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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Jan 31, 2019	2019_705109_0001	011951-18, 028282-18, 030694-18, 033154-18	Complaint

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 Humber Heights
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

SUSAN SQUIRES (109), ANGIE KING (6445)

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): Janurary 15, 16, 17, 18, 21, 22, 23, 24, 25, 2019

The following intakes were inspected during this Complaint Inspection:
Log # 011951-18 related to alleged abuse and falls.
Log # 033154-18 related to skin and wound care.
Log # 028282-18 related to RQI follow up to compliance order #001.
Log # 030694-18 related to RQI follow up to compliance order #002.

During the course of the inspection, the inspector(s) spoke with Acting Assistant General Manager, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Support Lead (BSO), Neighbourhood Coordinator, Physiotherapist (PT), Kinesiologist, Nurse Practitioner (NP), Assistant Director of Care (ADOC), residents, and family members.

During the course of the inspection the inspectors(s) conducted health record reviews, observed the care activities, reviewed applicable policies, and reviewed staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
1 VPC(s)
1 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
O.Reg 79/10 s. 36.	CO #001	2018_484646_0004	109

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

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

Findings/Faits saillants :

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

The Ministry of Health and Long-term Care (MOHLTC) issued a compliance order #2018_484646_0004 to the home on June 5, 2018, due to unsafe use of transferring devices and techniques for resident #008. During the course of the inspection and review of the records including the plan of care, non-compliance was identified related to the written plan of care.

Review of the plan of care for a specified date, for resident #008 stated that the resident required a specified lift and transfer technique with two team members to assist. It also stated in the same plan of care, that they must use a third person to assist. The home used a documentation system called "point of care" which included computer tablets with information for the staff to follow in implementing the plan of care. PSW #129 showed the inspector the point of care documentation program on the tablet for resident #008. The direction to the staff indicated that two staff, not three staff, are required to assist resident the the lift and transfer technique.

Review of an assessment, stated that resident #008 required extensive assistance of “2+ staff” for the specified lift and transfer technique.

During an interview, PSW #129 told the inspector that they do not use three persons to transfer resident #008 because it is difficult to find a third person when there are only two PSW's on that wing. They would ask a third person if the resident was being really challenging otherwise resident #008 was always transferred by two staff members. PSW #129 was not aware of the plan of care directing the staff to have three persons present for all transfers.

Observation of the lift and transfer of resident #008 showed that two staff members transferred resident #008 to the bed. The bedside lift logo showed two staff to be participating in the care activity.

This finding was reviewed with the Acting Assistant General Manager #101. Based on the lack of clarity in the plan of care for resident #008 providing unclear direction for the front line staff, this finding is warranted. [s. 6. (1) (c)]

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

A complaint was received at the Ministry of Health and Long-term Care from the family member of resident #003 regarding the home not providing adequate care.

Record review for the specified time frame, of the progress notes, medication records, and pain assessment tools indicated that resident #003 experienced significant pain.

Review of the physician's orders indicated that on a specified date, the home's physician had ordered a referral to the Geriatrician. The referral was not faxed until 12 days later. When the inspector asked RN #104 about the referral they contacted the Geriatrician's office and was informed that they had not received this referral and therefore no appointment had been made. RN #104 stated that someone should have followed up on this referral to ensure that an appointment was made.

Review of an email communication between resident #003's family member and ADOC #114 on a specified date, indicated that the home had applied for external consult and program to come in and assess the resident. ADOC #114 responded to the email and informed the family member that the resident was not eligible for this program.

Record review of the progress notes indicated that resident #003 returned to the home from the hospital. Review of specified assessments which were conducted every three

hours showed that the resident continued to experience pain since returning to the home.

During an interview on at the tine of the inspection, ADOC #114 confirmed the email communication, and also noted that the resident is now on eligible for the program. When asked by inspector if they had contacted the external consult and program about the resident now that the resident is eligible, ADOC #114 indicated that they had not contacted them as of yet.

This finding was reviewed with the Acting Assistant General Manager #101. Based upon this information of the home failing to follow through on the physician's order to have resident #003 examined by a specialist until it was inquired upon by the inspector, and the resident's ongoing uncontrolled pain, this non-compliance is warranted.   Further to this, with respect to the external consult and program, the home did not follow up on their plan of care to engage this team to help manage the pain for resident #003. [s. 6. (7)]

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and   O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

In accordance with O.Reg. 79/10, s. 53(2) the licensee is required to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The home uses a pain assessment tool as part of their electronic documentation system. The tool is called the PAINAD Extension-SV. According to the home's policy entitled "Pain Management Program", the procedure for completion and documentation of the pain assessment is done on several different occasions including quarterly – any level of pain should be assessed or with significant change of status, or where a resident is on analgesics. The policy also indicated that pain assessments were to be completed at a minimum of weekly when a scheduled pain medication does not relieve the pain and pain remains regardless of the support strategies.

There is inconsistency across the units in the home related to when and how often the homes pain assessment tool is implemented by the staff.

Review of current records including the plan of care, assessments, medication records, and progress notes identified resident #004 had chronic pain which required scheduled narcotic analgesics. The last PAINAD Extension-sv had not been completed for over five months at the time of the inspection.

During an interview, resident #004 told the inspector that they felt pain every day.

Interview with RPN #106 indicated resident #004 had chronic pain which required scheduled narcotic analgesic. When asked where the pain assessments were located, RPN #106 stated that there had not been an assessment completed on the home's assessment tool for over five months.

Review of current records including the plan of care, assessments, medication records, and progress notes identified resident #005 had chronic pain which required scheduled narcotic analgesics. The last PAINAD Extension-sv had not been completed for over four months.

Interview with RPN #115 indicated resident #005 had chronic pain which required scheduled narcotic analgesic. When asked where the pain assessments were located, RPN #115 stated that there had not been an assessment completed on the home's assessment tool for four months and added that there should have been an assessment

conducted since this date.

During an interview the Acting Assistant General Manager #101 told the inspector that the staff are required to conduct pain assessments using the homes clinically appropriate assessment tool as outlined in the policy. For residents who have chronic pain, assessments should be done at least on a quarterly basis.

Based on the finding that resident #004 and #005 both had daily narcotic analgesics for pain control, and the homes expectation that the staff will follow their policy related to completing pain assessments, this finding is warranted. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The LTCH submitted a CIS report to the MOHLTC regarding an incident which occurred on a specified date. The report indicated that resident #001 was pushed by resident #037, fell and sustained an injury. The report indicated that it was alleged resident to resident abuse.

Review of the homes Code of Conduct Policy, Subject: Investigation Process for Suspected Resident to Resident Abuse, Procedure #11 stated Charge Nurse or leadership team member to begin investigation immediately. All witnesses must be interviewed, and the facts documented. An Internal Incident Form must be completed. Further review of the homes Code of Conduct Policy, the Investigation process for suspected resident to resident abuse, Human Resources Tab 04-06A Policy number four stated abusive acts will be documented and reported to appropriate authorities and will be monitored by the neighborhood team.

During an interview the Acting Assistant General Manager #101 told the inspector that the appropriate authorities were not notified as per the home's policy. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported was immediately investigated.

The LTCH submitted a CIS report to the MOHLTC regarding an incident which occurred on a specified date. The report indicated that resident #001 was pushed by resident #037, fell and sustained an injury. The report indicated that it was alleged resident to resident abuse.

As per legislation, O. Reg., 79/10, subject to subsection 2 (1) of the Act, it defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Review of the home's internal Incident Report SV 1-V1 on the date of the incident, for resident #037 indicated they pushed resident #001 to the floor which was witnessed by PSW #120.

During an interview RN #119 told the inspector that they did not recall the incident between resident #001 and resident #037.

During an interview the Acting Assistant General Manager #101 told the inspector that they had not investigated the alleged abuse which occurred between residents #001 and #037.

This non-compliance was discussed with the Acting Assistant General Manger #101. Based on the finding that the home did not conduct any investigation into the allegation of physical abuse this finding is warranted. Sample expansion did not find any further non-compliance related to this finding. [s. 23. (1) (a)]

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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) :	SUSAN SQUIRES (109), ANGIE KING (6445)
Inspection No. / No de l'inspection :	2019_705109_0001
Log No. / No de registre :	011951-18, 028282-18, 030694-18, 033154-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 31, 2019
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 Humber Heights 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pauline Dell'Oso

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

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_484646_0004, CO #002;

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 will be compliant with s. 6(7).
Specifically the licensee will ensure that resident #003 and any resident with chronic pain receives care as ordered by the physician and as specified in the plan.

Grounds / Motifs :

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

A complaint was received at the Ministry of Health and Long-term Care from the family member of resident #003 regarding the home not providing adequate care.

Record review for the specified time frame, of the progress notes, medication records, and pain assessment tools indicated that resident #003 experienced significant pain.

Review of the physician's orders indicated that on a specified date, the home's physician had ordered a referral to the Geriatrician. The referral was not faxed until 12 days later. When the inspector asked RN #104 about the referral they contacted the Geriatrician's office and was informed that they had not received this referral and therefore no appointment had been made. RN #104 stated that someone should have followed up on this referral to ensure that an appointment was made.

Review of an email communication between resident #003's family member and ADOC #114 on a specified date, indicated that the home had applied for external consult and program to come in and assess the resident. ADOC #114 responded to the email and informed the family member that the resident was not eligible for this program.

Record review of the progress notes indicated that resident #003 returned to the home from the hospital. Review of specified assessments which were conducted every three hours showed that the resident continued to experience pain since returning to the home.

During an interview on at the tine of the inspection, ADOC #114 confirmed the email communication, and also noted that the resident is now on eligible for the program. When asked by inspector if they had contacted the external consult and program about the resident now that the resident is eligible, ADOC #114 indicated that they had not contacted them as of yet.

This finding was reviewed with the Acting Assistant General Manager #101. Based upon this information of the home failing to follow through on the physician's order to have resident #003 examined by a specialist until it was inquired upon by the inspector, and the resident's ongoing uncontrolled pain, this non-compliance is warranted. Further to this, with respect to the external consult and program, the home did not follow up on their plan of care to engage this team to help manage the pain for resident #003. [s. 6. (7)]

The severity of this order is a level three as there was actual harm to the resident experiencing chronic pain. The scope is level one as there was only one resident affected. The compliance history is a level four which is ongoing non-compliance despite previous action taken by Ministry as follows:

• Compliance Order (CO) issued June 5, 2018 (2018_484646_0004)
• Voluntary plan of correction (VPC) issued on September 5, 2018 (2018_526645_0010)
• Voluntary plan of correction (VPC) issued on June 20, 2017 (2017_637500_0007).

(109)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2019

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 31st day of January, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SUSAN SQUIRES

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