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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Mar 17, 2021	2021_792659_0005	022702-20, 023589-20, 024041-20, 025995-20, 000519-21, 001948-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Riverside Glen
60 Woodlawn Road East Guelph ON N1H 8M8

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

JANETM EVANS (659), DANIELA LUPU (758)

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): February 22, 23, 24, 25 and 26, 2021.

The following intakes were completed during this inspection:
Log #001948-21 related to infection prevention and control practices (IPAC)
Log #000519-21 related to resident hospitalization for skin and wound issues
Log #022702-20 related to improper/incompetent care of a resident
Log #023589-20 related to a resident fall with injury
Log #024041-20 related to a resident fall with injury
Log #025995-20 related to a resident fall with injury

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), the Director of Care (DOC), the Assistant Director of Care (ADOC), Corporate Quality lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Attendants (PCAs), Recreation staff, the Kinesiologist and residents.

Observations were completed of Personal Protective Equipment (PPE) use, screening, social distancing, hand hygiene and staff to resident interactions. A review of relevant documentation, including but not limited to residents' progress notes, assessments and plans of care, audits and policies and procedures was completed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2021_796754_0001	659

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to three residents as specified in the plan.

a) A resident was at moderate risk for falls due to a history of falls with injury. Their plan of care for falls prevention directed staff to place their bed in the lowest position to prevent falls from the bed.

Observations completed over three days showed that the resident's bed was not placed in the lowest position while the resident was in bed. Staff were unaware that the bed should have been placed in the lowest position.

Not placing the bed in the lowest position increased the resident's risk for falls and injury.

Sources: observations, resident's progress notes, care plan and interviews with staff.

b) A resident was at moderate risk for falls due to a history of falls with injury. Their plan of care directed staff to ensure the call bell was within the resident's reach and to encourage the resident to call for assistance when needed.

Observations completed over three days showed the resident's call bell was not within their reach.

Not ensuring the call bell was within reach increased the resident's risk for falls and potential injury.

Sources: observations, resident's progress notes, fall risk assessments, care plan and interviews with staff.

c) A resident required oxygen therapy. Their plan of care directed staff to maintain a prescribed oxygen saturation for the resident and to ensure the call bell was within the resident’s reach.

A nurse observed that the resident was not wearing their oxygen; the oxygen and the resident's call bell were not within the resident's reach.

Staff said the resident had been removing their oxygen and throwing it on the floor. They planned to reapply it when the resident was calm but forgot to return.

Observations over two days showed the resident’s call bell was not within their reach.

There was no harm to the resident related to these incidents, however failing to ensure the resident could reach their call bell and their oxygen when required, put the resident at risk of respiratory distress without the ability to call staff for assistance.

Sources: Critical Incident System (CIS) Report; email from staff to management, observations, resident's plan of care, physician’s order, home’s investigation, interviews with staff. [s. 6. (7)]

2. The licensee has failed to ensure that when two residents were reassessed and their plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of their plan of care.

a) A resident was at high risk for falls. Their care plan interventions for falls prevention included proper footwear, reminding the resident not to self-transfer and calling for assistance. Over a two month period, the resident sustained three falls. When the resident's care plan was revised, different approaches were not considered until one month later when the resident fell and sustained an injury.

The delay in the revision of the resident's plan of care increased their risk of future falls and resulted in actual harm to the resident.

Sources: CIS report, falls incidents reports, falls risk assessments, care plan, progress

notes, the home's investigative notes, and interview with AGM and other staff.

b) A resident was at moderate risk for falls. Between July and October 2020, the resident sustained two falls. Their care plan was revised, but different approaches were not considered until November 2020, when they fell and sustained an injury.

Between January and February 2021, the resident had eight falls. Their plan of care was not revised to include different approaches for falls prevention until after their fall in February 2021, when safety checks were initiated.

Although the resident did not sustain injuries as a result of the falls after November 2020, the delayed revision of their plan of care increased the resident's risk for future falls and injuries.

Sources: CIS report, falls incidents reports, falls risk assessments, care plan, progress notes, the home's investigative notes, and interview with staff. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents who have been assessed as being potentially continent of bowel and bladder, received assistance and support from staff to become continent or continent some of the time.

a) A resident was assessed as being potentially continent of bowel and bladder and a toileting routine was implemented to maintain the resident's continence. Seven months later, they fell and sustained an injury. Their continence status had not changed however, their plan of care directed staff to use specified equipment when toileting the resident.

Staff members did not use the specified equipment to toilet the resident. The resident was emotional as staff no longer assisted them up to the toilet. No alternatives were offered to the resident to maintain their continence status.

The lack of alternatives to maintain the resident's continence status resulted in emotional distress to the resident and increased their risk of complications associated with incontinence.

Sources: resident's progress notes, continence evaluation assessments, RAIMDS assessments, kinesiology program for active living (PAL) assessment, care plan and interviews with staff and AGM.

b) A resident was assessed as being potentially continent of bowel and bladder and a prompted voiding program was implemented to maintain the resident's continence.

One month later, the physician ordered a specific device be used to assist the resident when transferring to the toilet. Despite the resident's ability to use the ordered device, the resident's plan of care did not direct staff to assist the resident up to toilet. No alternatives were offered to promote the resident's continence. The resident was reported as being upset that staff did not assist them up to the toilet.

The lack of alternatives to maintain the resident's continence status resulted in emotional distress to the resident and increased their risk of complications associated with incontinence.

Sources: resident's progress notes, continence evaluation assessments, RAIMDS assessments, kinesiology program for active living (PAL) assessments, physician's orders, care plan and interviews with staff. [s. 51. (2) (d)]

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 two identified residents receive assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

Issued on this 31st day of March, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659), DANIELA LUPU (758)
Inspection No. / No de l'inspection :	2021_792659_0005
Log No. / No de registre :	022702-20, 023589-20, 024041-20, 025995-20, 000519-21, 001948-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 17, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Riverside Glen 60 Woodlawn Road East, Guelph, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee must:

1) Ensure that the three identified residents receive care as set out in the plan of care in relation to falls prevention interventions.

2) As part of the home's rounds conducted each shift, ensure that the identified resident has access to their oxygen, and also ensure that the two specified residents have access to their call bell.

3) Conduct a weekly audit of the safety rounds for the three specified residents to ensure that the residents' plan of care is followed. The audits should be documented and include the name of the person conducting the audit, the date and time, the results of the audit and actions taken. A copy of the audit must be kept available in the home. The audits are to be conducted until such time as compliance is achieved and maintained for a period of one month.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to three residents as specified in the plan.

a) A resident was at moderate risk for falls due to a history of falls with injury. Their plan of care for falls prevention directed staff to place their bed in the lowest position to prevent falls from the bed.

Observations completed over three days showed that the resident's bed was not

placed in the lowest position while the resident was in bed. Staff were unaware that the bed should have been placed in the lowest position.

Not placing the bed in the lowest position increased the resident's risk for falls and injury.

Sources: observations, resident's progress notes, care plan and interviews with staff.

b) A resident was at moderate risk for falls due to a history of falls with injury. Their plan of care directed staff to ensure the call bell was within the resident's reach and to encourage the resident to call for assistance when needed.

Observations completed over three days showed the resident's call bell was not within their reach.

Not ensuring the call bell was within reach increased the resident's risk for falls and potential injury.

Sources: observations, resident's progress notes, fall risk assessments, care plan and interviews with staff.

c) A resident required oxygen therapy. Their plan of care directed staff to maintain a prescribed oxygen saturation for the resident and to ensure the call bell was within the resident's reach.

A nurse observed that the resident was not wearing their oxygen; the oxygen and the resident's call bell were not within the resident's reach.

Staff said the resident had been removing their oxygen and throwing it on the floor. They planned to reapply it when the resident was calm but forgot to return.

Observations over two days showed the resident's call bell was not within their reach.

There was no harm to the resident related to these incidents, however failing to ensure the resident could reach their call bell and their oxygen when required,

put the resident at risk of respiratory distress without the ability to call staff for assistance.

Sources: Critical Incident System (CIS) Report; email from staff to management, observations, resident's plan of care, physician's order, home's investigation, interviews with staff. [s. 6. (7)]

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

Severity: Failure to ensure that the care was provided as outlined in residents' plans of care, increased the risk of harm to the residents.

Scope: The scope of this non-compliance was widespread as three of four residents reviewed, did not receive care as set out in the plan of care.

Compliance History: Two written notification (WN), two voluntary plan of corrections (VPC) and one compliance order (CO) which was complied with, were issued to the home related to this section of legislation in the past 36 months.
(758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s. 6 (11) of the LTCHA, 2007.

Specifically, the licensee must:

1) Ensure that when the two identified residents' plans of care are being revised because the care set out in the plans of care in relation to falls prevention and management were not effective, that different approaches are considered in the revision of the plans of care.

Grounds / Motifs :

1. The licensee has failed to ensure that when two residents were reassessed and their plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of their plan of care.

2. The licensee has failed to ensure that when two residents were reassessed and their plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of their plan of care.

a) A resident was at high risk for falls. Their care plan interventions for falls prevention included proper footwear, reminding the resident not to self-transfer

and calling for assistance. Over a two month period, the resident sustained three falls. When the resident's care plan was revised, different approaches were not considered until one month later when the resident fell and sustained an injury.

The delay in the revision of the resident's plan of care increased their risk of future falls and resulted in actual harm to the resident.

Sources: CIS report, falls incidents reports, falls risk assessments, care plan, progress notes, the home's investigative notes, and interview with AGM and other staff.

b) A resident was at moderate risk for falls. Between July and October 2020, the resident sustained two falls. Their care plan was revised, but different approaches were not considered until November 2020, when they fell and sustained an injury.

Between January and February 2021, the resident had eight falls. Their plan of care was not revised to include different approaches for falls prevention until after their fall in February 2021, when safety checks were initiated.

Although the resident did not sustain injuries as a result of the falls after November 2020, the delayed revision of their plan of care increased the resident's risk for future falls and injuries.

Sources: CIS report, falls incidents reports, falls risk assessments, care plan, progress notes, the home's investigative notes, and interview with staff. [s. 6. (11) (b)]

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

Severity: Delays in considering different approaches in the revision of the residents' plans of care in relation to falls prevention, increased their risk for additional falls and injuries.

Scope: The scope of this non-compliance was a pattern as two out of three residents reviewed did not have different approaches considered in the revision of their plan of care for falls prevention interventions.

Compliance History: One Written Notification (WN) and one Voluntary Plan of Correction (VPC) were issued to the home related to the same sub-section of the legislation in the past 36 months.
(758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 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 17th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

Service Area Office /
Bureau régional de services : Central West Service Area Office