 29, 2019	2019_583117_0051 (A1)	021302-19	Critical Incident System

Licensee/Titulaire de permis

United Counties of Prescott and Russell
59 Court Street Box 304 L'Orignal ON K0B 1K0

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

Residence Prescott et Russell
1020 Cartier Boulevard HAWKESBURY ON K6A 1W7

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On November 19, 2019, the home's Administrator requested an extension to the compliance order CO #001 due date so as of December 16, 2019, to be able to ensure that all staff receive training and education as requested in the Compliance Order CO #001 issued on November 15, 2019. The request for extension was approved with a new compliance due date of January 1, 2020.

Issued on this 29th day of November, 2019 (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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée 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 29, 2019	2019_583117_0051 (A1)	021302-19	Critical Incident System

Licensee/Titulaire de permis

United Counties of Prescott and Russell
59 Court Street Box 304 L'Orignal ON K0B 1K0

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

Residence Prescott et Russell
1020 Cartier Boulevard HAWKESBURY ON K6A 1W7

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended 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): November 6 and 7, 2019 and offsite November 5 and 8, 13, 14, 2019

The inspection relates to log # 021302-19, a critical incident report (CIS #M567-000010-19) regarding a resident's unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nursing Supervisor, the Food Service Supervisor, a Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several residents and a family member.

During the course of the inspection, the inspector reviewed an identified resident's health care record, observed the provision of beverage and snacks, reviewed the licensee's security video footage and reviewed dietary beverage and snack menu.

The following Inspection Protocols were used during this inspection:

Food Quality
Hospitalization and Change in Condition
Nutrition and Hydration

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

1 WN(s)
0 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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan, specifically to the provision of dietary snacks.

On November 7, 2019, inspector #117 observed PSW #008 pass the afternoon beverage and snack pass on a resident home area. PSW #008 was observed to ask resident #002 their choice of beverage and snack. Resident #002 requested a pudding. PSW #008 provided to and assisted resident #002 in taking a "Snack Pack" butterscotch pudding. PSW #008 said inspector #117 that the resident was diabetic and able to have puddings. PSW #008 did not verify the snack and beverage dietary menu that was attached to the snack cart in regard to diabetic snack options.

As per the snack and beverage dietary menu, resident #002 is identified as requiring a regular diabetic diet. The snack menu identifies that "Kozy Shack" diet puddings are to be offered to residents on a diabetic diet. In the unit servery there are "Kozy Shack" diet puddings available to residents. Discussion held with the Food Service Supervisor (FSS) regarding the selection of puddings offered to residents. The FSS said that there are several pudding choices offered in the snack menu. However, only "Kozy Shack" puddings are to be approved for and are to be offered to diabetic residents. PSW #008 said that she was not aware of the differences in puddings for various resident dietary needs and did say that she had not verified the snack and beverage dietary menu when they had offered and provided to resident #002 a butterscotch Snack Pack pudding.

As such, PSW #008 did not provide to resident #002 their planned care, a diabetic snack, as specified in the resident's plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan, specifically as it relates to the provision of therapeutic texture diets.

Resident #001 was identified as being as having dysphagia and was on pureed diet with thickened fluids. As per the resident's plan of care, resident #001 required supervision and partial assistance during meal times. The plan of care also noted that the resident used as wheelchair for mobility and was able to self mobilize when in their room and unit hallways.

On a specified day in 2019, PSW# 004 passed the afternoon beverage and snack collation on a resident home area. PSW #004 entered resident #001's room and placed a glass of thickened juice and a regular texture snack on the resident's dresser. Resident #001 was resting in bed.
Several minutes later, PSW #003 entered resident #001's room, assisted the resident to get up and seated in the resident's wheelchair. PSW #003 noted the snack on the dresser and prepared it for eating and left it on the dresser. PSW #003 left the resident's room and went to assist PSW #005 with the care of another resident.

Several minutes later, RPN #006 was in the hallway, preparing medication for a resident when they heard a noise, turned and saw resident #001 seated in their wheelchair, in the hallway several feet away from them. RPN #006 went to the resident's assistance, noted that the resident was unresponsive, having difficulty breathing and was choking. The RPN noted that the resident was holding part of a snack in their hand. RPN #006 brought the resident to the unit infirmary room to provide emergency assistance with the aide of RN # 007. The DOC and Nursing Supervisor were immediately notified of the situation and went to the infirmary to aid RPN #006 and RN#007 with emergency response measures. Nursing staff were unable to dislodge the food item choking the resident and resident #001 passed away.

The Nursing Supervisor spoke with PSW #003 immediately after the incident. The nursing supervisor said to the inspector that PSW #004 had informed them that they had left the identified food item on resident #001's dresser as a snack, without having verified the snack and beverage dietary menu attached the collation cart. They were not aware that resident #001 was identified as requiring pureed snacks.

During a discussion with inspector #117, PSW #003 said that they were aware that resident #001 was on a pureed diet. PSW #003 said that they had seen the identified food item on the resident's dresser and had not verified the snack and beverage dietary menu to see if there were any changes to the resident's dietary needs. PSW #003 said that they had prepared the snack for the resident and left the snack on the dresser, beside a glass of thickened juice, to go and get articles to puree the food item. PSW #003 said that they were stopped by PSW # 005 who requested their aid to help them provide care to another resident. PSW #003 said they went to with PSW #005 to assist with the other resident's care and did not return to resident #001's room to puree the food item.

PSW #003, #008, #009 and #010, RPN #006 and RN #007 all said that resident #001 was able to self mobilize in their wheelchair. They also said that resident #001 was able to eat and drink their offered snacks and beverages independently. RPN #006 and RN #007 said that they had not seen any staff member give the food item to resident #001.

As such, on a specified day in 2019, PSW #003 and PSW #004 left a regular texture food item on resident #001's dresser for a snack. They did not provide resident #001 with a pureed snack as specified in the resident's plan of care. It is noted that the inspector is unable to determine if on the specified date, a staff member gave the snack to the resident or if resident #001 took the snack by themselves. [s. 6. (7)]

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

Issued on this 29th day of November, 2019 (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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by LYNE DUCHESNE (117) - (A1)
Inspection No. / No de l’inspection :	2019_583117_0051 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021302-19 (A1)
Type of Inspection / Genre d’inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 29, 2019(A1)
Licensee / Titulaire de permis :	United Counties of Prescott and Russell 59 Court Street, Box 304, L'Orignal, ON, K0B-1K0
LTC Home / Foyer de SLD :	Residence Prescott et Russell 1020 Cartier Boulevard, HAWKESBURY, ON, K6A-1W7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Alexandre Gorman

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 United Counties of Prescott and Russell, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.6 (7)

Specifically, the licensee shall:
a) Ensure that the plan of care for resident #002, and any other resident on a therapeutic pureed and diabetic diet, is provided to the residents as specified in their plans of care, during the provision of beverages and snacks
b) Review with all Personal Support Workers (PSW) the beverage and snack dietary menu, specifically in regard to therapeutic pureed and diabetic snack options, measure adherence to the beverage and snack dietary menu on a weekly basis on all units for a duration of three (3) consecutive weeks, and take necessary corrective actions if PSWs do not adhere to the established menu.
c) A written record must kept of everything required under (b).

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan, specifically to the provision of dietary snacks.

OOn November 7, 2019, inspector #117 observed PSW #008 pass the afternoon beverage and snack pass on a resident home area. PSW #008 was observed to ask resident #002 their choice of beverage and snack. Resident #002 requested a pudding. PSW #008 provided to and assisted resident #002 in taking a "Snack Pack" butterscotch pudding. PSW #008 said inspector #117 that the resident was diabetic and able to have puddings. PSW #008 did not verify the snack and beverage dietary menu that was attached to the snack cart in regard to diabetic snack options.

As per the snack and beverage dietary menu, resident #002 is identified as requiring a regular diabetic diet. The snack menu identifies that "Kozy Shack" diet puddings are to be offered to residents on a diabetic diet. In the unit servery there are "Kozy Shack" diet puddings available to residents. Discussion held with the Food Service Supervisor (FSS) regarding the selection of puddings offered to residents. The FSS said that there are several pudding choices offered in the snack menu. However, only "Kozy Shack" puddings are to be approved for and are to be offered to diabetic residents. PSW #008 said that she was not aware of the differences in puddings for various resident dietary needs and did say that she had not verified the snack and beverage dietary menu when they had offered and provided to resident #002 a butterscotch Snack Pack pudding.

As such, PSW #008 did not provide to resident #002 their planned care, a diabetic snack, as specified in the resident's plan of care.

(117)

2. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan, specifically as it relates to the provision of therapeutic texture diets.

Resident #001 was identified as being as having dysphagia and was on pureed diet with thickened fluids. As per the resident's plan of care, resident #001 required supervision and partial assistance during meal times. The plan of care also noted that the resident used as wheelchair for mobility and was able to self mobilize when in their room and unit hallways.

On a specified day in 2019, PSW# 004 passed the afternoon beverage and snack collation on a resident home area. PSW #004 entered resident #001's room and placed a glass of thickened juice and a regular texture snack on the resident's dresser. Resident #001 was resting in bed.

Several minutes later, PSW #003 entered resident #001's room, assisted the resident to get up and seated in the resident's wheelchair. PSW #003 noted the snack on the dresser and prepared it for eating and left it on the dresser. PSW #003 left the resident's room and went to assist PSW #005 with the care of another resident.
Several minutes later, RPN #006 was in the hallway, preparing medication for a resident when they heard a noise, turned and saw resident #001 seated in their wheelchair, in the hallway several feet away from them. RPN #006 went to the resident's assistance, noted that the resident was unresponsive, having difficulty breathing and was choking. The RPN noted that the resident was holding part of a snack in their hand. RPN #006 brought the resident to the unit infirmary room to provide emergency assistance with the aide of RN # 007. The DOC and Nursing Supervisor were immediately notified of the situation and went to the infirmary to aid RPN #006 and RN#007 with emergency response measures. Nursing staff were unable to dislodge the food item choking the resident and resident #001 passed away.

The Nursing Supervisor spoke with PSW #003 immediately after the incident. The nursing supervisor said to the inspector that PSW #004 had informed them that they had left the identified food item on resident #001's dresser as a snack, without having verified the snack and beverage dietary menu attached the collation cart. They were not aware that resident #001 was identified as requiring pureed snacks.

During a discussion with inspector #117, PSW #003 said that they were aware that resident #001 was on a pureed diet. PSW #003 said that they had seen the identified food item on the resident's dresser and had not verified the snack and beverage dietary menu to see if there were any changes to the resident's dietary needs. PSW #003 said that they had prepared the snack for the resident and left the snack on the dresser, beside a glass of thickened juice, to go and get articles to puree the food item. PSW #003 said that they were stopped by PSW # 005 who requested their aid to help them provide care to another resident. PSW #003 said they went to with PSW #005 to assist with the other resident's care and did not return to resident #001's

room to puree the food item.
PSW #003, #008, #009 and #010, RPN #006 and RN #007 all said that resident #001 was able to self mobilize in their wheelchair. They also said that resident #001 was able to eat and drink their offered snacks and beverages independently. RPN #006 and RN #007 said that they had not seen any staff member give the food item to resident #001.

As such, on a specified day in 2019, PSW #003 and PSW #004 left a regular texture food item on resident #001's dresser for a snack. They did not provide resident #001 with a pureed snack as specified in the resident's plan of care.

It is noted that the inspector is unable to determine if on the specified date, a staff member gave the snack to the resident or if resident #001 took the snack by themselves.

The severity of this issue was determined to be actual harm. The scope was determined to be a pattern. The home has a compliance history, with non-compliance being issued under a different subsection.

- LTCHA s.6 (5) and s. 6 (9)1. : were issued both as a WN on February 7, 2017 under inspection # 2016_289550_0041

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2020(A1)

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

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:

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

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

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

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 29th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by LYNE DUCHESNE (117) - (A1)

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 : Ottawa Service Area Office