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
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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
Jul 16, 2020	2020_746692_0013	004790-20, 004817-20, 007948-20	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

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): July 6-10, 2020.

The Following intake(s) were inspected upon during this Complaint Inspection:
-One log, which was related to a complaint that was submitted to the home related to an allegation of resident neglect; and,

-One log, which was related to a complaint that was submitted to the Director related to an allegation of staff to resident physical abuse.

The following Critical Incident System (CIS) intake related to the same concerns (staff to resident physical abuse) was completed during this Complaint inspection.

A Follow Up Inspection #2020_746692_0014 and a Critical Incident System Inspection #2020_746692_0015 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physician, Nurse Practitioner (NP), Co-Director of Care (Co-DOC), Staff Educator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), families and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, the home's complaint log, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 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 :

1. The licensee has failed to ensure that residents were not neglected by staff.

A written complaint was submitted to the Director by the home on an identified date, that the home had received by resident #002's Substitute Decision Maker (SDM) on that date. A review of the written complaint indicated that the SDM of resident #002 had complained that they had not been informed that the resident was refusing treatment for three to four days, the ordered diagnostic tests had not been completed, causing them to be admitted to the hospital, which resulted in a negative outcome.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) 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 jeopardizes the health, safety or well-being of one or more residents".

Inspector #692 reviewed the health care records for resident #002. A review of the resident's progress notes described that over eight days the resident complained of pain, was observed exhibiting signs of pain, refusing meals and treatments; a physician order diagnostic test that was not completed in the time specified by the physician; assessment by a Nurse Practitioner with a second diagnostic test ordered; and the SDM being notified on the ninth day.

A further review of resident #002's health care records, Inspector #692 was unable to locate that the resident's attending physician had been notified of the resident's change in condition prior to transfer to the hospital.

Inspector #692 reviewed the home's internal investigation notes, which indicated the home had identified opportunities for improvement based on the outcome of their investigation. These included the following:
-education regarding College of Nurses documentation expectations;
-review of assessment skills and escalation of ill resident to the Nurse Practitioner (NP)

and the Physician, an identified symptom should not wait four days for assessment;
-documentation of treatment delays, and escalate to the Physician for appropriate timeframe follow up;
-timeliness of processing of orders; and,
-making SDMs aware of withheld or refused treatments and change in condition.

In an interview with Inspector #692, Personal Support Worker (PSW) #121 identified that they had provided direct care for resident #002. PSW #121 indicated that they recalled resident #002 complaining of pain in a specified area and an identified symptom for approximately four days prior to them being transferred to the hospital.

During separate interviews with Registered Practical Nurses (RPN)s #110 and #113, they both identified that resident #002 had been exhibiting signs of pain in a specified area and an identified symptom for approximately three to four days prior to them being transferred to the hospital. They both indicated that they had thought resident #002 had been experiencing a different diagnosis, and that was why they were exhibiting the pain and identified symptom. Both RPN #110 and #113 identified that resident #002 had been refusing their treatments and meals during this time. RPN #110 indicated that they called NP #114 on an identified date, to assess resident #002, as at this time they felt there was something more serious occurring. Both RPN #110 and #113 indicated that they had not notified resident #002's physician or NP #114 when resident #002 had begun exhibiting a change in their condition, and they should have at that time.

Inspector #692 interviewed NP #114, who indicated that they were called by RPN #110 on an identified date, to attend the home to assess resident #002, who had been experiencing pain in a specified area and an identified symptom for three to four days. NP #114 indicated that RPN #110 had identified that they had thought resident #002 had a different diagnosis; however, called the NP to assess. NP #114 identified that they had been upset the following day, as they had been told the resident had not had the diagnostic test completed, as the registered staff had forgotten to process the requisition. NP #114 indicated that they had not been made aware when resident #002 had a change in their condition, to their knowledge the resident's physician was not made aware, and that they should have been notified right away.

During an interview with Physician #120, they identified that they had been resident #002's primary physician. They recalled assessing resident #002 on an identified date, at which time they ordered a diagnostic test of a specific area and for alternate directions for refused treatment. Physician #120 indicated that they had not been made aware that

resident #002 had been experiencing pain in a specified area and an identified symptom, and had been continuing to refuse treatments and meals, until the resident had been admitted to the hospital. Physician #120 further indicated that they had not been made aware that there had been a delay in the completion of the ordered diagnostic test and that NP #114 was called to assess the resident prior to them being notified. Physician #120 identified that their expectation was that they were notified immediately when there was a change in the resident's health status, especially if a resident was exhibiting signs of pain in a specified area and an identified symptom.

During an interview with the Director of Care (DOC), they identified that registered staff were to notify the physician at the time when a resident had a change in their health status, taking the physician's guidance for treatment. The DOC indicated that when resident #002 had begun to exhibit signs of pain in a specified area and an identified symptom, the registered staff were to notify their physician right away, ensuring they identify all aspects of their care, including refusals and delays in treatment. The DOC identified that the registered staff had not collaborated with Physician #120, as they did not notify them of the change in status for resident #002, and they should have. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM, if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A written complaint was submitted to the Director by the home on an identified date, that the home had received by resident #002's Substitute Decision Maker (SDM) on that date. A review of the written complaint indicated that the SDM of resident #002 had complained that they had not been informed that the resident was refusing treatment for three to four days, the diagnostic tests had not been completed, causing them to be admitted to the hospital, which resulted in a negative outcome.

Please see Written Notification (WN) #1, finding #1, for further details.

During separate interviews with PSW #121 and RPNs #110 and #113, they all identified to Inspector #692 that resident #002 had been exhibiting signs of pain in a specified area and an identified symptom for approximately three to four days prior to them being transferred to the hospital. RPNs #110 and #113 identified that resident #002 had been refusing their treatments and meals during this time. Both RPN #110 and #113 indicated that they had not notified resident #002's SDM when resident #002 had begun exhibiting a change in their condition, and they should have at that time.

Inspector #692 interviewed NP #114, who indicated that they were called by RPN #110 on an identified date, to attend the home to assess resident #002. NP #114 indicated that RPN #110 had contacted the resident's SDM that day in their presence and that was the first time the SDM had been notified of the residents change in health status, and that they should have been notified right away.

During an interview with Physician #120, they identified that they had been resident #002's primary physician. Physician #120 further indicated that resident #002's SDM had not been notified when the resident had begun to exhibit pain in a specified area and an identified symptom, as well that they had been refusing treatments and meals.

During an interview with the DOC, they indicated to Inspector #692 that when there had been a change in a resident's health status, the SDM of the resident was to be contacted immediately. The DOC further indicated that as a result of the SDM not being notified immediately of resident #002's change in condition and refusals, the SDM was not able to participate in the resident's care. The DOC indicated that when resident #002 had begun to exhibit signs of pain in a specified area and an identified symptom, the registered staff were to notify their SDM right away, ensuring they identified all aspects of their care, including refusals and delays in treatment. The DOC identified that the registered staff had not collaborated with resident #002's SDM, as they did not notify

them of the change in status for resident #002, and they should have. [s. 6. (5)]

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 ensuring that the resident's substitute decision maker (SDM) is given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 13th day of August, 2020

[redacted]

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) :	SHANNON RUSSELL (692), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2020_746692_0013
Log No. / No de registre :	004790-20, 004817-20, 007948-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 16, 2020
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	James Abraham

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 Barrie Long Term Care Centre 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

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 : 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 s. 19 (1) of the Long Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee shall:
1.Develop and implement a process to audit the monitoring of the follow up completed when a resident is exhibiting a change in status routinely, and follow up with any deficiencies;
2.Maintain records of the completed audits, including the follow up that was completed;
3.Ensure all registered staff are trained on the process required for notifying the residents Attending Physician when there is a change in the resident's condition; and,
4.Maintain a record of re-training provided, including dates, times, attendees, trainers and material taught.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by staff.

A written complaint was submitted to the Director by the home on an identified date, that the home had received by resident #002's Substitute Decision Maker (SDM) on that date. A review of the written complaint indicated that the SDM of resident #002 had complained that they had not been informed that the resident was refusing treatment for three to four days, the ordered diagnostic tests had not been completed, causing them to be admitted to the hospital, which resulted in a negative outcome.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care

Homes Act (LTCHA) 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 jeopardizes the health, safety or well-being of one or more residents".

Inspector #692 reviewed the health care records for resident #002. A review of the resident's progress notes described that over eight days the resident complained of pain, was observed exhibiting signs of pain, refusing meals and treatments; a physician order diagnostic test that was not completed in the time specified by the physician; assessment by a Nurse Practitioner with a second diagnostic test ordered; and the SDM being notified on the ninth day.

A further review of resident #002's health care records, Inspector #692 was unable to locate that the resident's attending physician had been notified of the resident's change in condition prior to transfer to the hospital.

Inspector #692 reviewed the home's internal investigation notes, which indicated the home had identified opportunities for improvement based on the outcome of their investigation. These included the following:
-education regarding College of Nurses documentation expectations;
-review of assessment skills and escalation of ill resident to the Nurse Practitioner (NP) and the Physician, an identified symptom should not wait four days for assessment;
-documentation of treatment delays, and escalate to the Physician for appropriate timeframe follow up;
-timeliness of processing of orders; and,
-making SDMs aware of withheld or refused treatments and change in condition.

In an interview with Inspector #692, Personal Support Worker (PSW) #121 identified that they had provided direct care for resident #002. PSW #121 indicated that they recalled resident #002 complaining of pain in a specified area and an identified symptom for approximately four days prior to them being transferred to the hospital.

During separate interviews with Registered Practical Nurses (RPN)s #110 and #113, they both identified that resident #002 had been exhibiting signs of pain in a specified area and an identified symptom for approximately three to four days

prior to them being transferred to the hospital. They both indicated that they had thought resident #002 had been experiencing a different diagnosis, and that was why they were exhibiting the pain and identified symptom. Both RPN #110 and #113 identified that resident #002 had been refusing their treatments and meals during this time. RPN #110 indicated that they called NP #114 on an identified date, to assess resident #002, as at this time they felt there was something more serious occurring. Both RPN #110 and #113 indicated that they had not notified resident #002's physician or NP #114 when resident #002 had begun exhibiting a change in their condition, and they should have at that time.

Inspector #692 interviewed NP #114, who indicated that they were called by RPN #110 on an identified date, to attend the home to assess resident #002, who had been experiencing pain in a specified area and an identified symptom for three to four days. NP #114 indicated that RPN #110 had identified that they had thought resident #002 had a different diagnosis; however, called the NP to assess. NP #114 identified that they had been upset the following day, as they had been told the resident had not had the diagnostic test completed, as the registered staff had forgotten to process the requisition. NP #114 indicated that they had not been made aware when resident #002 had a change in their condition, to their knowledge the resident's physician was not made aware, and that they should have been notified right away.

During an interview with Physician #120, they identified that they had been resident #002's primary physician. They recalled assessing resident #002 on an identified date, at which time they ordered a diagnostic test of a specific area and for alternate directions for refused treatment. Physician #120 indicated that they had not been made aware that resident #002 had been experiencing pain in a specified area and an identified symptom, and had been continuing to refuse treatments and meals, until the resident had been admitted to the hospital. Physician #120 further indicated that they had not been made aware that there had been a delay in the completion of the ordered diagnostic test and that NP #114 was called to assess the resident prior to them being notified. Physician #120 identified that their expectation was that they were notified immediately when there was a change in the resident's health status, especially if a resident was exhibiting signs of pain in a specified area and an identified symptom.

During an interview with the Director of Care (DOC), they identified that registered staff were to notify the physician at the time when a resident had a change in their health status, taking the physician's guidance for treatment. The DOC indicated that when resident #002 had begun to exhibit signs of pain in a specified area and an identified symptom, the registered staff were to notify their physician right away, ensuring they identify all aspects of their care, including refusals and delays in treatment. The DOC identified that the registered staff had not collaborated with Physician #120, as they did not notify them of the change in status for resident #002, and they should have.

The severity of this issue was determined to be a level three, as there was actual risk. The scope of the issue was a level one, as the incident was isolated. The home has a level two compliance history with no related noncompliance with this subsection in the last 36 months with this section of the LTCHA. (692)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 28, 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:

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

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 16th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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