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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Public Copy/Copie 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
Oct 21, 2019	2019_704682_0028	014937-19, 016980-19, 017241-19, 018271-19, 018398-19, 019254-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

West Park Health Centre
103 Pelham Road St. Catharines ON L2S 1S9

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

AILEEN GRABA (682), LISA BOS (683)

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): September 27, 30, October 1, 2, 3, 4, 8, 9, 10, 11, 2019.

The following Critical Incident inspections were conducted concurrently with complaint inspection 2019_704682_0027:
014937-19 related to prevention of abuse and neglect
016980-19 related to prevention of abuse and neglect
017241-19 related to prevention of abuse and neglect
018271-19 related to falls prevention
018398-19 related to prevention of abuse and neglect
019254-19 related to plan of care

The following Complaint inspections was conducted concurrently:
018675-19 related to prevention of abuse and neglect
018708-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Director of Care (DOC), Manager of Recreation Services, Resident Assessment Instrument (RAI) Coordinator, Nursing Clerk, Office Manager, Maintenance and Housekeeping staff, Registered Staff; Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) toured the home; reviewed investigative notes, staffing schedules, resident health records; meeting minutes, program evaluations,
policies and procedures, complaints binder, maintenance request logs, Critical Incident System (CIS) submissions; observed residents and provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **2 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. A) The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director.

A review of the CI report identified that responsive behaviours was documented for resident #002 on identified dates. A CI report was also submitted to the Director on an identified date, related to an incident by resident #002 to a co-resident. A review of the clinical record for resident #002 indicated that they had a cognitive deficit and responsive behaviours. As per the written plan of care, the resident had interventions to prevent any further behavioural incidents, some of which was discontinued on a identified date. A review of the electronic record for resident #006 indicated that they demonstrated behaviours. In an interview with resident #002, they stated that they deal with their problems. Resident #002 recalled having an altercation with resident #006 On an identified date, resident #002 pointed out resident #006 to Inspector #683 and indicated that they were supposed to stay away from them. In an interview with staff #120, they indicated they observed the altercation between resident #002 and resident #006. In an interview with the Executive Director (ED), they acknowledged that resident #006 was not protected from abuse by anyone.

B) A Critical Incident (CI) report was submitted to the Director, resident #005 had an altercation with resident #002.

The CI report indicated that resident #005 sustained an injury. A review of the clinical record for resident #002 indicated that they had a cognitive deficit with a history of responsive behaviours, documented on identified dates. A review of the clinical record for resident #005 indicated that they had a cognitive deficit. Their written plan of care indicated that they had a history of responsive behaviours. Resident #005's clinical record was reviewed and a progress note indicated that resident #005 had an altercation with resident #002. The progress note further identified that both residents were having altercations prior to this event. A progress note and a skin assessment indicated that resident #005 had sustained an injury. On an identified date, the physician documented that they assessed resident #005 related to the injury and ordered medical intervention. The ED confirmed that an injury was identified with resident #005, and they acknowledged that the injury was believed to be from the altercation. The home did not ensure that resident #005 was protected from abuse abuse by anyone [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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #683 observed resident #007 with responsive behaviours. Staff #120 indicated that they attempted interventions in response to resident #007 behaviours but they were not effective. They indicated that they called for assistance. A review of the written plan of care in place for resident #007, indicated that they required assistance with activities of daily living (ADL's), due to cognitive impairment and risk of falls. The goal was for the resident to maintain independence with ADL's and interventions were identified. In an interview with staff #120 and staff #121, they indicated that the resident required a level

of assistance with ADL's. In an interview with the RAI-Coordinator , they indicated that as per their discussion with staff #108, resident #007 required a level of assistance with ADL's. The RAI-Coordinator acknowledged that resident #007's care plan did not provide clear direction in relation to the level of assistance with ADL's that was required for resident #007. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #007 was provided to them as specified in the plan.

A review of the written plan of care for resident #007 identified that they were at risk for falls. The resident had various interventions in place to try and prevent falls. On an identified date. Inspector #683 observed resident #007 without their fall intervention. Staff #113 applied the resident's intervention but the intervention was not in working order. In an interview with the Acting Director of Care (DOC) #107, they identified that the resident's intervention was in their care plan. They identified that the resident's intervention was repaired. Inspector #683 and the ED went to observe the resident's intervention. The ED tested the resident's intervention with the help of staff #124, and acknowledged that the intervention was not in working order. Staff #124 indicated that sometimes the intervention worked and sometimes it did not. The home did not ensure that resident #007 fall intervention that was set out in the plan of care was provided to them as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and any other time when the resident's care needs changed.

Inspector #683 observed resident #007 with responsive behaviours. Staff #120 indicated that they attempted interventions in place but were ineffective. A review of the written plan of care in place for resident #007, identified that they had a continence assessment. A review of the most recent Minimum Data Set (MDS) assessment , indicated that the resident had a continence assessment. In an interview with the RAI-Coordinator, they reviewed the MDS assessment, and acknowledged that resident #007 had a decline in their health status and that the continence assessment had changed and their written plan of care should have been updated to reflect the change. In an interview with staff #113, they identified that resident #007 continence had changed. Staff #113 reviewed the resident's written plan of care upon request by Inspector #683 and acknowledged that it needed to be updated. The home did not ensure that resident #007's written plan of care was revised when their continence status changed. [s. 6. (10) (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 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; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed to respond to these behaviours, where possible.

Inspector #683 observed resident #007 with responsive behaviours. Staff #120 indicated that they attempted interventions in place but were ineffective. Inspector #683 called the for assistance. Staff #120 remained standing at their medication cart. A review of the clinical record for resident #007 indicated that they had a cognitive deficit. Their most recent Minimum Data Set (MDS) assessment, indicated that they demonstrated

behavioural symptoms and that the behaviour was not easily altered.

A review of the progress notes for resident #007 identified that they had a history of responsive behaviours, which was documented on identified dates. Resident #007's written plan of care identified that they demonstrated behaviours. Interventions were in in place to respond to some of the resident's behaviours. In interviews with staff #100, staff #113, staff #120, staff #121 and the RAI-Coordinator, they indicated that the resident was known to have responsive behaviours. In an interview with the RAI-Coordinator , they acknowledged that not all behaviours were identified in their plan of care. The home did not ensure that strategies were developed for resident #007's known behaviour. [s. 53. (4) (b)]

2. A CI was submitted to Director.

A clinical record review indicated that resident #001 had a known history of cognitive deficit. A review of resident's #001 care plan identified that resident #001 had responsive behaviours with interventions. A clinical record review included progress notes that resident #001 was exhibiting responsive behaviours. A review of investigative notes identified that staff #100 met with the Director of Care (DOC) #126 after the incident and informed them of the responsive behaviours. During an interview, staff #100 confirmed that they had worked on identified dates and that resident #001 had responsive behaviours throughout the shift. Staff #100 acknowledged that resident #001 had a history of responsive behaviours and that they did not implement strategies in the resident's plan of care. During an interview staff #118 stated that they observed resident #001 responsive behaviours. Staff #116 also confirmed that when staff #100 left the care area, resident #001 had no further incidents. During an interview, the ED confirmed that staff #100 did not implement strategies in response to resident's #001 known responsive behaviour. The ED confirmed that staff #100 was no longer assigned to care for resident #001. The home did not ensure that when resident #001 was demonstrating responsive behaviours, strategies were developed or implemented to respond to their behaviours. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

Issued on this 21st day of October, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AILEEN GRABA (682), LISA BOS (683)
Inspection No. / No de l'inspection :	2019_704682_0028
Log No. / No de registre :	014937-19, 016980-19, 017241-19, 018271-19, 018398-19, 019254-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 21, 2019
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	West Park Health Centre 103 Pelham Road, St. Catharines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sharon Darby

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 CVH (No. 1) LP, 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) (b)

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 LTCHA, 2007.

The licensee shall prepare, submit and implement a plan to ensure that resident #006, and any other resident are protected from abuse by resident #002. The plan must include, but is not limited, to the following:

a) A description of the interventions that will be implemented to ensure that resident #006 and any other resident are protected from physical abuse by resident #002.

b) A description of the training and education that will occur related to the physical responsive behaviours demonstrated by resident #002 for all staff having contact with the resident. Identify who will be responsible for providing the education, and the dates the training will occur.

Please submit the written plan for achieving compliance for inspection 2019_704682_0028 to Aileen Graba, LTC Homes Inspector, MOLTC, by email to HamiltonSAO.moh@ontario.ca by November 5, 2019.

Please ensure that the submitted written plan does not contain any personal information/ personal health information (PI/PHI).

Grounds / Motifs :

1. 1. A) The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director.

A review of the CI report identified that responsive behaviours was documented for resident #002 on identified dates. A CI report was also submitted to the Director on an identified date, related to an incident by resident #002 to a co-resident. A review of the clinical record for resident #002 indicated that they had a cognitive deficit and responsive behaviours. As per the written plan of care, the resident had interventions to prevent any further behavioural incidents, some of which was discontinued on a identified date. A review of the electronic record for resident #006 indicated that they demonstrated behaviours. In an interview with resident #002, they stated that they deal with their problems. Resident #002 recalled having an altercation with resident #006 On an identified date, resident #002 pointed out resident #006 to Inspector #683 and indicated that they were supposed to stay away from them. In an interview with staff #120, they indicated they observed the altercation between resident #002 and resident #006. In an interview with the Executive Director (ED), they acknowledged that resident #006 was not protected from abuse by anyone.

B) A Critical Incident (CI) report was submitted to the Director, resident #005 had an altercation with resident #002.

The CI report indicated that resident #005 sustained an injury. A review of the clinical record for resident #002 indicated that they had a cognitive deficit with a history of responsive behaviours, documented on identified dates. A review of the clinical record for resident #005 indicated that they had a cognitive deficit. Their written plan of care indicated that they had a history of responsive behaviours. Resident #005's clinical record was reviewed and a progress note indicated that resident #005 had an altercation with resident #002. The progress note further identified that both residents were having altercations prior to this event. A progress note and assessment , indicated that resident #005 had sustained an injury. On an identified date, the physician documented that they assessed resident #005 related to the injury and ordered medical intervention. The ED confirmed that an injury was identified with resident #005, and they acknowledged that the injury was believed to be from the altercation. The home did not ensure that resident #005 was protected from abuse abuse by anyone [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual

harm to the residents. The scope of the issue was a level 2 as it was related to two of three residents reviewed. The home had a level 3 compliance history as they had one or more non-compliances, one of which was the same subsection that included:

• written notification (WN) issued May 30, 2019 (2019_575214_0016);
• WN issued February 12, 2019 (2019_743536_0004);
• compliance order (CO) #002 issued December 13, 2018, with a compliance due date of May 28, 2019 (2018_575214_0013);
• Voluntary plan of correction (VPC) issued August 21, 2017 (2017_575214_0010).

(683)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 14, 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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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 21st day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Aileen Graba

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