Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 17, 2016;	2016_378116_0006 (A2)	001506-16/025563-15	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - VAUGHAN
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

SARAN DANIEL-DODD (116) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

As per the licensee request, the compliance date was extended from June 22, 2016 to June 29, 2016.

Issued on this 22 day of June 2016 (A2)

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

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

SARAN DANIEL-DODD (116) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 12, 16, 17, 18, 19 & March 3, 4, 7, 8, 9, 2016.

Inspector #116 attended the home to conduct a complaint inspection related to discharge of resident #001. During the course of the inspection the inspector observed staff to resident interactions and meal service. The following were reviewed: resident #001's health record.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), recreation manager, housekeeping staff, manager(s), placement facilitator and specialized nurse from an identified organization, social workers at an identified health service organization and substitute decision-maker(s) for resident #001.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Falls Prevention

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

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that before a resident is discharged, notice of the discharge was given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct, as far in advance of the discharge as possible or if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge.

Resident #001 was admitted to the home with identified medical diagnoses.

Review of the progress notes indicates that on an identified date, resident #001 was transferred to the hospital for further assessment due to a change in condition. Review of the resident's progress notes revealed and interview with the Executive Director confirmed that the home began to consider discharge as an option for the resident three months prior, and subsequently made the decision to discharge the resident. On an identified date, the licensee provided a notice of discharge to the resident's substitute decision-maker(s). The E.D. confirmed that resident #001 is his/her own POA however; the licensee did not provide a notice of discharge to the resident and is unaware whether the resident has been informed of the discharge. The licensee did not provide a notice of discharge to resident #001. The licensee did not provide a notice of discharge to resident #001's SDMs in advance of the discharge.
The E.D. stated that prior to the discharge, the home made several requests over an identified period, to meet with the SDMs to discuss specific changes within the resident's condition and to discuss next steps. The requests to meet were declined. Although previous attempts to discuss next steps with the SDMs were unsuccessful, there were no circumstances to make it impossible to provide notice as far in advance as possible before the discharge. [s. 148. (1) (b)]

2. Before the licensee purported to discharge resident #001 under subsection 145(1), the licensee failed to: (b) collaborate with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

A critical incident report was submitted to the Ministry of Health and Long Term Care indicating that resident #001 was discharged from the home on an identified date.

Inspector #116 reviewed resident #001's health care record. The progress notes indicated that on an identified date, resident #001 was transferred to the hospital for further assessment. On an identified date, the licensee contacted an appropriate placement coordinator to inform them of their intent to discharge the resident.
During an interview, the E.D. informed inspector #116 that the home considered

the identified health service organization as an alternate arrangement for accommodation as resident #001 was admitted to the health service organization at the time of discharge and provides a specialized environment. An interview with the Executive Director confirmed that the licensee's decision to discharge the resident was made on a specified date.

The inspector interviewed a manager from the appropriate placement coordinator and inquired whether the identified health service organization would be defined as alternate accommodation. The manager stated that the definition is broad however, in this case it would be anywhere other than the LTC home. The inspector further inquired whether the placement coordinator considers the identified health service organization as permanent alternate accommodation for an individual to reside in the event of discharge from a long term care facility. The manager indicated that the purpose of the identified health service organization is to receive treatment and to be stabilized but it is never to be considered as a permanent residence.

Inspector #116 spoke with the specialized nurse who informed the inspector that the identified health service organization is considered as a discharge point but not as a permanent end point as it is a mechanism to stabilize a resident in order to return back into the community or a residential setting. Review of the resident's health record and further interview with the identified nurse confirmed that different options were suggested for the licensee to take into consideration prior to discharge however, the licensee's final decision was to discharge the resident. Furthermore, both parties confirmed that the appropriate placement coordinator does not consider the identified health service organization as a permanent alternative arrangement for the accommodation, care and secure environment required by the resident.

Interviews held with the resident's SDMs relayed that the wish of both the resident and the SDMs is for the resident to remain at the home.
Inspector #116 reviewed a copy of the discharge letter. The notice of discharge does not provide details of the supporting facts or a reason as they relate to the resident's current condition and care needs. Further interview with the E.D. and the DOC confirmed that the written notice of discharge is unclear and does not set out a detailed explanation of the supporting facts, as they relate both to the home and to resident #001's condition and requirements for care that justify the licensee's decision to discharge the resident.

Therefore, the home failed to collaborate with the appropriate placement coordinator to make alternative arrangements for the accommodation, care and secure environment required by the resident, and failed to provide a written notice to the resident and resident's SDMs setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Despite the scope of this issue being isolated to one resident and the home not having any previous non compliance under O.Reg.79/10, s. 148(2), the decision to issue the compliance order was based on the severity of, the risk or potential for actual harm to resident #001.

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

Issued on this 22 day of June 2016 (A2)

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAN DANIEL-DODD (116) - (A2)

Inspection No. / No de l'inspection : 2016_378116_0006 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 001506-16/025563-15 (A2)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 17, 2016;(A2)

Licensee / Titulaire de permis : 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

LTC Home / Foyer de SLD : LEISUREWORLD CAREGIVING CENTRE - VAUGHAN
5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

Ontario

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kerri Judge

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To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Order / Ordre :

(A2)
In the case of resident #001, the licensee shall:
1) Return resident #001, if the resident so chooses, into the same class of accommodation, the same room, and the same bed in the room that the resident had prior to discharge as if the placement coordinator authorized admission to the home on the date the resident returns to the home, and provide care and services as per the resident's assessed needs.
2) Collaborate with the current health service organization where resident #001 currently resides to ensure that care and services as per the resident's assessed needs is provided.

The licensee shall also ensure that in the case of resident #001, if the resident is to be discharged in the future, that the following are met prior to discharge:

3) Collaboration with the appropriate placement co-ordinator and other health service organizations, and that alternative arrangements for the continuing accommodation, care and secure environment required by the resident are made.

4) A written notice is provided to the resident and the resident's SDMs, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge resident #001.

Grounds / Motifs :

1. The licensee has failed to ensure that before a resident is discharged, notice of the discharge was given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct, as far in advance of the discharge as possible or if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge.

Resident #001 was admitted to the home with identified medical diagnoses. Review of the progress notes indicates that on an identified date, resident #001 was transferred to the hospital for further assessment due to a change in condition. Review of the resident's progress notes revealed and interview with the Executive Director confirmed that the home began to consider discharge as an option for the resident three months prior, and subsequently made the decision to discharge the resident. On an identified date, the licensee provided a notice of discharge to the resident's substitute decision-maker(s). The E.D. confirmed that resident #001 is his/her own POA however; the licensee did not provide a notice of discharge to the resident and is unaware whether the resident has been informed of the discharge. The licensee did not provide a notice of discharge to resident #001. The licensee did not provide a notice of discharge to resident #001's SDMs in advance of the discharge.
The E.D. stated that prior to the discharge, the home made several requests over an identified period, to meet with the SDMs to discuss specific changes within the resident's condition and to discuss next steps. The requests to meet were declined. Although previous attempts to discuss next steps with the SDMs were unsuccessful, there were no circumstances to make it impossible to provide notice as far in advance as possible before the discharge. [s. 148. (1) (b)]

(116)

(A1)
2. Before the licensee purported to discharge resident #001 under subsection 145(1), the licensee failed to: (b) collaborate with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition

and requirements for care, that justify the licensee's decision to discharge the resident.

A critical incident report was submitted to the Ministry of Health and Long Term Care indicating that resident #001 was discharged from the home on an identified date.

Inspector #116 reviewed resident #001's health care record. The progress notes indicated that on an identified date, resident #001 was transferred to the hospital for further assessment due to a change in condition. On an identified date, the licensee contacted the appropriate placement coordinator to inform them of their intent to discharge the resident. Interviews held with a manager of the appropriate placement coordinator and a speciality nurse contradicted with the E.D. regarding alternate accommodation for the resident. The manager at the appropriate placement coordinator and the specialty nurse indicated that during the interdisciplinary meeting on an identified date, they were informed by the licensee that the resident currently was an in-patient at an identified health service organization. During an interview, the E.D. informed inspector #116 that the home considered the identified health service organization as an alternate arrangement for accommodation as resident #001 was admitted to the identified health service organization at the time of discharge and provides a specialized environment.

An interview with the Executive Director confirmed that the licensee's decision to discharge the resident was made on an identified date. The inspector interviewed a manager from the appropriate placement coordinator and inquired whether the identified health service organization would be defined as alternate accommodation. The manager stated that the definition is broad however, in this case it would be anywhere other than the LTC home. The inspector further inquired whether the placement coordinator considers the identified health service organization as permanent alternate accommodation for an individual to reside in the event of discharge from a long term care facility. The manager indicated that the purpose of the identified health service organization is to receive treatment and to be stabilized but it is never to be considered as a permanent residence. Inspector #116 spoke with the specialized nurse who informed the inspector that the identified health service organization is considered as a discharge point but not as a permanent end point as it is a mechanism to stabilize a resident in order to return back into the community or a residential setting. Review of the resident's health record and further interview with the identified nurse confirmed that different options were suggested for the licensee to take into consideration prior to discharge however, the licensee's final decision was to discharge the resident. Furthermore, both parties confirmed that the appropriate placement coordinator does not consider the identified health service organization as a permanent alternative arrangement for the accommodation, care

and secure environment required by the resident. Interviews held with the resident's SDMs relayed that the wish of both the resident and the SDMs is for the resident to remain at the home where his mother resides.
Inspector #116 reviewed a copy of the discharge letter. The notice of discharge does not provide details of the supporting facts or a reason as they relate to the resident's current condition and care needs. Further interview with the E.D. and the DOC confirmed that the written notice of discharge is unclear and does not set out a detailed explanation of the supporting facts, as they relate both to the home and to resident #001's condition and requirements for care that justify the licensee's decision to discharge the resident.

On an identified date, inspector #109 spoke with a staff member at an identified health service organization who revealed that on a specified date, resident #001 was ready for discharge. The interview held with the staff member revealed and record review on an identified date confirmed that the DOC at the LTCH home was made aware that resident #001 was ready to be returned to the LTC home. The DOC stated that the resident was already discharged because the home cannot manage the required care. The DOC stated that they would have a discussion with the team and communicate with the staff member by a disclosed date. As of an identified date, resident #001 remained at the identified health service organization.

Therefore, the home failed to collaborate with the appropriate placement co-ordinator and other health service organizations and make alternative arrangements for the accommodation, care and secure environment required by the resident, and to provide a written notice to the resident and resident's SDMs setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Further, as the identified leave of absence ended on an identified date, which is prior to the identified allotment specified within the Regulations, resident #001 was never discharged. Resident #001 remains a resident at the LTC home. The resident is not required to apply for re-admission to the home, and resident #001 is not required to pay the co-payment from an identified date, as the discharge was not done in accordance with the requirements in the Regulation and since the purported discharge, the licensee improperly refused to allow the resident to return to the home in the same class of accommodation, same room and same bed in the room that the resident had.

Despite the scope of this issue being isolated to one resident and the home not having any previous non compliance under O.Reg.79/10, s. 148(2), the decision to issue the compliance order was based on the severity of, the risk or potential for actual harm to resident #001.

(116)

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

Jun 29, 2016(A2)

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 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 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22 day of June 2016 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN DANIEL-DODD - (A2)

Service Area Office /
Bureau régional de services : Toronto