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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2013	2013_159178_0003	T-0033-13	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 - LAWRENCE
2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4

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

SUSAN LUI (178)

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): January 28, 29, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Staff, Personal Support Workers.

During the course of the inspection, the inspector(s) observed resident care, reviewed resident records, reviewed home training records and policies.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Hospitalization and Death

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
Staff interviews and review of home and resident records confirm that staff did not use safe transferring techniques when assisting Resident # 1 to transfer from his/her wheelchair to bed on an identified date.
The resident was being transferred from wheelchair to bed using a hoyer mechanical lift.
The first staff member applied the lift sling to the resident, but did not ensure that the sling was properly attached to the lift.
Two staff members were present in the room during the transfer, but the second staff member was near the door of the room, and out of reach of the resident when the first staff member began operating the mechanical lift.
The two staff members participating in the mechanical lift transfer were participating in an unrelated discussion at the time of the lift.
When the first staff member began to operate the lift, lifting the resident out of the wheelchair, the upper strap of the sling came off of the lift, thereby tilting the resident and allowing the resident's head to strike the arm of the wheelchair.
The resident suffered a laceration to the left ear, and some hematoma to the left side of his/her head. The resident was sent to hospital by ambulance, and was diagnosed with an acute subarachnoid hemorrhage.
The resident returned to the home with a recommendation for palliative care. The resident expired three days later. The cause of death was determined by the coroner to be subarrachnoid hemorrhage as a consequence of a fall and head injury. [s. 36.]

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. 76. Training

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Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff of the home are trained in the safe and correct use of equipment relevant to the staff member's responsibilities, including mechanical lifts, before performing their responsibilities, as required in O.Reg. 79/10 s. 218.2.

Staff interviews and employee record review revealed that at least one identified direct care staff member was not orientated or trained in the use of mechanical lifts before performing her responsibilities.
This staff member was later involved in an incident involving a mechanical lift, in which a resident was seriously injured and subsequently died as a result of the injuries. [s. 76. (2) 11.]

2. The licensee has failed to ensure that all staff who provide direct care to residents are provided with training related to safe and correct use of equipment relevant to the staff member's responsibilities, including mechanical lifts, on either an annual basis, or based on the individual staff member's assessed training needs, as required in O.Reg. 79/10, s. 218.2 and s. 219(1).

Staff interviews and review of home training records indicate that during 2012 only 83 out of 227 direct care staff received retraining in the safe and correct use of mechanical lifts. [s. 76. (4)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for Resident # 1 sets out clear directions to staff and others who provide direct care to the resident.
Staff interviews and record review confirm that the written plan of care for Resident # 1 for transferring states that the resident requires the use of a hoyer lift with the assistance of two staff members to transfer, but does not indicate what size of sling should be used when transferring this resident via hoyer lift.
Various direct care staff, registered staff and management staff were unable to confirm which size of sling this resident requires for use with the hoyer lift. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for Resident # 2 sets out clear directions to staff and others who provide direct care to the resident.
Staff interviews and record review confirm that the plan of care for Resident # 2 for transferring states that the resident is to be transferred to and from bed using a mechanical hoyer lift with the assistance of two staff members. However, the plan of care does not state what size of sling should be used for this resident with the mechanical hoyer lift. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care for Resident # 3 sets out clear directions to staff and others who provide direct care to the resident.
Staff interviews and record review confirm that Resident # 3 requires the use of a mechanical ceiling lift and two staff assistance for all transfers. However, the plan of care for this resident does not state what size of sling should be used for this resident with the mechanical ceiling lift. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plans of care for all residents sets out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director

setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director under the Long Term Care Homes Act (LTCHA) immediately, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.
Resident # 1 expired on an identified date. The cause of death was determined by a coroner to be a subarachnoid hemorrhage as a consequence of a fall and head injury. The resident sustained the head injury in the long term care home nine days prior to his/her death, while being transferred using a mechanical lift. [s. 107. (1)]

2. The licensee failed to inform the Director under the LTCHA no later than one business day after the occurrence of the incident of an injury in respect of which a person is taken to hospital.
On an identified date, Resident # 1 sustained a lacerated ear and subarachnoid hemorrhage as a result of a fall from a mechanical lift while being transferred from wheelchair to bed. The resident was transported to hospital and remained there for six days, and then returned to the home. The home did not inform the Director under the LTCHA of the incident until ten days after the incident occurred, after the resident had expired as a result of his/her injuries. The home then notified the Director of the initial incident, but failed to inform the Director of the fact that the resident had expired. [s. 107. (3)]

3. The written report informing the Director under the LTCHA of the incident resulting in Resident # 1 being sent and admitted to hospital, failed to include the outcome or current status of the individual involved in the incident.
Resident # 1 died as a result of injuries sustained in the incident when the resident fell and hit his/her head during a transfer with a mechanical lift. The written report which the home submitted informing the Director of the incident failed to include the fact that the resident had died. [s. 107. (4) 3.]

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 28th day of February, 2013

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

Susan Lin (178)

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178)
Inspection No. / No de l'inspection :	2013_159178_0003
Log No. / Registre no:	T-0033-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 7, 2013
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 - LAWRENCE 2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HYACINTH DALEY ~~MARLENE VAN HAM (ACTING)~~

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

Ministére 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

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:

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

Ministére 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

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare and implement a plan to ensure that staff use safe transferring techniques when using mechanical lifts to assist residents.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
Staff interviews and review of home and resident records confirm that staff did not use safe transferring techniques when assisting Resident # 1 to transfer from his/her wheelchair to bed on an identified date.
The resident was being transferred from wheelchair to bed using a hoyer mechanical lift.
The first staff member applied the lift sling to the resident, but did not ensure that the sling was properly attached to the lift. Two staff members were present in the room during the transfer, but the second staff member was near the door of the room, and out of reach of the resident when the first staff member began operating the mechanical lift. The two staff members participating in the mechanical lift transfer were participating in an unrelated discussion at the time of the lift. When the first staff member began to operate the lift, lifting the resident out of the wheelchair, the upper strap of the sling slipped off of the lift, thereby tilting the resident and allowing the resident's head to strike the arm of the wheelchair.
The resident suffered a laceration to the left ear, and some hematoma to the left side of his/her head. The resident was sent to hospital by ambulance, and diagnosed with an acute subarachnoid hemorrhage.
The resident returned to the home with a recommendation for palliative care.
The resident expired three days later. The cause of death was determined by the coroner to be subarrachnoid hemorrhage as a consequence of a fall and head injury. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2013

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

Ministére 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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee shall prepare and implement a plan to ensure that all direct care staff receive training related to safe and correct use of mechanical lifts, on either an annual basis, or based on the individual staff member's assessed training needs, as required in O.Reg. 79/10, s. 218. 2 and s. 219(1).

Grounds / Motifs :

1. The licensee has failed to ensure that all staff who provide direct care to residents are provided with training related to safe and correct use of equipment relevant to the staff member's responsibilities, including mechanical lifts, on either an annual basis, or based on the individual staff member's assessed training needs, as required in O.Reg. 79/10, s. 218.2 and s. 219(1).

Staff interviews and review of home training records indicate that during 2012 only 83 out of 227 direct care staff received retraining in the safe and correct use of mechanical lifts.
An identified staff member who did not receive training related to the safe and correct use of mechanical lifts in 2012 was involved in an incident in which a resident was seriously injured during a transfer with a mechanical lift. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2013

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

Ministére 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

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall prepare and implement a plan to ensure that all direct care staff are trained in the safe and correct use of equipment relevant to the staff member's responsibilities, including mechanical lifts, before performing their responsibilities, as required in O.Reg. 79/10 s. 218.2.

Grounds / Motifs :

1. The licensee has failed to ensure that all direct care staff of the home are trained in the safe and correct use of equipment relevant to the staff member's responsibilities, including mechanical lifts, before performing their responsibilities, as required in O.Reg. 79/10 s. 218.2.

Staff interviews and record review revealed that at least one identified direct care staff member was not orientated or trained in the use of mechanical lifts before performing her responsibilities.
This staff member was later involved in an incident involving a mechanical lift, in which a resident was seriously injured and subsequently died as a result of the injuries. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2013

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
Performance Improvement and Compliance 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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.

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

Ministére 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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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 7th day of February, 2013

Signature of Inspector / Signature de l'inspecteur : Susan Lui (178)

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

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